HSTA VOLUNTARY EMPLOYEES BENEFICIARY ASSOCIATION TRUST

VOLUNTARY BENEFITS

February 2024

IMPORTANT

In this booklet, we have attempted to explain as briefly as possible the benefits provided to eligible employees and their dependents. The Trust Agreement, Plan Documents, policies, contracts, and rules and regulations adopted by the Board of Trustees are the final authorities in all matters relating to the HSTA Voluntary Employees Beneficiary Association Trust. Copies of these documents are available for you to inspect at the Trust Office during regular business hours.

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HSTA VOLUNTARY EMPLOYEES BENEFICIARY ASSOCIATION TRUST VOLUNTARY BENEFITS

TABLE OF CONTENTS

Page

SUMMARY OF IMPORTANT BENEFIT CHANGES 3

INFORMATION REQUIRED BY THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA) 5

GENERAL INFORMATION
Who is Eligible? 8
Dependent Coverage 9
Enrollment Applications 9

PACIFIC GUARDIAN LIFE INSURANCE COMPANY – LIFE INSURANCE
Basic Plan 11
Basic Plus Plan 11
Optional Supplemental Term Life Insurance 12
Premium Rates 13
Evidence of Insurability 13
Dependent Coverage 13
Accidental Death and Dismemberment Benefits (AD&D) 14
Beneficiary Designation 16
Termination of Insurance 17
Conversion Rights 17
How to File a Claim 17

AMERICAN FIDELITY ASSURANCE COMPANY – SHORT-TERM DISABILITY INCOME PROTECTION INSURANCE
Who is Eligible? 19
Disability Benefits 19
When You Are Eligible for a Monthly Benefit 20
Termination of Benefits 20
Termination of Insurance 20
Exclusions 21
How to File a Claim 21

HARTFORD LIFE & ACCIDENT INSURANCE COMPANY – LONG-TERM INCOME PROTECTION INSURANCE
Who is Eligible? 22
Benefit Options 22
Elimination Period Options 22
When You Are Eligible for a Monthly Benefit 23
Termination of Benefits 23
Exclusions 24
How to File a Claim 24
Ability Assist 24
Travel Assist 24

TABLE OF CONTENTS

Page

METROPOLITAN LIFE INSURANCE COMPANY – CRITICAL ILLNESS INSURANCE

Who is Eligible? 25
Dependent Coverage 25
Benefit Options 25
Covered Conditions and Schedule of Insurance 26
Supplemental Health Screening Benefit 27
General Exclusions and Limitations 27
How to File a Claim 28
Payment of Benefits 29
When Insurance Ends 30
Continued Insurance 30

METROPOLITAN LIFE INSURANCE COMPANY – ACCIDENT INSURANCE

Who is Eligible? 32
Dependent Coverage 32
Changes in Coverage 32
Benefit Options and Schedule of Insurance 32
General Exclusions and Limitations 36
How to File a Claim 37
Payment of Benefits 38
When Insurance Ends 39
Continued Insurance 39

UNUM LIFE INSURANCE COMPANY OF AMERICA – LONG-TERM CARE INSURANCE

Who is Eligible? 41
Base Coverage for Active Participants 41
Base Coverage for Retired Participants 41
Dependent Coverage 42
Additional Buy-Up Coverage Options 42
When You Are Eligible for a Monthly Benefit 43
Definitions and Benefits 43
When Monthly Benefits End 45
Changes in Coverage 45
Continuation of Coverage 45
How to File a Claim 45
Exclusions 46

USE AND DISCLOSURE OF YOUR HEALTH INFORMATION 47

CLAIMS AND APPEALS PROCEDURE

Designation of an Authorized Representative 49
Insured Claims 49
Eligibility and Other Appeals 50

STATEMENT OF ERISA RIGHTS 51

SUMMARY OF IMPORTANT BENEFIT CHANGES

Several important benefit changes have been made in your Health and Welfare benefits since the previous Summary Plan Description published in May 2019. You have been previously notified of these changes and their effective dates. However, as part of our ongoing process to familiarize you with the benefit programs and to comply with Federal Law, the changes have been incorporated in this booklet revision.

Items that have been significantly changed, along with the page number where the complete text of the change is located, are as follows:

TRUST ADMINISTRATION

A. Effective October 1, 2020, Hawaii Benefit Administrators, Inc. replaced Benefit Plan Solutions, Inc. as the Contract Administrator.

B. Effective September 1, 2022, Rael & Letson replaced Benefit Plan Solutions, Inc. as the Plan Consultant.

LIFE INSURANCE PLAN

A. Effective November 1, 2017, Optional Supplemental Term Life Insurance coverage amounts increased for Class I members (page 12).

CRITICAL ILLNESS INSURANCE PLAN

A. Effective May 1, 2022, the following changes were made to the Critical Illness Insurance Plan:

1. WHO IS ELIGIBLE. The eligibility criteria for enrolling in the Plan include a minimum work requirement of 17.5 hours per week (page 25).
2. 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 (page 25).
3. COVERED CONDITIONS. The schedule of covered conditions and benefit amounts is revised (pages 26 - 27).
4. SUPPLEMENTAL HEALTH SCREENING BENEFIT. The health screening benefit is $100 per covered person per year and there is no waiting period 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 (page 27).
5. GENERAL EXCLUSIONS AND LIMITATIONS. The general exclusions and limitations that apply to all covered conditions and benefits of the plan are clarified and restated (page 27).
6. BENEFIT SUSPENSION PERIOD BETWEEN OCCURRENCES. 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 (page 28).

   - An **Initial Benefit Separation Period of 30 days** must elapse between an occurrence of a covered condition for which a benefit is payable and an occurrence of a different covered condition, in order for an Initial Benefit to be payable for the later covered condition.
   - A **Recurrence Benefit Separation Period of 90 days** must elapse between the most recent occurrence of a covered condition for which a benefit was payable and a subsequent occurrence of the same covered condition.

7. 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, or write to MetLife at the following address (page 28):

   Metropolitan Life Insurance Company
   Attention: Critical Illness 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 (page 29).

   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 (page 29).

ACCIDENT INSURANCE PLAN

A. Effective May 1, 2022, the group Accident Insurance policy offered through UNUM Life Insurance Company of America is replaced by Accident Insurance offered through Metropolitan Life Insurance Company. A summary description of the MetLife plan is provided on pages 32 - 40.

INFORMATION REQUIRED BY THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

NAME OF THE PLAN

HSTA Voluntary Employees Beneficiary Association Plan

PLAN SPONSOR AND ADMINISTRATOR

Board of Trustees
HSTA Voluntary Employees
Beneficiary Association Trust
1259 Aala Street, Suite 202
Honolulu, Hawaii 96817

PLAN IDENTIFICATION NUMBERS

Assigned by Internal Revenue Service – Employer Identification Number (EIN) 23-7296050
Assigned by Plan Sponsor - Plan Number 505

TYPE OF PLAN

Employee Welfare Benefit Plan, providing Life Insurance, Short-Term Disability Income Protection Insurance, Long-Term Income Protection Insurance, Critical Illness Insurance, Accident Insurance and Long-Term Care Insurance

TYPE OF ADMINISTRATION

The Board of Trustees has engaged Hawaii Benefit Administrators, Inc. at 1259 Aala Street, Suite 202, Honolulu, Hawaii 96817 to serve as Contract Administrator for the HSTA Voluntary Employees Beneficiary Association Trust.

AGENT FOR SERVICE OF LEGAL PROCESS

Hawaii Benefit Administrators, Inc.
1259 Aala Street, Suite 202
Honolulu, Hawaii 96817

Service of legal process may also be made upon a Plan Trustee.

NAME, TITLE, AND PRINCIPAL PLACE OF BUSINESS ADDRESS OF EACH PLAN TRUSTEE

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PLAN'S REQUIREMENTS FOR ELIGIBILITY AND BENEFITS

The Plan's requirements for eligibility are described in the GENERAL INFORMATION section beginning on page 8 of this booklet and in each benefit section.

SOURCE OF CONTRIBUTIONS

The funds out of which all Plan benefits and expenses are paid are contributed by: 1) participants through payroll and retirement check deductions and cash payments, 2) investment earnings, and 3) experience refunds.

FUNDING MEDIUM

All contributions are transmitted to the HSTA Voluntary Employees Beneficiary Association Trust and deposited with First Hawaiian Bank in a checking account out of which premium payments are made to the insurance carriers that provide benefits. Funds in excess of those needed for immediate requirements are held in savings accounts, Time Certificates of Deposit, and other investments in accordance with the investment guidelines established by the Board of Trustees.

FISCAL YEAR

The Plan's fiscal records are kept on a plan year basis, September 1 through August 31.

DISCRETIONARY AUTHORITY OF PLAN ADMINISTRATOR

The Board of Trustees is the Plan Administrator and has the full discretionary authority to interpret, apply, and administer the Plan, and has the exclusive right to construe the terms of the Plan to determine eligibility for benefits and amounts of benefits under the Plan. However, with respect to coverage and eligibility under a specific insurance plan, the terms of the applicable policy will govern. Any interpretation or determination made by the Board of Trustees in the exercise of its discretion will be final and binding and will be given full force and effect unless it can be shown that the interpretation or determination was arbitrary and capricious.

PLAN AMENDMENT AND TERMINATION

The Trust Agreement for the HSTA Voluntary Employees Beneficiary Association Trust gives the Board of Trustees sole authority to determine eligibility requirements for Plan benefits, the nature and amount of Plan benefits and required contributions for benefits.

The Trust may be amended or terminated by a two-thirds vote of the entire Board of Trustees at meetings duly called or noticed for that purpose.

The termination of the Plan, or any part of the Plan, shall not by itself terminate the Trust.

If Plan benefits are amended or eliminated, participants and beneficiaries are eligible for only those benefits which are available after the amendment or elimination of benefits. **Participants and beneficiaries have the obligation to read all participant and beneficiary notices issued pertaining to the amendment or elimination of benefits.**

Benefits under the Trust are not vested or guaranteed. If the HSTA Voluntary Employees Beneficiary Association Trust is terminated, participants and beneficiaries have the obligation to read the Summary Plan Description (SPD) and all participant and beneficiary notices issued concerning termination of the Plan and/or the Trust, and once notified, should contact the various insurance carriers for information on conversion to an individual plan, if applicable.

Upon termination of the HSTA Voluntary Employees Beneficiary Association Trust, the assets of the Trust may be transferred to another trust for substantially similar purposes. Otherwise, any and all assets remaining shall be first used to satisfy all legal debts of the Trust, and the remaining assets shall be used solely to provide benefits and for expenses of administration incident to providing said benefits as the Plan may provide. Participants and beneficiaries have no right to any remaining assets of the Trust.

GENERAL INFORMATION

WHO IS ELIGIBLE?

To qualify for coverage under the Trust's benefit plans, you must meet the qualifications stated below for each plan. In addition, you must complete and submit the required enrollment forms to the HSTA Voluntary Employees Beneficiary Association Trust Office. Coverage for you and your eligible dependents, if applicable, will be effective on the first day of the calendar month following the receipt of your completed enrollment forms by the Trust Office.

Life Insurance – Basic Plan

- Be an Active, Associate, or Retired HSTA Member.

Life Insurance – Basic Plus Plan

- Be an Active, Associate, or Retired HSTA Member.

Short-Term Disability Income Protection Insurance

- Be an Active HSTA Member, **and**
- Be actively employed in Bargaining Unit 5 in the field of education and working a minimum of 17.5 hours per week.

Long-Term Income Protection Insurance

- Be an Active HSTA Member regularly employed on a scheduled basis and working a minimum of 17.5 hours per week, **or**
- Be an Associate HSTA Member regularly employed by the State of Hawaii, **or**
- Be a regularly scheduled employee of the Hawaii State Teachers Association.

