HSTA VOLUNTARY EMPLOYEES BENEFICIARY ASSOCIATION TRUST

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March 2023

TO: All Participants

RE: SUMMARY OF MATERIAL MODIFICATIONS
METROPOLITAN LIFE CRITICAL ILLNESS INSURANCE

This notice is a Summary of Material Modifications describing important changes to the HSTA Voluntary Employees Beneficiary Association Trust Voluntary Benefits coverage and amends the Plan booklet dated May 2019 previously distributed to you. **Please read this notice carefully as it may impact your current benefit coverage.** Please keep this notice with your Plan booklet for future reference.

***This Summary of Material Modifications does not replace or supersede the plan documents (e.g., insurance contract, policy, or certificate) that govern eligibility or benefits under the Critical Illness Insurance Plan. In the case of any conflict or inconsistency between this summary and the plan documents, the plan documents will govern*.**

Effective May 1, 2022, the following changes have been made to the MetLife Critical Illness Insurance Plan described on pages 23-30 of the Plan booklet dated May 2019:

1. Page 23: WHO IS ELIGIBLE? The eligibility criteria for enrolling in the plan include a minimum work requirement of 17.5 hours per week. All Active and Associate HSTA Members and regularly scheduled employees of the Hawaii State Teachers Association working at least 17.5 hours per week are eligible to apply for coverage.

2. Page 23: TOTAL BENEFIT AMOUNT. The plan maximum of 300% of the Benefit Amount elected is eliminated. There is no lifetime dollar benefit maximum for benefits paid under this plan for covered conditions. However, benefits for most covered conditions are limited to one time per covered person.

3. Pages 24-26: COVERED CONDITIONS. The schedule of covered conditions and benefit amounts is as follows.

SCHEDULE OF INSURANCE

COVERED CONDITION	INITIAL BENEFIT	RECURRENCE BENEFIT
Benign Brain Tumor	100% of Benefit Amount	100% of Initial Benefit Amount
Cancer		
Invasive Cancer	100% of Benefit Amount	100% of Initial Benefit Amount
Non-Invasive Cancer	25% of Benefit Amount	100% of Initial Benefit Amount
Skin Cancer	5% of Benefit Amount, but not less than $250	None
Cardiovascular Disease treated with Coronary Artery Bypass Graft	100% of Benefit Amount	100% of Initial Benefit Amount
Childhood Disease	100% of Benefit Amount	None
Cerebral palsy Cleft lip or cleft palate Cystic fibrosis Diabetes (type 1) Down syndrome Sickle cell anemia Spina bifida		
Functional Loss		
Coma	100% of Benefit Amount	100% of Initial Benefit Amount
Loss of ability to speak, hearing or sight	100% of Benefit Amount	None
Paralysis of two or more limbs	100% of Benefit Amount	None
Heart Attack		
Heart Attack	100% of Benefit Amount	100% of Initial Benefit Amount
Sudden cardiac arrest	100% of Benefit Amount	None
Infectious Disease		
Bacterial cerebrospinal meningitis COVID-19 Diphtheria Encephalitis	25% of Benefit Amount	None
Legionnaire's disease Lyme disease Malaria Necrotizing fasciitis Osteomyelitis Rabies Tetanus Tuberculosis	100% of Benefit Amount	None

SCHEDULE OF INSURANCE

COVERED CONDITION	INITIAL BENEFIT	RECURRENCE BENEFIT
Kidney Failure	100% of Benefit Amount	None
Major Organ Transplant	100% of Benefit Amount	None
Progressive Disease	100% of Benefit Amount	None
Addison's disease ALS Alzheimer's disease Huntington's disease Multiple sclerosis Muscular dystrophy Myasthenia gravis Parkinson's disease (advanced) Poliomyelitis Systemic lupus erythematosus (SLE) Systemic sclerosis (scleroderma)		
Severe Burn	100% of Benefit Amount	100% of Initial Benefit Amount
Stroke	100% of Benefit Amount	100% of Initial Benefit Amount

4. Page 27: HEALTH SCREENING BENEFIT. The health screening benefit is $100 per covered person per year and there is no waiting period for a covered person to be eligible for this benefit. A listing of the screening and preventive measures for which a benefit may be paid can be found in your Certificate of Insurance.

5. Page 27: HOW TO FILE A CLAIM. For assistance in filing a claim you can contact a MetLife representative toll-free at 1-866-626-3705, Monday through Friday between 8:00 a.m. and 11:00 p.m. Eastern Standard Time. You may also write to MetLife at the following address:

   Metropolitan Life Insurance Company
   Attention: Critical Insurance Product
   P.O. Box 80826
   Lincoln, NE 68501-0826
   FAX: 1-866-268-2621

   If your claim is denied in whole or in part, you may appeal the decision by filing a written request to MetLife within 180 days of receiving the notice of denial. Your written appeal must include the following information:

   - Name of the covered person
   - Claim number
   - Group policy number and name of the group policy holder
   - An explanation of why you are appealing the decision

As part of your appeal, you may submit any written comments, documents, records, or other information relating to your claim. MetLife will conduct a review of your claim and notify you in writing within 45 days of receiving your appeal request of its decision on appeal or if additional time will be required to complete the review and the reason the additional time is required.