Critical Illness Insurance

- Be an Active HSTA Member regularly employed on a scheduled basis and working a minimum of 17.5 hours per week, **or**
- Be an Associate HSTA Member regularly employed by the State of Hawaii and working a minimum of 17.5 hours per week, **or**
- Be a regularly scheduled employee of the Hawaii State Teachers Association and working a minimum of 17.5 hours per week.

Accident Insurance

- Be an Active HSTA Member regularly employed on a scheduled basis and working a minimum of 17.5 hours per week, **or**
- Be an Associate HSTA Member regularly employed by the State of Hawaii and working a minimum of 17.5 hours per week, **or**
- Be a regularly scheduled employee of the Hawaii State Teachers Association and working a minimum of 17.5 hours per week.

Long-Term Care Insurance

- Be an Active, Associate, or Retired HSTA Member, **and**
- Be enrolled and continuously covered as an eligible participant under one or more of the Trust's benefit plans, other than the Long-Term Care Insurance Plan.

DEPENDENT COVERAGE

Dependent coverage is available for Life Insurance, Critical Illness Insurance, Accident Insurance and Long-Term Care Insurance. Please refer to those sections for specific details concerning eligibility and enrollment of dependents.

ENROLLMENT APPLICATIONS

To enroll for coverage under the Trust's benefit plans, you must complete and forward to the Trust Office, the documents stated below.

Life Insurance - Basic Plan

- HSTA Voluntary Employees Beneficiary Association Trust Group Life Insurance Enrollment Application form
- Evidence of Insurability (EOI) form when required

Life Insurance - Basic Plus Plan

- HSTA Voluntary Employees Beneficiary Association Trust Group Life Insurance Enrollment Application form
- Evidence of Insurability (EOI) form when required

Short-Term Disability Income Protection Insurance

- HSTA Voluntary Employees Beneficiary Association Trust Short-Term Disability Income Protection Insurance Enrollment form
- Evidence of Insurability (EOI) form when required

Long-Term Income Protection Insurance

- HSTA Voluntary Employees Beneficiary Association Trust Long-Term Income Protection Insurance Enrollment form
- Evidence of Insurability (EOI) form when required

Critical Illness Insurance

- HSTA Voluntary Employees Beneficiary Association Trust Critical Illness Insurance Enrollment Application form

Accident Insurance

- HSTA Voluntary Employees Beneficiary Association Trust Accident Insurance Enrollment Application form

Long-Term Care Insurance

- HSTA Voluntary Employees Beneficiary Association Trust Long-Term Care Insurance Benefit Election form
- Application for Group Long-Term Care Insurance Evidence of Insurability (EOI) form when required

IMPORTANT – NOTIFY THE TRUST WHEN THERE IS A CHANGE IN YOUR PERSONAL OR FAMILY STATUS

It is important to keep the Trust Office informed of any change in your personal or family status or contact information. Be sure to let the Trust Office know if:

- You or a covered family member has a change of name, mailing address or phone number,
- You get married, divorced, or widowed,
- A covered family member dies,
- You wish to add an additional dependent (such as a new baby or an adopted child) or there is a change in the status of a dependent child,
- You become disabled, or
- You wish to change your beneficiary designation for Life Insurance, Short-Term Disability Income Protection Insurance, Critical Illness Insurance, or Accident Insurance.

In addition, if you are covered under the Short-Term Disability Income Protection Insurance Plan or the Long-Term Income Protection Insurance Plan, you must inform the Trust Office of any change in your salary.

PACIFIC GUARDIAN LIFE INSURANCE COMPANY

Life Insurance

Life Insurance provides financial protection for your loved ones in the event of your death. Active, Associate, and Retired HSTA Members are eligible for life insurance coverage.

The following is a summary of coverage for informational purposes only. In the event of a conflict between this summary and the HSTA Voluntary Employees Beneficiary Association Trust group policy with Pacific Guardian Life Insurance Company and the Pacific Guardian Life Certificate of Insurance sent to you, the policy and Certificate will govern.

BASIC PLAN

Active, Associate, and Retired HSTA Members are eligible for coverage under the Basic Plan. If you enroll in the Basic Plan, you are covered for life insurance according to the following schedule:

BASIC PLAN	COVERAGE AMOUNT
Class I (Active and Associate Members)	
Under 65 years of age	$ 15,000
Age 65 - 69	$ 9,750
Age 70 - 74	$ 6,750
Age 75 - 79	$ 4,500
Age 80 and over	$ 3,000
Class II (Retired Members)	$ 2,000

BASIC PLUS PLAN

Active, Associate, and Retired HSTA Members are eligible for coverage under the Basic Plus Plan. If you enroll in the Basic Plus Plan, you and your enrolled dependents are covered for life insurance according to the following schedule:

BASIC PLUS PLAN	COVERAGE AMOUNT
Class I (Active and Associate Members)	
Basic Life Insurance	
Under 45 years of age	$ 55,000
Age 45 - 49	$ 45,000
Age 50 - 54	$ 39,000
Age 55 - 59	$ 30,000
Age 60 - 64	$ 22,000
Age 65 - 69	$ 16,000
Age 70 - 74	$ 16,000
Age 75 and over	$ 7,000

BASIC PLUS PLAN	COVERAGE AMOUNT
Class I Dependent Term Life Insurance - Family	
Spouse	$ 2,500[1]
[1] Members may elect to purchase up to a maximum of four units of additional Dependent Term Life Insurance for a covered spouse (each unit is equal to $2,500), up to a maximum coverage amount of $12,500.	
Children	
At least 14 days old	$ 100
6 months to 2 years of age	$ 400
2 years to 3 years of age	$ 800
3 years to 4 years of age	$ 1,200
4 years to 5 years of age	$ 1,600
5 years to 19 years of age (or to 23 years of age if a full-time student, or to any age if handicapped)	$ 2,000
Class I Supplemental Spouse Term Life Insurance	$ 6,000[2]
[2] The amount of Spouse insurance (Dependent Term Life Insurance and Supplemental Spouse Term Life Insurance combined) may never exceed 50% of the amount of insurance in force for the member.	
Class II (Retired Members) **Basic Life Insurance**	
Under 60 years of age	$ 16,000
Age 60 - 64	$ 12,300
Age 65 - 74	$ 6,900
Age 75 and over	$ 3,000
Class II Dependent Term Life Insurance	
Spouse	$ 1,500

OPTIONAL SUPPLEMENTAL TERM LIFE INSURANCE

Members enrolled in the Basic Plus Plan may also elect to purchase up to **four** units of optional Supplemental Term Life Insurance up to the maximum total coverage amount (Basic Life Insurance and Supplemental Term Life Insurance combined) shown in the schedule below.

SUPPLEMENTAL TERM LIFE INSURANCE	UNIT OF SUPPLEMENTAL COVERAGE	MAXIMUM TOTAL COVERAGE AMOUNT
Class I (Active & Associate Members)		
Under 45 years of age	$ 30,316	$ 176,264
Age 45 - 49	$ 30,390	$ 166,560
Age 50 - 54	$ 30,179	$ 159,716
Age 55 - 59	$ 22,045	$ 118,180
Age 60 - 64	$ 19,039	$ 98,156
Age 65 - 69	$ 10,037	$ 56,148
Age 70 - 74	$ 10,037	$ 56,148
Age 75 and over	$ 5,062	$ 27,248

SUPPLEMENTAL TERM LIFE INSURANCE	UNIT OF SUPPLEMENTAL COVERAGE	MAXIMUM TOTAL COVERAGE AMOUNT
Class II (Retired Members)		
Under 60 years of age	$ 10,000	$ 56,000
Age 60 - 64	$ 7,800	$ 43,500
Age 65 - 74	$ 3,300	$ 20,100
Age 75 and over	$ 800	$ 6,200

PREMIUM RATES

Please refer to the Benefit Schedule which you may obtain from the Trust Office for current monthly premium rates.

EVIDENCE OF INSURABILITY

Evidence of insurability in a form prescribed by Pacific Guardian Life will be required if application for insurance is made more than 60 days after a member's eligibility date, or if a member elects to increase Supplemental or Dependent Life Insurance.

DEPENDENT COVERAGE

Dependent Term Life Insurance is available to eligible dependents of Class I and Class II members enrolled in the Basic Plus Plan. **For Class I members (Active and Associate HSTA Members),** eligible dependents include your legal spouse and unmarried children under 19 years of age. **For Class II members (Retired Members),** only your legal spouse is eligible for Dependent Term Life Insurance.

The term "children" includes your natural child or legally adopted child. Dependent children who are full-time students at an accredited school, college, or university will continue to be eligible for Dependent Life Insurance from 19 years of age through 22 years of age. In order for your dependent child to be covered as a full-time student, you must certify annually, and as requested by the Trust Office, that he or she is a full-time student at an accredited school, college, or university by completing the Student Certification form issued to you by the Trust Office. **Failure to submit the required certification will result in cancellation of the child's coverage.** You are also responsible for promptly notifying the Trust Office, in writing, of any change in your dependent's eligibility status outside the annual certification.

Dependent Life Insurance will be continued in force for a child who, upon attaining 19 years of age is mentally or physically incapable of earning his or her own living and dependent upon the member for support and maintenance provided that proof of such incapacity is furnished to Pacific Guardian Life within 31 days of the child attaining age 19. Failure to submit required proof of incapacity or to permit an examination of the child when requested by Pacific Guardian Life shall result in termination of the continued coverage. Coverage for such child will terminate upon the earliest of the following: his or her handicap ceases, or insurance would terminate for other reasons other than the dependent child's age.

To enroll a new spouse or dependent child for Dependent Life Insurance coverage, you must submit an application for enrollment within 60 days of the date of marriage, birth, or legal adoption. If you do not submit an enrollment application during this 60-day period, you must wait until the next open enrollment period to enroll your new dependent and submit Evidence of Insurability at that time.

If your spouse is also an eligible participant, he or she cannot be covered as a "Spouse" but must apply for coverage as an individual member. If both you and your spouse are insured members, your children may be covered as dependents of either member, but not both.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS (AD&D)

Class I members (Active and Associate HSTA Members) enrolled in the Basic Plus Plan are also covered for Accidental Death and Dismemberment benefits (AD&D). The Principal Sum Amount of AD&D benefits is equal to the insured member's life insurance amount under Basic Life Insurance and Supplemental Term Life Insurance. If you die as a result, directly and solely, from an injury and no other cause, AD&D insurance may pay an additional amount. If you sustain a covered loss as provided in the Table of Losses below, AD&D will pay the benefit as shown in the Table. The covered loss must result directly from an injury caused by an accident and must occur within 90 days following the date of the accident.

AD&D TABLE OF LOSSES

IN THE EVENT OF:	BENEFIT AMOUNT
Loss of life	Full Amount
Loss of both hands or feet	Full Amount
Loss of sight of both eyes	Full Amount
Loss of one hand and one foot	Full Amount
Loss of one hand and sight of one eye	Full Amount
Loss of one foot and sight of one eye	Full Amount
Loss of speech and hearing in both ears	Full Amount
Total paralysis of both upper and both lower extremities (quadriplegia)	Full Amount
Total paralysis of both upper or both lower extremities (paraplegia)	Three-Fourths Full Amount
Total paralysis of one lower extremity and one upper extremity on the same side (hemiplegia)	One-Half Full Amount
Loss of one hand	One-Half Full Amount
Loss of one foot	One-Half Full Amount
Loss of speech	One-Half Full Amount
Loss of hearing in both ears	One-Half Full Amount
Loss of sight of one eye	One-Half Full Amount
Paralysis of one upper or lower limb (uniplegia)	One-Quarter Full Amount
Loss of all four fingers of the same hand	One-Quarter Full Amount
Loss of thumb and index finger of the same hand	One-Quarter Full Amount

- "Loss of a hand or foot" means actual severance at or above the wrist or ankle joint.
- "Loss of sight" means total and irrecoverable loss of sight in the injured eye.
- "Loss of thumb and index finger of the same hand means complete severance through or above the metacarpophalangeal joints of the same hand (the joints between the fingers and the hand).
- "Paralysis" means complete loss of motor function due to lesion of the neural or muscular mechanism as determined by a physician.
- "Loss of speech" means total, permanent, and irrecoverable loss of audible communication.
- "Loss of hearing" means total, permanent deafness in both ears which cannot be corrected to any functional degree by an aid or device.

AD&D Exclusions

AD&D does not cover a loss that results directly or indirectly from any one or more of the following:

- Sickness, disease, or infirmity of the mind or body including mental or emotional distress
- Ptomaine or bacterial infections, except pus-forming infections resulting from an injury that is not excluded by these exclusions
- Medical or surgical treatment, except when it is both treatment of an injury that meets the requirements of a covered loss and treatment performed within 90 days after the injury occurred
- Any declared or undeclared insurrection, international armed conflict or conflict involving any armed forces, war or act of war
- Unlawful participation in a riot or other public disturbance
- An assault or felony or attempt to commit an assault or felony
- Intentionally self-inflicted injury, whether or not the covered loss was intended
- Suicide or attempted suicide, whether sane or insane
- Riding in or ascending to or descending from any kind of aircraft: as a passenger on any kind of aircraft operated by or for any armed forces; or as a pilot or crew member; or as a participant in aviation training; or as a participant in a sporting event or hobby
- Voluntarily or involuntarily taking any drug or poison or inhaling gas that is not prescribed by a physician
- Intentionally taking any drug that is not prescribed by a physician
- Being under the influence of alcohol as defined by the law of the state where the loss occurs
- Participation in hazardous activities such as skydiving, motor racing, hang-gliding, scuba, skin or deep-sea diving, dirt bike racing, mountain climbing, using off-road vehicles, or bungee jumping
- Driving or riding in any speed contest or race or the testing of any land or water motor vehicle on any race track, speedway or testing area, including joyriding and/or street racing
- An accident occurring while serving on full-time active duty of more than 30 days in any armed forces

AD&D Special Education Benefits

A Special Education Benefit may be paid as follows if the insured member dies as the result of a covered loss and is survived by a spouse and one or more dependent children.

Child Benefit: For each child under age 25 who is enrolled as a full-time student at an accredited post-secondary educational institution at the time of the insured member's death or is at the 12th grade level and within one year after the insured's death, enrolls as a full-time student at an accredited college, university, or vocational school and incurs expense for tuition, fees, books, room and board, transportation and any other costs payable directly to or approved and certified by such educational institution, the cost of such incurred expense up to 2% of the insured member's Principal Sum Amount or $2,500, whichever is less, will be paid each year, per dependent child, for up to four straight years after enrollment begins.

Spouse Benefit: If, within one year after the insured member's death, his or her surviving spouse enrolls in any accredited school for the purpose of retraining or refreshing skills needed for employment and incurs expense payable directly to or approved and certified by such school, the cost of such incurred expense up to $3,000 will be paid for up to one year after enrollment begins.

AD&D Seat Belt Benefit and Airbag Benefit

An additional 50% of the Accidental Death and Dismemberment Benefit, subject to a maximum of $100,000, may be paid in the event the insured member suffers loss of life or limb as the result of a covered loss which occurs while driving or riding in an automobile if all of the following are true:

- The automobile is equipped with seat belts which meet federal safety standards and were installed by the automobile manufacturer, and which have not been altered.
- The seat belt was in actual use and properly fastened at the time of the accident.
- The position of the seat belt is certified in the official report of the accident or by the investigating officer.
- The insured member is driving or riding in an automobile driven by a licensed driver who was neither intoxicated, driving while impaired, or under the influence of drugs (unless taken as prescribed by a licensed physician), at the time of the accident.

If an automobile is equipped with airbags and an airbag is activated as the result of the same automobile accident causing a covered loss, an additional benefit equal to $10,000 or 10% of the Accidental Death and Dismemberment Benefit, whichever is less, will be payable for each airbag activated within the automobile causing such covered loss. Activation of the airbag must be verified as part of the official report of the accident, or certified, in writing, by the investigating officer. No airbag benefit is payable unless the Seat Belt Benefit is paid.

AD&D Repatriation Benefit

Pacific Guardian Life may pay up to $5,000 for the preparation and transportation of an insured member's body for burial or cremation. Payment may be made if the insured member suffered a loss of life at least 75 miles away from his or her principal residence or in a foreign country.

BENEFICIARY DESIGNATION

On your Group Life Insurance Enrollment Application form, you may name anyone you wish as your beneficiary to receive your life insurance. You may change your beneficiary at any time by submitting a Life Insurance Beneficiary Designation/Name Change form to the Trust Office. The change will take effect as of the date that you sign the form when it is received by the Trust Office. Pacific Guardian Life will honor a beneficiary change request only if it is recorded before any payment has been made.

When Pacific Guardian Life receives due proof of your death, the amount of life insurance on your life may be paid. Payment will be made in a lump sum to the beneficiary or beneficiaries named in writing by you, provided the names are on file with the Trust Office.

Unless you request otherwise in your filed beneficiary designation, payment shall be made as follows:

(a) If more than one beneficiary is named, each will be paid an equal share.

(b) If any named beneficiary dies before you, his/her share will be divided equally among the named beneficiaries who survive you.

(c) If no beneficiary is named, or if no named beneficiary survives you, Pacific Guardian Life may, at the Company's option, pay the first of the following classes of successive preference beneficiaries who survive you:

  (i) all to your surviving spouse; or

  (ii) if your spouse does not survive you, in equal shares to your surviving children; or

  (iii) if your spouse and no child survives you, in equal shares to your surviving parents; or

  (iv) if your spouse, no child, or no parent survives you, in equal shares to your surviving brothers and sisters; or

  (v) if none of the above survives you, to your estate.

The life insurance on your spouse or children is payable to you in the event of their death. If you do not survive the payment of the Dependent coverage benefit, Pacific Guardian Life will pay your estate.

Any payment made in accordance with the preceding provisions shall release Pacific Guardian Life from further liability for the amount paid.

TERMINATION OF INSURANCE

Life Insurance coverage for the insured member will end on the earliest of the following dates:

(a) The date this policy terminates;

(b) The date you cease to be a member of an Eligible Class;

(c) The date your Eligible Class is eliminated;

(d) The date you enter the armed forces, other than for reserve duty of 30 days or less; or

(e) The last day of the last period for which timely premium payment was made in full.

Dependent Life Insurance coverage for your enrolled dependents will end on the earliest of the following dates:

(a) The last day of the month in which you die;

(b) The date your life insurance coverage terminates;

(c) The date Dependent Life Insurance benefits are discontinued;

(d) The date you cease to be a member of an Eligible Class that provides for Dependent Life Insurance;

(e) The date the dependent enters any armed forces, other than for reserve duty of 30 days or less;

(f) The date the dependent is no longer defined as an eligible dependent herein; or

(g) The last day of the last period for which timely premium payment was made in full.

CONVERSION RIGHTS

A conversion privilege is allowed when your life insurance terminates for reasons other than non-payment of premiums. If you become ineligible for coverage, your life insurance and Dependent Life Insurance for your dependents will be continued for 31 days following the termination of your eligibility. During this 31-day period, you and/or your dependents have the right to obtain an individual life insurance policy issued by Pacific Guardian Life.

(a) You may convert all or part of the amount of insurance that ends due to the end of your membership in an Eligible Class.

(b) A covered dependent may convert all or part of the amount of Dependent Life Insurance that ends due to termination of the insured member's life insurance because of death or termination of membership in the class eligible for coverage.

A conversion policy may be an individual life insurance policy of any type other than term life insurance but will not include accidental death, disability, or other supplementary benefits. The policy will be issued without medical examination at Pacific Guardian Life's regular premium rates. The amount of your individual policy cannot exceed the amount of insurance for which you were covered under the group policy. You must apply and pay for the first premium within 31 days after your insurance terminates.

If you die during the 31 days allowed for conversion but before an individual policy has become effective, Pacific Guardian Life may pay your beneficiary the amount of life insurance that could have been converted.

HOW TO FILE A CLAIM

Life Insurance and Accidental Death Benefits

- The Trust Office must be notified when a covered individual dies.
- The Beneficiary (or the Beneficiary's authorized representative) must complete and submit **IRS Form W-9** (Request for Taxpayer Identification Number and Certification) and a **certified copy of the Death Certificate** to the Trust Office. If the Beneficiary is a Trust, a copy of the Trust instrument and all amendments, if applicable, must also be submitted to the Trust Office.

- In the case of an Accidental Death claim, an Autopsy Report and Toxicology Report must also be submitted to the Trust Office.
- Upon notification and receipt of the required documentation, the Trust Office will complete the necessary forms and transmit them together with the required documentation to Pacific Guardian Life.

Accidental Dismemberment or Loss of Sight Benefits

- You must complete and submit a **Claim for Group Accidental Dismemberment or Loss of Sight Benefits** form to the Trust Office.
- Upon receipt of the required documentation, the Trust Office will transmit your claim to Pacific Guardian Life.

The preceding life insurance benefits are insured under a contract issued by Pacific Guardian Life Insurance Company, Limited, 1440 Kapiolani Boulevard, Suite 1700, Honolulu, Hawaii 96814. The services provided by Pacific Guardian Life include the payment of claims and the handling of claims appeals.

The preceding is for informational purposes only and is only a summary provided to help you understand your life insurance coverage from Pacific Guardian Life. Its contents are subject to the provisions of the Group Term Life Insurance Master Contract with Pacific Guardian Life Insurance Company, Limited, and all amendments thereto, which contain all the terms and conditions of coverage and benefits. These documents are on file with the HSTA Voluntary Employees Beneficiary Association Trust Office. If the terms of the preceding Plan summary differ from the policy documents, the policy will govern. Please refer to the policy documents and your Certificate of Insurance, which you received when you enrolled in the life insurance plan, for specific questions about coverage.

AMERICAN FIDELITY ASSURANCE COMPANY

Short-Term Disability Income Protection Insurance

Short-Term Disability Income Protection Insurance provides income protection if you become disabled due to an accidental injury or sickness and cannot work. It will help replace a portion of the income you would have earned had the disability not occurred. "Disabled" or "Disability" means that you are unable to perform the material and substantial duties of your regular occupation.

The following is a summary of coverage for informational purposes only. In the event of a conflict between this summary and the HSTA Voluntary Employees Beneficiary Association Trust group policy with American Fidelity Assurance Company and the American Fidelity Certificate of Insurance sent to you, the policy and Certificate will govern.

WHO IS ELIGIBLE?

All Active HSTA Members who are actively employed in Bargaining Unit 5 in the field of education and working a minimum of 17.5 hours per week are eligible to enroll in the Short-Term Disability Income Protection Insurance Plan. Associate, Retired and Student Members are not eligible for this benefit, nor are substitute teachers.

You must be on Active Employment on the day your coverage would become effective. Otherwise, your coverage will become effective on the first day of the month following the date you resume Active Employment.

"Active Employment" means you are doing in the usual manner all of the regular duties of your employment on a full-time basis on a scheduled work day and these duties are being done at one of the places of business where you normally do such duties or at some location to which your employment sends you. You will be said to be on Active Employment on a day which is not a scheduled work day only if you are **not** disabled and would be able to perform in the usual manner all the regular duties of your employment if it were a scheduled work day. Active Employment includes paid vacation leave.