A legal action on a claim may only be brought against MetLife during a certain period. This period begins 60 days after the date proof of your claim is filed and ends three years after the date such proof is required to be filed.

6. Page 28-29: GENERAL EXCLUSIONS AND LIMITATIONS. The following exclusions and limitations apply to all covered conditions and benefits of this plan. Please note that certain covered conditions have additional exclusions and limitations that are set forth in the benefit provisions of your Certificate of Insurance.

   Benefits will not be paid for any covered condition caused by, or that takes place during:

   - Covered person's active participation in an insurrection, rebellion, riot or terrorist act;
   - Covered person's engagement in any illegal occupation or activity that constitutes a felony under the laws of the jurisdiction in which the activity took place;
   - Covered person's intentionally self-inflicted injury;
   - Covered person's suicide or attempted suicide (while sane or insane);
   - War, whether declared or undeclared; or act of war;
   - Covered person's operation, while intoxicated, of a motor vehicle involved in the incident. Motor vehicle means any vehicle that is powered by a motor, including but not limited to an automobile, boat, motorcycle, truck, all-terrain vehicle, or snow mobile. For purposes of this exclusion, intoxicated means that the covered person's blood alcohol level met or exceeded .08%; or blood delta-9-tetrahydrocannabinol (THC) level met or exceeded the limit established by the laws of the jurisdiction for drug-impaired driving where the incident took place;
   - Covered person voluntarily taking or using any drug, medication or sedative unless it is taken or used as prescribed by a physician or is an over-the-counter drug, medication or sedative taken according to package directions;
   - Activities required by the covered person's service in the armed forces or any auxiliary unit of the armed forces of any country or international authority.

   In addition, benefits will not be paid for:

   - Any covered condition for which diagnosis is made outside the United States, Canada or Mexico unless the diagnosis is confirmed in the United States, in which case the covered condition will be deemed to occur on the date the diagnosis is made outside the United States, Canada or Mexico.

- A covered condition that is caused by or results from a preexisting condition if the covered condition occurs during the first six (6) months that a covered person is insured under the plan. A preexisting condition is a sickness or injury for which, in the three (3) months before a covered person becomes insured under this plan, medical advice, treatment or care was sought by such covered person, or was recommended by, prescribed by or received from a physician or other practitioner of the healing arts. For purposes of satisfying this limitation, the plan will not consider the following to be medical advice, treatment or care: (i) maintenance drug therapy prescribed during remission of a covered condition; or (ii) routine medical assessments to verify that a covered condition is no longer present or remains in remission. EXCEPTION: This preexisting condition limitation does not apply to benefits relating to a heart attack or stroke.

Your Certificate of Insurance contains certain proof requirements, exclusions, limitations, and other provisions that may reduce benefits or prevent a covered person from receiving benefits under the plan. Please read your entire Certificate carefully.

7. Page 29: BENEFIT SUSPENSION PERIOD BETWEEN OCCURENCES. The **Benefit Separation Period** is the number of days that must elapse between occurrences of a covered condition in order for a benefit to be payable.

   An **Initial Benefit Separation Period of 30 days** must elapse between the occurrence of a covered condition for which a benefit is payable and the occurrence of a different covered condition in order for an Initial Benefit to be payable for the later covered condition.

   In the event another covered condition occurs within the 30-day Initial Benefit Separation Period, the following rules apply:

   1. If the Initial or Recurrence Benefit paid by the plan for the prior covered condition is less than the Initial Benefit amount for the new covered condition, the plan will pay an additional amount which is equal to the difference between the amount the plan would have paid for the new covered condition and the amount paid for the prior covered condition.
   2. If the Initial or Recurrence Benefit paid by the plan for the prior covered condition is equal to or exceeds the Initial Benefit amount for the new covered condition, an additional amount is not payable.

   A Recurrence Benefit is a benefit as specified in the Schedule of Insurance that is payable for another occurrence of the same covered condition for the same covered person for whom the plan has already paid a benefit. For a Recurrence Benefit to be payable, a **Recurrence Benefit Separation Period of 90 days** must elapse from the date of the most recent occurrence of the same covered condition for which a benefit was payable.

In accordance with ERISA reporting requirements, this document serves as your Summary of Material Modifications to the Plan. Please keep this important notice with your Plan booklet for easy reference to all Plan provisions.