DISABILITY BENEFITS

Monthly amounts of disability benefits are available from $200 to $7,500 in $100 increments. Your disability benefit will be the amount applied for and issued, not to exceed 60% of your monthly compensation. If applicable, your disability benefit will be reduced by deductible sources of income.

Elimination Period

The Elimination Period is the number of consecutive days you must be disabled and under the regular care of a physician before benefits become payable. The Elimination Period for accidental injury or sickness (includes pregnancy) is as follows:

- Accidental Injury: Seven days **or** after the end of accumulated sick leave, whichever is greater
- Sickness: Seven days **or** after the end of accumulated sick leave, whichever is greater

Your benefits begin on the 8th day of disability **or** after the end of accumulated sick leave, whichever is greater, due to a covered accidental injury or sickness.

Maximum Disability Period

You have the option to purchase Plan I which provides for a 90-day maximum disability period, or Plan II which provides for a 180-day maximum disability period. Your monthly premium will depend on the disability benefit level and the plan selected. Please refer to the Benefit Schedule which you may obtain from the Trust Office for current premium rates.

Leave of Absence

Your coverage may be continued for up to one year during a Leave of Absence approved in writing by your Employer.

WHEN YOU ARE ELIGIBLE FOR A MONTHLY BENEFIT

Disability benefits will be provided when you furnish Proof of Loss that you are disabled and under the regular and appropriate care of a physician. Disability must be due to a covered accidental injury or sickness and begin while your coverage is in force. Disability payments will be provided for each period you remain disabled and under the care of a physician which continues beyond the Elimination Period.

Disability payments will be provided for only one disability when more than one disability exists at the same time or disability results from two or more causes.

If any disability payment is to be paid for less than a full month, the amount of the benefit will be reduced pro rata on the basis that one day's benefit equals one thirtieth (1/30) the disability benefit.

Disability will be deemed to have commenced on the date you first receive personal treatment from a physician following continuous cessation of work.

Successive Disabilities

Successive disabilities are those disabilities which result from the same or related causes for which benefits are payable and will be considered one period of disability unless the disabilities are separated by your return to Active Employment or any other gainful occupation for at least three consecutive months. A disability due to a different or unrelated cause will be considered a new period of disability.

Any disability which begins after termination of coverage will not be considered a successive disability and will not be covered.

TERMINATION OF BENEFITS

Disability payments will end on the earliest of the following dates:

(a) The date you are no longer disabled.

(b) The date your Disability Earnings are more than 60% of your monthly compensation. "Disability Earnings" means the gross monthly earnings you receive while disabled and working.

(c) The date you die.

(d) The last day disability payments are made according to the Schedule of Benefits.

(e) The date you fail to provide written proof of disability satisfactory to American Fidelity.

(f) The date you cease to be under the regular and appropriate care of a physician, or refuse to undergo examination by a physician, or refuse vocational testing when American Fidelity requires such examination or testing.

(g) The date you refuse to receive medical treatment that is generally acknowledged by physicians to cure or improve your condition so as to reduce its disabling effect.

(h) The date you refuse to try or attempt to work with the assistance of modifications made to your work environment, functional job elements or work schedule, or adaptive equipment or devices that a physician has indicated will allow a return to your own occupation and which accommodations are approved by your Employer.

TERMINATION OF INSURANCE

Your insurance coverage will end on the earliest of the following dates:

(a) The date you do not meet the eligibility requirements as defined in the Plan.

(b) The date you retire.

(c) The date you cease to be on Active Employment, except as provided for under the Leave of Absence provision.

(d) The end of the last period for which premium has been paid.

(e) The date the Plan is discontinued.

If your coverage ends as a result of your termination of Active Employment and such termination is caused by an accidental injury or sickness for which disability benefits would be payable and disability is established prior to the termination of Active Employment, then disability benefits will be paid as if such termination had not occurred.

Termination of this Plan will have no effect on disability payments which began before such termination.

EXCLUSIONS

This Plan does not cover any loss which results from:

(a) Intentionally self-inflicted injury.

(b) An act of war.

(c) Accidental injury sustained or sickness contracted while in the service of the armed forces of any country.

(d) Commitment of a felony.

(e) Penal incarceration. Benefits for disability or any other loss will not be paid for any period for which you are incarcerated in a penal or correctional institution for a period of 30 consecutive days or longer.

(f) Accidental injury or sickness arising out of and in the course of any occupation for wage or profit for which you are entitled to Workers' Compensation.

HOW TO FILE A CLAIM

Written proof of loss must be sent to American Fidelity Assurance Company at 9000 Cameron Parkway, Oklahoma City, Oklahoma 73114, or to the Trust Office. Such proof of loss should be made within 30 days after any loss covered by the Plan. If it is not reasonably possible to give proof of loss within that time, your claim may not be denied or reduced due to the delay. Proof of loss, provided at your expense, must show:

(a) That you are under the regular and appropriate care of a physician;

(b) The date your disability began;

(c) The cause of your disability;

(d) The appropriate documentation of your monthly compensation;

(e) The extent of your disability, including restrictions and limitations preventing you from performing your regular occupation; and

(f) The name and address of any hospital or institution where you received treatment, including all attending physicians.

Proof of loss must be sent to American Fidelity within 90 days after the loss. Late proof of loss may be accepted if it was not reasonably possible to give proof within 90 days and the proof of loss is given within one year from the date of loss. This 1-year limit will not apply in the absence of legal capacity.

The preceding short-term disability income protection insurance benefits are insured under a contract issued by American Fidelity Assurance Company, 9000 Cameron Parkway, Oklahoma City, Oklahoma 73114. The services provided by American Fidelity include the payment of claims and the handling of claims appeals.

The preceding is for informational purposes only and is only a summary provided to help you understand your short-term disability income protection insurance coverage from American Fidelity. Its contents are subject to the provisions of the Group Master Policy with American Fidelity Assurance Company, and all amendments thereto, which contain all the terms and conditions of coverage and benefits. These documents are on file with the HSTA Voluntary Employees Beneficiary Association Trust Office. If the terms of the preceding Plan summary differ from the policy documents, the policy will govern. Please refer to the policy documents and your Certificate of Insurance, which you received when you enrolled in the short-term disability income protection insurance plan, for specific questions about coverage.

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

Long-Term Income Protection Insurance

Long-Term Income Protection Insurance provides income protection if you become disabled and unable to work for an extended period of time.

The following is a summary of coverage for informational purposes only. In the event of a conflict between this summary and the HSTA Voluntary Employees Beneficiary Association Trust group policy with Hartford Life and Accident Insurance Company and the Hartford Certificate of Insurance sent to you, the policy and Certificate will govern.

WHO IS ELIGIBLE?

All Active HSTA Members regularly employed on a scheduled basis and working a minimum of 17.5 hours per week, Associate HSTA Members regularly employed by the State of Hawaii, and regularly scheduled employees of the Hawaii State Teachers Association are eligible to enroll in the Long-Term Income Protection Insurance Plan.

Evidence of insurability in a form prescribed by Hartford will be required if application for insurance is made more than 60 days after a member's eligibility date.

If you are absent from work due to a disabling condition on the day your coverage would otherwise have become effective, your effective date will be deferred until you return to work on an active basis.

BENEFIT OPTIONS

If you become totally disabled and have purchased coverage under the Long-Term Income Protection Insurance Plan, you will receive a percentage of your regular monthly income, depending on which of the following options you have selected:

Option I 50% of your regular monthly income

Option II 60% of your regular monthly income

Option III 66 ⅔% of your regular monthly income

The maximum benefit amount payable is $5,000.00 per month. Your benefit payments will be offset by any sources of income for which you are eligible, as described in your Certificate of Insurance, such as Workers' Compensation, sick pay and Social Security. However, in no event will your benefit payment be less than $50.00 per month.

ELIMINATION PERIOD OPTIONS

The Elimination Period is the period of time you must be disabled before benefits become payable. Your benefit payments will begin after you have been totally disabled for a specified period of time, depending on which of the following Elimination Periods you have selected:

Option I Six (6) month Elimination Period

Option II Nine (9) month Elimination Period

Option III Eighteen (18) month Elimination Period*

Option IV Twenty-four (24) month Elimination Period*

***Note**: Effective February 1, 2009, Option III and Option IV are no longer offered to new enrollees.

WHEN YOU ARE ELIGIBLE FOR A MONTHLY BENEFIT

You will be paid a monthly benefit if:

1. You become totally disabled;
2. You are totally disabled throughout the Elimination Period;
3. You remain totally disabled beyond the Elimination Period;
4. You are under the regular care of a physician; and
5. You submit proof of loss satisfactory to Hartford.

"Totally Disabled" means that during the Elimination Period and for the next twenty-four (24) months you are unable to perform the duties of your own occupation on a regularly scheduled basis and as a result, you are earning less than 80% of your pre-disability earnings. Thereafter, "Total Disability" is defined as the inability to perform any occupation or work for which you are or could become qualified by training, education, or experience.

TERMINATION OF BENEFITS

If you become totally disabled, benefits will be paid until the earliest of the following dates:

1. The date you are no longer totally disabled.
2. The date you fail to furnish proof that you are continuously disabled.
3. The date you are no longer under the regular care of a physician or refuse to be examined, if Hartford requires an examination.
4. The date you die.
5. The date determined in accordance with the Maximum Duration of Benefits Table below, which shows the maximum duration for which benefits may be paid.

Maximum Duration of Benefits Table

AGE WHEN TOTALLY DISABLED	MAXIMUM BENEFIT DURATION
Prior to age 63	To **Normal Retirement Age*** or 42 months, if greater
Age 63	36 months
Age 64	30 months
Age 65	24 months
Age 66	21 months
Age 67	18 months
Age 68	15 months
Age 69 and over	12 months
Mental Illness/Substance Abuse (if not confined)	24 months

* **Normal Retirement Age** means the Social Security Normal Retirement Age as determined by your date of birth.

EXCLUSIONS

The Plan does not cover and no benefit will be payable for any disability which is caused by, due to, or contributed to by:

1. Your commission of or attempt to commit a felony, or being engaged in an illegal occupation;
2. An intentionally self-inflicted injury;
3. War or any act of war (declared or not); or
4. A pre-existing condition. (A pre-existing condition means any disability, diagnosed or undiagnosed, for which you received medical care within 90 days prior to the effective date of your coverage or of a change in your coverage.)

HOW TO FILE A CLAIM

If you become totally disabled:

- Notify the HSTA Voluntary Employees Beneficiary Association Trust Office as soon as possible. Written notice of your claim must be provided to Hartford within 30 days after you become disabled. A claim form for providing proof of loss will then be sent to you. Proof of loss may include but not be limited to documentation of your disability, your earnings or income, and medical information.
- You, your physician, and your employer must complete the claim form. The completed claim form is to be sent to the HSTA Voluntary Employees Beneficiary Association Trust Office who will forward the claim form to Hartford. Written proof of loss must be sent to Hartford within 90 days after the start of your disability.

ABILITY ASSIST

Ability Assist is a series of free support benefits for those enrolled in the Long-Term Income Protection Insurance Plan:

1. Toll free access to counselors (800) 964-3577 available 24 hours a day, 7 days a week.
2. Telephone assessments, referrals to local resources and services such as assistive equipment and home remodeling and respite care for caregivers.
3. Ability Assist interactive web services with additional information and resources as well as self-assessment tools.
4. Up to five face-to-face assessment and counseling sessions.

TRAVEL ASSIST

Travel Assist is available to enrollees who travel more than 100 miles from their primary home. Members can call (800) 243-6108 24 hours a day, 7 days a week for free access to travel assistance including:

1. Pre-trip Information
2. Emergency Medical Assistance
3. Emergency Personal Services

The preceding long-term income protection insurance benefits are insured under a contract issued by Hartford Life and Accident Insurance Company, 200 Hopmeadow Street, Simsbury, Connecticut 06089. The services provided by Hartford Life and Accident Insurance Company include the payment of claims and the handling of claims appeals.

The preceding is for informational purposes only and is only a summary provided to help you understand your long-term income protection insurance coverage from Hartford. Its contents are subject to the provisions of the group insurance policy with Hartford Life and Accident Insurance Company, and all amendments thereto, which contain all the terms and conditions of coverage and benefits. These documents are on file with the HSTA Voluntary Employees Beneficiary Association Trust Office. If the terms of the preceding Plan summary differ from the policy documents, the policy will govern. Please refer to the policy documents and your Certificate of Insurance, which you received when you enrolled in the long-term income protection insurance plan, for specific questions about coverage.

METROPOLITAN LIFE INSURANCE COMPANY

Critical Illness Insurance

Critical Illness Insurance will provide a lump sum payment when you are diagnosed with one of the covered conditions. This plan does not provide any type of medical coverage and is not a substitute for medical coverage or disability insurance. You should have medical insurance in place when you apply for coverage under this plan.

The following is a summary of coverage for informational purposes only. In the event of a conflict between this summary and the HSTA Voluntary Employees Beneficiary Association Trust group policy with Metropolitan Life Insurance Company and the MetLife Certificate of Insurance sent to you, the policy and Certificate will govern.

WHO IS ELIGIBLE?

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 enroll in the Critical Illness Insurance Plan.

DEPENDENT COVERAGE

When you apply for insurance for yourself, you may also apply for coverage for your dependents. Eligible dependents include your legal spouse and unmarried children under 19 years of age.

The term "children" includes a natural child, an adopted child, a stepchild, or a foster child who is dependent upon you for financial support. Dependent children who are full-time students at an accredited school, college, or university will continue to be eligible for dependent coverage from 19 years of age through 22 years of age. In order for your dependent child to be covered as a full-time student, you must certify annually, and as requested by the Trust Office, that he or she is a full-time student at an accredited school, college, or university by completing the Student Certification form issued to you by the Trust Office. **Failure to submit the required certification will result in cancellation of the child's coverage.** You are also responsible for promptly notifying the Trust Office, in writing, of any change in your dependent's eligibility status outside the annual certification.

To add a new spouse or dependent child, you must submit an application for enrollment within 30 days of the date of marriage, birth, adoption, or legal guardianship. If you do not submit an enrollment application within this 30-day period, you must wait until the next open enrollment period to add your new dependent.

If your spouse is also an eligible participant, he or she cannot be covered as a "Spouse" but must apply for coverage as an individual member. If both you and your spouse are insured members, your children may be covered as dependents of either member, but not both.

Dependent insurance will take effect on the date MetLife approves each dependent for coverage provided that the dependent is not confined at home under a physician's care, receiving or applying to receive disability benefits from any source, or hospitalized. **Exception:** Approval is not required for your newborn children. Once you have dependent insurance for at least one dependent child, if another child becomes your dependent, that child will automatically be covered.

BENEFIT OPTIONS

Benefit Amount means the amount used by the plan to determine the benefit payable for a covered condition. You may elect one of the following Benefit Amounts for yourself and your covered dependents:

Option I $15,000

Option II $30,000

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.

COVERED CONDITIONS AND SCHEDULE OF INSURANCE

The Critical Illness Insurance Plan provides payments for the following covered conditions based on a percentage of the Benefit Amount elected. **This is only a summary of coverage. In the event of a conflict between this summary and your Certificate of Insurance, the Certificate will prevail. Please review your Certificate of Insurance for information on specific terms, conditions and exclusions of coverage.**

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 Cerebral palsy Cleft lip or cleft palate Cystic fibrosis Diabetes (type 1) Down syndrome Sickle cell anemia Spina bifida	100% of Benefit Amount	None
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
Infectious Disease Legionnaire's disease Lyme disease Malaria Necrotizing fasciitis Osteomyelitis Rabies Tetanus Tuberculosis	100% of Benefit Amount	None

COVERED CONDITION	INITIAL BENEFIT	RECURRENCE BENEFIT
Kidney Failure	100% of Benefit Amount	None
Major Organ Transplant	100% of Benefit Amount	None
Progressive Disease 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)	100% of Benefit Amount	None
Severe Burn	100% of Benefit Amount	100% of Initial Benefit Amount
Stroke	100% of Benefit Amount	100% of Initial Benefit Amount

SUPPLEMENTAL HEALTH SCREENING BENEFIT

SUPPLEMENTAL BENEFIT	BENEFIT AMOUNT	BENEFIT MAXIMUM
Health Screening Please refer to your Certificate of Insurance for a listing of the screening/preventive measures for which the Health Screening Benefit may be paid.	$100 per covered person	Once per Calendar Year

GENERAL EXCLUSIONS AND LIMITATIONS

The following exclusions apply to all covered conditions and benefits of this plan. Please note that certain covered conditions have additional exclusions 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.

Benefit Suspension Period Between Occurrences

The **Benefit Separation Period** is the number of days that must elapse between occurrences of covered conditions 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.

Preexisting Condition Limitation

Benefits will not be paid for 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. Preexisting condition means 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 the 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 to the covered person 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.

HOW TO FILE A CLAIM

You can designate another person to act on your behalf in the handling of your benefit claims. In order to do so, you must complete and file a form with the Trust Office and/or the insurance carrier that identifies the individual that is authorized to act on your behalf as your authorized representative. If you designate an authorized representative to act on your behalf, all correspondence and benefit determinations will be directed to your authorized representative, unless you direct otherwise. You may also request that this information be provided to both you and your authorized representative.

To file a claim for benefits, notice of the claim and proof of the claim must be submitted as follows:

Step 1: You must give notice by writing or calling MetLife within 30 days of the date of your loss.

Step 2: MetLife will send you a claim form and instructions on how to complete it. You should receive the form within 15 days of giving notice of your claim.

Step 3: When you receive the claim form, you should fill it out as instructed and return it with the required proof of claim.

Step 4 You must provide proof of your claim within 90 days of the date of your loss. If notice or proof of your claim is not given within the time limits described, the delay will not cause a claim to be denied or reduced if such notice and proof are given as soon as reasonably possible, but in no event later than 15 months from the date of your loss.

Your Certificate of Insurance contains specific proof requirements for covered conditions. You may be required to also provide authorization for MetLife to obtain medical records and other information pertinent to your claim and/or be examined by an independent physician at the Company's expense.

For assistance in filing a claim or if you have any questions regarding claims and appeals procedures, contact the Trust Office or 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 Illness Insurance Product
P.O. Box 80826
Lincoln, NE 68501-0826
FAX: 1-866-268-2621

Appealing a Claim Decision

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.

Time Limit on Legal Actions

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.

PAYMENT OF BENEFITS

Benefit payments will be made to you while you are living and to your designated beneficiary upon your death. On your Critical Illness Insurance Enrollment Application form, you may name anyone you wish as your beneficiary. You may change your beneficiary at any time by submitting a Beneficiary Designation/Name Change form to the Trust Office. The change will take effect as of the date that you sign the form and will not apply to any payment made before the change request was recorded.

If you designate a beneficiary, upon your death, any amount that is due or becomes due will be paid to the beneficiary or beneficiaries named in writing by you, provided the names are on file with the Trust Office.

Unless you request otherwise in your filed beneficiary designation, payment shall be made as follows:

(a) If more than one beneficiary is named, each will be paid an equal share.

(b) If any named beneficiary dies before you, his/her share will be divided equally among the named beneficiaries who survive you.

(c) If no beneficiary is named, or if no named beneficiary survives you, MetLife may, at the Company's option, pay the first of the following classes of successive preference beneficiaries who survive you:

   (i) all to your surviving spouse;

   (ii) if your spouse does not survive you, in equal shares to your surviving children;

   (vi) if no child survives you, in equal shares to your surviving parents;

   (vii) if no parent survives you, in equal shares to your surviving brothers and sisters;

   (viii) if none of the above survives you, to your estate.

WHEN INSURANCE ENDS

Your insurance will end on the earliest of the following dates:

- the end of the period for which the last full premium has been paid
- the date you cease to be in an eligible class
- the date insurance ends for your class
- the date you die
- the date this plan ends

A dependent's insurance will end on the earliest of the following dates:

- the end of the period for which the last full premium has been paid
- the date the person ceases to be an eligible dependent under this plan
- the date your insurance ends
- the date you cease to be in a class that is eligible for dependent insurance
- the date dependent insurance ends for all members or for your class

CONTINUED INSURANCE

If your insurance ends because you cease to be in an eligible class, you may continue coverage for yourself and your dependents by submitting a written request to MetLife within 31 days. You must also make the first premium payment for continued insurance during this 31-day period. Your premium rate for continued insurance will be the same as the premium rate charged under the group plan. Increases or decreases in the group premium will apply to the premium you pay for continued insurance.

If elected, your continued insurance will end on the earliest of the following dates:

- the end of the period for which the last full premium has been paid
- the date group insurance ends for the class that you are in
- the date group insurance ends for the class you were last in before obtaining continued insurance
- the date you die
- the date this plan ends

If elected, continued dependent insurance will end on the earliest of the following dates:

- the end of the period for which the last full premium has been paid
- the date the person ceases to be an eligible dependent under this plan
- the date your continued insurance ends for any reason
- the date dependent insurance ends for all members under the group insurance
- the date dependent insurance ends for the class that you are in
- the date dependent insurance ends for the class you were last in before obtaining continued insurance

At the end of the continuation periods listed above, if you resume membership in an eligible class at that time, you will continue to be insured under the group policy. If you do not resume membership in an eligible class at that time, your employment will be considered to end and your insurance and dependent insurance will end.

The preceding critical illness insurance benefits are insured under a contract issued by Metropolitan Life Insurance Company, 200 Park Avenue, New York, New York, 10166-0188. The services provided by MetLife include the payment of claims and the handling of claims appeals.

The preceding is for informational purposes only and is only a summary provided to help you understand your critical illness insurance coverage from MetLife. Its contents are subject to the provisions of the group insurance policy with Metropolitan Life Insurance Company, and all amendments thereto, which contain all the terms and conditions of coverage and benefits. These documents are on file with the HSTA Voluntary Employees Beneficiary Association Trust Office. If the terms of the preceding Plan summary differ from the policy documents, the policy will govern. Please refer to the policy documents and your Certificate of Insurance, which you received when you enrolled in the critical illness insurance plan, for specific questions about coverage.

METROPOLITAN LIFE INSURANCE COMPANY

Accident Insurance

Accident Insurance will pay lump-sum benefits for covered injuries and expenses, including emergency room care and related surgery resulting from a covered accident. This benefit can help offset your out-of-pocket expenses that medical insurance does not pay, including deductibles and co-pays.

The following is a summary of coverage for informational purposes only. In the event of a conflict between this summary and the HSTA Voluntary Employees Beneficiary Association Trust group policy with Metropolitan Life Insurance Company and the MetLife Certificate of Insurance sent to you, the policy and Certificate will govern.

WHO IS ELIGIBLE?

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 under the Accident Insurance Plan.

DEPENDENT COVERAGE

When you apply for insurance for yourself, you may also apply for coverage for your dependents. Eligible dependents include your legal spouse and unmarried children under 19 years of age.

The term "children" includes a natural child, an adopted child, a stepchild, or a foster child who is dependent upon you for financial support. Dependent children who are full-time students at an accredited school, college, or university will continue to be eligible for dependent coverage from 19 years of age through 22 years of age. In order for your dependent child to be covered as a full-time student, you must certify annually, and as requested by the Trust Office, that he or she is a full-time student at an accredited school, college, or university by completing the Student Certification form issued to you by the Trust Office. **Failure to submit the required certification will result in cancellation of the child's coverage.** You are also responsible for promptly notifying the Trust Office, in writing, of any change in your dependent's eligibility status outside the annual certification.

To add a new spouse or dependent child, you must submit an application for enrollment within 30 days of the date of marriage, birth, adoption, or legal guardianship. If you do not submit an enrollment application within this 30-day period, you must wait until the next open enrollment period to add your new dependent.

If your spouse is also an eligible participant, he or she cannot be covered as a "Spouse" but must apply for coverage as an individual member. If both you and your spouse are insured members, your children may be covered as dependents of either member, but not both.

CHANGES IN COVERAGE

Outside of your initial eligibility period, you can elect coverage and/or make a change in your benefit option only during the annual open enrollment period. You can cancel your coverage at any time by notifying the Trust Office in writing. Coverage for you and any enrolled family members will end on the first day of the month following the date of notification.

BENEFIT OPTIONS AND SCHEDULE OF INSURANCE

You may elect either the **Gold Plan** or **Platinum Plan** benefit option for yourself and your covered dependents. Before making your selection, please review the current Schedule of Insurance and monthly premium amounts which may be obtained from the Trust Office.

The following is a summary of benefits under the Accident Insurance Plan. **This is only a summary of coverage. In the event of a conflict between this summary and your Certificate of Insurance, the Certificate will prevail. Please review your Certificate of Insurance for information on specific terms, conditions and exclusions of coverage.**

Schedule of Insurance

ACCIDENTAL DEATH	GOLD PLAN BENEFIT AMOUNT	PLATINUM PLAN BENEFIT AMOUNT
Basic Accidental Death Benefit		
Member	$25,000	$50,000
Spouse	$10,000	$20,000
Dependent Child	$5,000	$10,000
Accidental Death – Common Carrier Benefit		
Member	$50,000	$150,000
Spouse	$20,000	$60,000
Dependent Child	$10,000	$30,000
The Accidental Death benefit amount will be reduced by the amount of any Accidental Dismemberment/Functional Loss/Paralysis Benefit and Modification Benefit paid for injuries sustained by the covered person in the same accident for which the Accidental Death Benefit is being paid.		

ACCIDENTAL DISMEMBERMENT/ FUNCTIONAL LOSS/PARALYSIS	GOLD PLAN BENEFIT AMOUNT	PLATINUM PLAN BENEFIT AMOUNT
Basic Dismemberment Benefit		
Loss of one finger or one toe	$750	$1,000
Loss of one arm or one leg	$10,000	$15,000
Loss of one hand or one foot	$10,000	$15,000
Loss of two or more fingers or toes in any combination	$1,500	$2,000
Basic Functional Loss Benefit		
Loss of sight in one eye	$10,000	$15,000
Loss of hearing in one ear	$10,000	$15,000
Catastrophic Dismemberment Benefit		
Loss of both arms or both legs or one arm and one leg	$20,000	$100,000 (Member) $50,000 (Spouse/Child)
Loss of both hands or both feet or one hand and one foot	$20,000	$100,000 (Member) $50,000 (Spouse/Child)
Catastrophic Functional Loss Benefit		
Loss of sight in both eyes	$20,000	$100,000 (Member) $50,000 (Spouse/Child)
Loss of hearing in both ears	$20,000	$100,000 (Member) $50,000 (Spouse/Child)
Loss of ability to speak	$20,000	$100,000 (Member) $50,000 (Spouse/Child)

ACCIDENTAL DISMEMBERMENT/ FUNCTIONAL LOSS/PARALYSIS	GOLD PLAN BENEFIT AMOUNT	PLATINUM PLAN BENEFIT AMOUNT
Paralysis Benefit		
One limb (monoplegia)	$0	$100,000 (Member) $50,000 (Spouse/Child)
Two limbs (paraplegia or hemiplegia	$10,000	$100,000 (Member) $50,000 (Spouse/Child)
Four limbs (quadriplegia)	$20,000	$100,000 (Member) $50,000 (Spouse/Child)

ACCIDENTAL INJURY	GOLD PLAN BENEFIT AMOUNT	PLATINUM PLAN BENEFIT AMOUNT
Fracture Benefit		
Closed Reduction	$100 to $4,000	$200 to $5,000
Open Reduction	$200 to $8,000	$400 to $10,000
Chip Fracture Benefit	25% of applicable benefit for the bone involved	25% of applicable benefit for the bone involved
Full Dislocation Benefit		
Closed Reduction	$100 to $4,000	$200 to $5,000
Open Reduction	$200 to $8,000	$400 to $10,000
Partial Dislocation Benefit	25% of applicable benefit for the joint involved	25% of applicable benefit for the joint involved
Burn Benefit (depending on percentage of burnt skin)		
Second Degree Burn	$75 to $1,000	$100 to $1,500
Third Degree Burn	$1,250 to $10,000	$1,500 to $15,000
Skin Graft Benefit for a burn for which the Burn Benefit was paid	50% of the Burn Benefit that was paid	50% of the Burn Benefit that was paid
Concussion Benefit	$250	$500
Coma Benefit	$7,500	$10,000
Laceration Benefit (depending on length of cut and type of repair)	$50 to $400	$75 to $700
Broken Tooth Benefit		
Crown	$200	$300
Extraction	$100	$150
Filling	$25	$50
Eye injury Benefit	$300	$400

ACCIDENT – MEDICAL TREATMENT AND SERVICES	GOLD PLAN BENEFIT AMOUNT	PLATINUM PLAN BENEFIT AMOUNT
Ambulance Benefit		
Air ambulance	$750	$1,500
Ground ambulance	$200	$400
Emergency Care Benefit		
Emergency Room	$150	$200
Physician's Office or Urgent Care	$75	$100
Non-Emergency Initial Care Benefit	$75	$100
Medical Testing Benefit	$150	$200
Physician Follow-up Visit Benefit	$75	$100
Transportation Benefit	$400	$500
Therapy Services Benefit	$35	$50
Pain Management Benefit (Epidural anesthesia)	$75	$100
Prosthetic Device Benefit		
One device only	$750	$1,000
More than one device	$1,500	$2,000
Medical Appliance Benefit		
Brace, cane, crutches	$75	$150
Walker - expected use less than 1 year	$150	$200
Walker - expected use 1 year or longer	$300	$400
Walking boot	$75	$150
Wheel chair or motorized scooter – expected use less than 1 year	$200	$300
Wheel chair or motorized scooter – expected use 1 year or longer	$750	$1,000
Other medical mobility device	$75	$150
Medical Appliance Benefit limit for all medical appliances, combined, per covered person, per accident	$750	$1,000
Modification Benefit	$1,000	$1,500
Blood/Plasma/Platelets Benefit	$400	$500

ACCIDENT – MEDICAL TREATMENT AND SERVICES	GOLD PLAN BENEFIT AMOUNT	PLATINUM PLAN BENEFIT AMOUNT
Surgery Benefit		
Surgical Repair	$150 to $1,500	$200 to $2,000
Exploratory Surgery	$150	$200
Other Outpatient Surgery	$300	$400
ACCIDENT – HOSPITAL BENEFITS	**GOLD PLAN BENEFIT AMOUNT**	**PLATINUM PLAN BENEFIT AMOUNT**
Hospital admission	$1,000	$1,500
Intensive care (ICU) admission	$1,000	$1500
Hospital confinement (per day)	$200	$300
ICU confinement (per day)	$200	$300
Inpatient rehabilitation (per day)	$150	$200
OTHER BENEFITS	**GOLD PLAN BENEFIT AMOUNT**	**PLATINUM PLAN BENEFIT AMOUNT**
Lodging Benefit (per day) for companion of covered person who is hospitalized	$200	$300
Organized Sports Activity Injury Benefit Rider	An additional 25% of eligible Accidental Injury, Accident – Medical Treatment and Services, and Accident – Hospital benefits will be paid if accident is due to an organized sports activity	An additional 25% of eligible Accidental Injury, Accident – Medical Treatment and Services, and Accident – Hospital benefits will be paid if accident is due to an organized sports activity

GENERAL EXCLUSIONS AND LIMITATIONS

The following exclusions and limitations apply to the payment of all benefits under this plan. Please note that certain benefits are subject to additional exclusions and limitations which are set forth in the benefit provisions of your Certificate of Insurance.

The plan will not pay benefits for any loss for a covered person caused by the covered person's sickness, or the diagnosis or treatment of such sickness, except for the covered person's use of:

- Any drug, medication or sedative that is taken or used as prescribed by a physician; or
- An over-the-counter drug, medication or sedative taken as directed.

The Plan will not pay benefits for any loss for a covered person caused or contributed by:

- Covered person's voluntary use, by any means of 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 as directed;
- Covered person's voluntary use of alcohol in combination with any drug, medication or sedative;
- Covered persons voluntary use of poison, gas, or fumes;
- Covered person's suicide or attempted suicide (while sane or insane);
- Covered person's intentionally self-inflicted injury;
- War, whether declared or undeclared; or act of war;

- 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 occurred;
- Covered person's infection, other than an infection occurring in an external wound resulting from an injury;
- Food poisoning;
- 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%;
- Dental or plastic surgery for cosmetic purposes, except when such surgery is performed to: (i) treat an injury; or (ii) correct a disorder of normal bodily function or structure that was caused by an injury for which coverage is not otherwise excluded under this plan; or (iii) reconstruct a part of the body which was disfigured or removed as a result of an injury for which coverage is not otherwise excluded under this plan;
- Covered person's mental illness, or the diagnosis or treatment of such mental illness, except for the covered person's use of: (i) any drug, medication or sedative that is taken or used as prescribed by a physician; or (ii) an over-the-counter drug, medication or sedative taken as directed;
- 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;
- Covered person's travel or flight in any aircraft except as a fare-paying passenger on a regularly scheduled charter or commercial flight;
- Covered person parachuting or otherwise exiting from a motorized or non-motorized aircraft while such aircraft is in flight, except for self-preservation;
- Covered person riding in or driving any motor-driven vehicle in a race, stunt show or speed test;
- Covered person participating in any semi-professional or professional competitive athletic activity for which any type of compensation or remuneration is received; or
- Covered person bungee jumping, base jumping, hang gliding, para-kiting, sail-gliding, scuba diving deeper than 130 feet, spelunking, or mountaineering including rock climbing using ropes and any other climbing equipment. For purposes of this exclusion, the term mountaineering does not include backpacking, mountain biking, hiking or trail running.

In addition, the plan will not pay benefits for:

- Covered person while incarcerated in any type of penal or detention facility; or
- Any medical treatment, services or transportation described in the Accident – Medical Treatment and Services Benefit section rendered outside of the United States, Canada or Mexico; or
- Any inpatient admission or stay in any medical or health care facility outside of the United States, Canada or Mexico.

Your Certificate of Insurance contains certain conditions, 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.

HOW TO FILE A CLAIM

You can designate another person to act on your behalf in the handling of your benefit claims. In order to do so, you must complete and file a form with the Trust Office and/or the insurance carrier that identifies the individual that is authorized to act on your behalf as your authorized representative. If you designate an authorized representative to act on your behalf, all correspondence and benefit determinations will be directed to your authorized representative, unless you direct otherwise. You may also request that this information be provided to both you and your authorized representative.

To file a claim for benefits, notice of the claim and proof of the claim must be submitted as follows:

Step 1: You must give notice by writing or calling MetLife within 30 days of the date of your loss.

Step 2: MetLife will send you a claim form and instructions on how to complete it. You should receive the form within 15 days of giving notice of your claim.

Step 3: When you receive the claim form, you should fill it out as instructed and return it with the required proof of claim.

Step 4 You must provide proof of your claim within 90 days of the date of your loss. If notice or proof of your claim is not given within the time limits described, the delay will not cause a claim to be denied or reduced if such notice and proof are given as soon as reasonably possible, but in no event later than 15 months from the date of your loss.

Your Certificate of Insurance contains specific proof requirements for covered benefits. You may be required to also provide authorization for MetLife to obtain medical records and other information pertinent to your claim and/or be examined by an independent physician at the Company's expense.

For assistance in filing a claim or if you have any questions regarding claims and appeals procedures, contact the Trust Office or 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: Accident Insurance Product
P.O. Box 80826
Lincoln, NE 68501-0826
FAX: 1-866-268-2621

Appealing a Claim Decision

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.

Time Limit on Legal Actions

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.

PAYMENT OF BENEFITS

Benefit payments will be made to you while you are living and to your designated beneficiary upon your death. On your Accident Insurance Enrollment Application form, you may name anyone you wish as your beneficiary. You may change your beneficiary at any time by submitting a Beneficiary Designation/Name Change form to the Trust Office. The change will take effect as of the date that you sign the form and will not apply to any payment made before the change request was recorded.

If you designate a beneficiary, upon your death, any amount that is due or becomes due will be paid to the beneficiary or beneficiaries named in writing by you, provided the names are on file with the Trust Office.

Unless you request otherwise in your filed beneficiary designation, payment shall be made as follows:

(a) If more than one beneficiary is named, each will be paid an equal share.

(b) If any named beneficiary dies before you, his/her share will be divided equally among the named beneficiaries who survive you.

(c) If no beneficiary is named, or if no named beneficiary survives you, MetLife may, at the Company's option, pay the first of the following classes of successive preference beneficiaries who survive you:

  (i) all to your surviving spouse;

  (ii) if your spouse does not survive you, in equal shares to your surviving children;

  (ix) if no child survives you, in equal shares to your surviving parents;

  (x) if no parent survives you, in equal shares to your surviving brothers and sisters;

  (xi) if none of the above survives you, to your estate.

WHEN INSURANCE ENDS

Your insurance will end on the earliest of the following dates:

- the end of the period for which the last full premium has been paid
- the date you cease to be in an eligible class
- the date insurance ends for your class
- the date you die
- the date this plan ends

A dependent's insurance will end on the earliest of the following dates:

- the end of the period for which the last full premium has been paid
- the date the person ceases to be an eligible dependent under this plan
- the date your insurance ends
- the date you cease to be in a class that is eligible for dependent insurance
- the date dependent insurance ends for all members or for your class

CONTINUED INSURANCE

If your insurance ends because you cease to be in an eligible class, you may continue coverage for yourself and your dependents by submitting a written request to MetLife within 31 days. You must also make the first premium payment for continued insurance during this 31-day period. Your premium rate for continued insurance will be the same as the premium rate charged under the group plan. Increases or decreases in the group premium will apply to the premium you pay for continued insurance.

If elected, your continued insurance will end on the earliest of the following dates:

- the end of the period for which the last full premium has been paid
- the date group insurance ends for the class that you are in
- the date group insurance ends for the class you were last in before obtaining continued insurance
- the date you die
- the date this plan ends

If elected, continued dependent insurance will end on the earliest of the following dates:

- the end of the period for which the last full premium has been paid
- the date the person ceases to be an eligible dependent under this plan
- the date your continued insurance ends for any reason
- the date dependent insurance ends for all members under the group insurance
- the date dependent insurance ends for the class that you are in
- the date dependent insurance ends for the class you were last in before obtaining continued insurance

At the end of the continuation periods listed above, if you resume membership in an eligible class at that time, you will continue to be insured under the group policy. If you do not resume membership in an eligible class at that time, your employment will be considered to end and your insurance and dependent insurance will end.

The preceding accident insurance benefits are insured under a contract issued by Metropolitan Life Insurance Company, 200 Park Avenue, New York, New York, 10166-0188. The services provided by MetLife include the payment of claims and the handling of claims appeals.

The preceding is for informational purposes only and is only a summary provided to help you understand your accident insurance coverage from MetLife. Its contents are subject to the provisions of the group insurance policy with Metropolitan Life Insurance Company, and all amendments thereto, which contain all the terms and conditions of coverage and benefits. These documents are on file with the HSTA Voluntary Employees Beneficiary Association Trust Office. If the terms of the preceding Plan summary differ from the policy documents, the policy will govern. Please refer to the policy documents and your Certificate of Insurance, which you received when you enrolled in the accident insurance plan, for specific questions about coverage.

UNUM LIFE INSURANCE COMPANY OF AMERICA

Long-Term Care Insurance

Long-Term Care Insurance provides benefits when you are disabled and need assistance either at home or in a facility with activities of daily living or require supervision to protect you from threats to health and safety due to severe cognitive impairment.

The following is a summary of coverage for informational purposes only. In the event of a conflict between this summary and the HSTA Voluntary Employees Beneficiary Association Trust group policy with UNUM Life Insurance Company of America and the UNUM Certificate of Insurance sent to you, the policy and Certificate will govern.

WHO IS ELIGIBLE?

If you are an HSTA Member **and** a Trust participant covered under at least one (1) of the Trust's insurance benefit plans other than the Long-Term Care Insurance Plan, you and your family members are eligible to apply for coverage under the Long-Term Care Insurance Plan.

BASE COVERAGE FOR ACTIVE PARTICIPANTS

If you are an Active Trust Participant working a minimum of 17.5 hours per week, you will be automatically enrolled for Base Coverage at no cost to you. The Base Coverage is as follows:

Elimination (Waiting) Period .... 90 consecutive days

Monthly Benefit Maximums*
Long-Term Care Facility $1,000
Assisted Living Facility $600
Professional Home Care Services $500

Lifetime Maximum Amount* $36,000

In addition to the Base Coverage, you may also apply for Additional Buy-Up Coverage described on following pages. However, you are responsible for the cost of all Additional Buy-Up Coverage. If you apply for Additional Buy-Up Coverage during an open enrollment period, you will not be required to furnish information on your health status. If you apply at any other time, you must submit information on your health status and the insurance company has the right to decide whether to accept or deny your request for coverage.

BASE COVERAGE FOR RETIRED PARTICIPANTS

If you are a Retired Trust Participant under age 85, you will be enrolled for Base Coverage at no cost to you after you have completed a questionnaire and the insurance company determines that you are not disabled at the time of enrollment. (**Note**: If you are currently a Retired Trust Participant but enrolled in the plan when you were an Active Trust Participant and have had continuous coverage, you will continue to have the coverage described for Active Trust Participants). The Base Coverage for Retired Trust Participants is as follows:

Elimination (Waiting) Period .... 90 consecutive days

Monthly Benefit Maximums*
Long-Term Care Facility $1,000
Assisted Living Facility $600
Professional Home Care Services $500

Lifetime Maximum Amount* $24,000

In addition to the Base Coverage, you may also apply for Additional Buy-Up Coverage described on the following pages. However, you are responsible for the cost of all Additional Buy-Up Coverage. You will be required to furnish information on your health status and the insurance company has the right to decide whether to accept or deny your request or coverage.

DEPENDENT COVERAGE

As long as you are enrolled for coverage under the Long-Term Care Insurance Plan, your family members may also apply for coverage. Eligible family members are your spouse, your children, your parents, stepparents, siblings, parents-in-law, grandparents, and grandparents-in-law. All family members applying for coverage must be between the ages of 18 and 84. All applications for coverage of your family members must include information on health status and the insurance company has the right to decide whether to accept or deny such requests for coverage. At a minimum, eligible family members must apply for the Base Coverage and you or your family member will be responsible for the entire cost of dependent coverage.

ADDITIONAL BUY-UP COVERAGE OPTIONS

You and your enrolled family members may apply for Additional Buy-Up Coverage as described below. You or your family members are responsible for the entire cost of Additional Buy-Up Coverage.

1. Increased Monthly Benefit Maximum*

Long-Term Care Facility Benefit.. Additional $500 increments, Up to a Total Monthly Benefit Maximum of $8,000

Note: Your Assisted Living Facility Monthly Benefit Maximum will be 60% of the Long-Term Care Facility Monthly Benefit. Your Professional Home Care Services Monthly Benefit Maximum will be 50% of the Long-Term Care Facility Monthly Benefit.

2. Total Home Care

If you choose this option, those services covered under Professional Home Care Services may also be provided by an informal caregiver, such as a friend or relative.

3. 5% Annual Simple Growth Inflation Protection

Example: A monthly benefit amount of $1,000 will be increased:

A. By $50 on January 1st of the next calendar year; and

B. By another $50 on each following January 1st.

If you choose this option, as long as your coverage remains in effect, these inflation increases will occur automatically regardless of your health or whether or not you are disabled. If you decline the inflation option at the time you apply for any coverage, you cannot add it to that coverage at a later date.

Your Monthly Benefit Maximum and Lifetime Maximum Amount will be adjusted to include any inflation option increases, if applicable.

4. Non-Forfeiture Benefit

If you choose this option and your premium payments stop after your coverage has been in force (you were continuously covered) for at least three years, your coverage will continue automatically with the same level of benefits, except for a reduction in your Lifetime Maximum Amount. Your Lifetime Maximum Amount under this option will be equal to the total premium paid up to the date you stopped paying premiums. In no event will the Lifetime Maximum Amount be less than one Long-Term Care Facility monthly benefit payment amount or exceed that which would have been paid had you not stopped paying premiums. No inflation protection increases, if applicable, will be made after the end of the period for which your premium payments stop.

5. Increased Lifetime Maximum Amount* (Applies to all Long-Term Care benefits)

If you choose this option, you may elect to increase the Lifetime Maximum Amount to:

A. If you are an Active Trust Participant (or eligible family member)

1. 36 times the "Long Term Care Facility" Amount; or
2. 48 times the "Long Term Care Facility" Amount; or
3. 72 times the "Long Term Care Facility" Amount

B. If you are a Retired Trust Participant (or eligible family member)

1. 24 times the "Long Term Care Facility" Amount; or
2. 36 times the "Long Term Care Facility" Amount; or
3. 60 times the "Long Term Care Facility" Amount

WHEN YOU ARE ELIGIBLE FOR A MONTHLY BENEFIT

You are eligible for a Monthly Benefit after all of the following are met:

1. You become disabled; and
2. You are receiving services in a Long-Term Care Facility or Assisted Living Facility or Professional Home Care Services (or Total Home Care if your plan includes a Total Home Care Benefit); and
3. You have satisfied your 90-day Elimination Period; and
4. A physician has certified that you are disabled. "Disabled" means you are unable to perform (without substantial assistance from another individual) two or more Activities of Daily Living (ADL) for a period of at least 90 days, or you require substantial supervision by another individual to protect you and others from threats to health or safety due to severe cognitive impairment. You will be required to submit a physician certification every 12 months.

The treatment and services you receive for your disability must be provided in accordance with a written plan of care developed by a licensed health care practitioner.

Important

If you have a loss of Activities of Daily Living (ADL) or severe cognitive impairment before your effective date of coverage, that loss or impairment will never be covered, unless you completely recover from that loss or impairment.

DEFINITIONS AND BENEFITS

Activities of Daily Living (ADL)

Activities of Daily Living (ADL) are:

1. **BATHING** - Washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower with or without equipment or adaptive devices.
2. **DRESSING** - Putting on and taking off all items of clothing, any necessary braces, fasteners, or artificial limbs.
3. **TOILETING** - Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
4. **TRANSFERRING** - Moving into or out of bed, chair, or wheelchair with or without equipment such as canes, walkers, crutches or grab bars or other supportive devices including mechanical or motorized devices.

5. **CONTINENCE** - The ability to maintain control of bowel or bladder function; or, when unable to maintain control of bowel or bladder functions, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).
6. **EATING** - Feeding oneself by getting food into the body from a receptacle (such as a plate, cup, or table) or by a feeding tube or intravenously.

Bed Reservation Benefit

If you are receiving a Long-Term Care Facility or Assisted Living Facility monthly benefit and your stay in the Facility is interrupted because you are hospitalized, UNUM will continue to pay the monthly benefit if a charge is made to reserve your accommodations in the facility, up to a maximum of 15 days per calendar year.

Elimination Period

The "Elimination Period" is the number of consecutive days during which you must be disabled and under the regular care of a Physician before benefits become payable.

Professional Home Care Services

Each calendar week that you receive at least one day of these services will be counted as seven days towards completing the Elimination Period. However, if you do not receive these services for at least one day within a calendar week, the Elimination Period will begin again.

The amount of your monthly benefit will be based on the coverage options you chose.

For Professional Home Care Services, the benefit payment will be based on the number of days you receive these services each month. A monthly benefit payable for less than one month will be paid at 1/30th of the monthly benefit amount for each day you are eligible for a monthly benefit.

Recurrent Disability

You will not have to complete a new Elimination Period if you become disabled again after the date UNUM stopped making monthly benefit payments to you for your previous disability.

Rehabilitation and Alternative Care Plans

While you are disabled, UNUM may contact you to suggest special services and/or equipment designed to help you regain the ability to independently perform the Activities of Daily Living. The use of such services/equipment must be medically necessary and appropriate for your disability and provided pursuant to a written plan of care developed by a licensed health care practitioner. The services/equipment must be intended to assist you in living at home or other residential housing by eliminating your need for substantial assistance. The services or equipment cannot be covered by other insurance or Medicare. The terms of an alternate care plan and the actual expenses that UNUM will pay will be subject to written mutual agreement between UNUM, you, and your Physician.

If, for any reason, you do not wish to participate in an Alternate Care Plan, your benefits will continue according to the coverage options you chose.

Respite Care Benefits

Respite care is care provided to you for a short period to allow your informal caregiver a break from his or her care giving responsibilities. Respite care may be provided to you by a formal caregiver, such as a Home Health Care Provider, Adult Day Care Facility, registered nurse, licensed practical nurse, or an informal caregiver, such as a friend or relative.

If you are not yet receiving monthly Home Care payments because you: 1) have not yet completed the Elimination Period or 2) have completed the Elimination Period but have chosen to postpone receipt of benefits in order to preserve your Lifetime Maximum Amount, you may request UNUM to pay you a benefit equal to 1/30th of your home care benefit for each day that you receive respite care up to a maximum of 15 days per calendar year. Respite care payments made to you count toward your Lifetime Maximum Amount.

Waiver of Premium

Once benefits become payable, there will be no more cost for your coverage as long as you are disabled. If you do not receive Professional Home Care Services for a period of 30 consecutive days, premium payments will again become due. If benefits are no longer payable, you *must* resume premium payments to continue your coverage. Premiums are *not waived* while you are receiving a payment for respite care.

WHEN MONTHLY BENEFITS END

Monthly benefit payments will end on the earliest of the following dates:

1. The date you are no longer disabled;
2. The expiration of your Physician certification;
3. The date you are no longer eligible for a monthly benefit under the coverage you chose;
4. The date your total benefit payments equal the Lifetime Maximum Amount; or
5. The date you die.

CHANGES IN COVERAGE

You can apply at any time to increase your coverage by filling out a new Benefit Election Form and Application for Long Term Care Insurance Evidence of Insurability (EOI) form. Your request is subject to approval by UNUM. If approved, the premium rate to be paid for the new coverage is based on your insurance age. To determine your insurance age, subtract your date of birth from your date of application for the increase in coverage.

CONTINUATION OF COVERAGE

If you become ineligible for coverage under the HSTA Voluntary Employees Beneficiary Association Trust's Long-Term Care Insurance Plan, you may elect converted coverage which means that the same coverage you had under this Plan can continue on a direct billing basis. You may not elect converted coverage if your coverage ended because you stopped paying premiums or if you are not insured under this Plan. Election of converted coverage must be made within 31 days of termination of your eligibility for coverage under the Trust.

HOW TO FILE A CLAIM

If you become disabled, you must notify UNUM in writing within 30 days and fill out a Long-Term Care Claim Form and send it to UNUM at the following address:

UNUM Life Insurance Company of America
The Benefits Center
PO Box 100196
Columbia, SC 29202

Claim forms are available from the Trust Office or UNUM. You must send UNUM the claim form no later than 90 days after the date you become disabled or as soon as it is reasonably possible to do so, but in no event more than one year after the time this proof is required.

You will be required to give UNUM information on your continued disability, when requested. UNUM may also require a claims assessment, which is a review done by UNUM to help in evaluating the disability. A face-to-face interview or examination by a Physician may also be required. If required, however, UNUM will pay for the cost of the interview or examination.

EXCLUSIONS

Coverage is not provided for:

- Disability caused by war (whether declared or not) or any act of war;
- Disability caused by attempted suicide (while sane or insane) or self-destruction;
- Disability caused by a commission of a crime for which you have been convicted under state or federal law or attempting to commit a crime under state or federal law;
- Disabilities or confinements during which you are outside the United States, its territories or possessions for longer than 30 days;
- Disability caused by alcoholism or alcohol abuse;
- Disability caused by voluntary use of any controlled substance unless the controlled substance is prescribed for you by a Physician ("Controlled substance" is defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970 and all amendments thereto);
- Periods in which you are confined in a hospital other than if you are confined in a nursing facility that is a distinctly separate part of a hospital, (this exclusion does not apply to those periods covered under the Bed Reservation Benefit).

The preceding long-term care insurance benefits are insured under a contract issued by UNUM Life Insurance Company of America, 2211 Congress Street, Portland, ME 04122. The services provided by UNUM Life Insurance Company of America include the payment of claims and the handling of claims appeals.

The preceding is for informational purposes only and is only a summary provided to help you understand your long-term care insurance coverage from UNUM. Its contents are subject to the provisions of the group insurance policy with UNUM Life Insurance Company of America, and all amendments thereto, which contain all the terms and conditions of coverage and benefits. These documents are on file with the HSTA Voluntary Employees Beneficiary Association Trust Office. If the terms of the preceding Plan summary differ from the policy documents, the policy will govern. Please refer to the policy documents and your Certificate of Insurance, which you received when you enrolled in the long-term care insurance plan, for specific questions about coverage.

USE AND DISCLOSURE OF YOUR HEALTH INFORMATION

The HSTA Voluntary Employees Beneficiary Association Trust is required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a federal law, to maintain the privacy of your health information. The Trust and its business associates may use or disclose your health information to the extent permitted by and in accordance with HIPAA and the regulations issued thereunder, including without limitation for the following purposes:

- Treatment;
- Payment;
- Health plan operations and plan administration; and
- As permitted or required by law.

Other than for the purposes stated above, your health information will not be used or disclosed without your written authorization. If you authorize the Trust to use or disclose your health information, you may revoke that authorization at any time in writing.

Under HIPAA, you have the following rights regarding your health information. You have the right to:

- Request restrictions on certain uses and disclosure of your health information;
- Receive confidential communications of your health information;
- Inspect and copy your health information;
- Request amendment of your health information if you believe your health records are inaccurate or incomplete; and
- Request a list of certain disclosures by the Trust of your health information.

You also have the right to make complaints to the Trust as well as the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Any complaints to the Trust should be made in writing to: *Privacy Officer, HSTA Voluntary Employees Beneficiary Association Trust Office, 1259 Aala Street, Suite 202, Honolulu, Hawaii 96817.* You will not be retaliated against, in any way, for filing a complaint.

The Trust has designated Hawaii Benefit Administrators, Inc. as the Trust's Privacy Officer and as its contact person for all issues regarding patient privacy and your privacy rights. For a copy of the privacy notice which provides a complete description of your rights under HIPAA's privacy rules, contact the Trust's Privacy Officer at *1259 Aala Street, Suite 202, Honolulu, Hawaii 96817, phone: (808) 440-6940 (Oahu) or 1(800) 637-4926 (Neighbor Islands), Monday through Friday, 8:00 a.m. to 5:00 p.m.*

For any questions or complaints regarding your health information and privacy rights related to the plans listed below, contact the following:

Life Insurance Plan

Pacific Guardian Life Insurance Company, Ltd.
1440 Kapiolani Boulevard, Suite 1700
Honolulu, Hawaii 96814
Attn: Group Department

Short-Term Disability Income Protection Insurance Plan

American Fidelity Assurance Company
9000 Cameron Parkway
Oklahoma City, Oklahoma 73114
Attn: Chief Compliance Officer/HIPAA

Long-Term Income Protection Insurance Plan

Hartford Life and Accident Insurance Company
Attn: Privacy Officer
33 New Montgomery Street
San Francisco, CA 94105
Attn: Employee Benefits Department Manager

Critical Illness Insurance Plan

MetLife Privacy Office
P.O. Box 489
Warwick, RI 02887-9954
privacy@metlife.com

Accident Insurance Plan

MetLife Privacy Office
P.O. Box 489
Warwick, RI 02887-9954
privacy@metlife.com

Long-Term Care Insurance Plan

UNUM Life Insurance Company of America
Attn: Privacy Officer
2211 Congress Street, C476
Portland, ME 04122

CLAIMS AND APPEALS PROCEDURE

If your claim or that of your dependent(s) for any benefit is wholly or partially denied by the Plan or insurance carrier, you will be provided with a written determination explaining the reasons for the denial.

DESIGNATION OF AN AUTHORIZED REPRESENTATIVE

You can designate another person to act on your behalf in the handling of your benefit claims. In order to do so, you must complete and file a form with the Trust Office and/or the insurance carrier that identifies the individual that is authorized to act on your behalf as your authorized representative. If you designate an authorized representative to act on your behalf, all correspondence and benefit determinations will be directed to your authorized representative, unless you direct otherwise. You may also request that this information be provided to both you and your authorized representative.

INSURED CLAIMS

Life insurance benefits are provided through Pacific Guardian Life Insurance Company. Short-Term Disability Income Protection Insurance benefits are provided through American Fidelity Assurance Company and Long-Term Income Protection Insurance benefits are provided through Hartford Life and Accident Insurance Company. Critical Illness Insurance and Accident Insurance benefits are provided through Metropolitan Life Insurance Company. Long-Term Care Insurance benefits are provided through Unum Life Insurance Company. If you have any questions regarding the claims and appeals procedures for these insured plans, contact the carrier at the address listed below.

Life Insurance Plan

Pacific Guardian Life Insurance Company, Ltd.
1440 Kapiolani Boulevard, Suite 1700
Honolulu, Hawaii 96814
Attn: Group Claims Department

Short-Term Disability Income Protection Insurance Plan

American Fidelity Assurance Company
AFES Benefits Department
P.O. Box 25160
Oklahoma City, Oklahoma 73125-0160

Long-Term Income Protection Insurance Plan

Benefit Management Services
Sacramento Disability Claim Office
The Hartford
P.O. Box 14302
Lexington, Kentucky 40512-4302

Critical Illness Insurance Plan

Metropolitan Life Insurance Company
Attn: Critical Illness Insurance Product
P.O. Box 80826
Lincoln, NE 68501-0826

Accident Insurance Plan

Metropolitan Life Insurance Company
Attn: Accident Insurance Product
P.O. Box 80826
Lincoln, NE 68501-0826

Long-Term Care Insurance Plan (Claims)

UNUM Life Insurance Company of America
The Benefits Center
P.O. Box 100196
Columbia, SC 29202

Long-Term Care Insurance Plan (Appeals)

UNUM Life Insurance Company of America
P.O. Box 9548
Portland, ME 04104

ELIGIBILITY AND OTHER APPEALS

The Trust Office serves as the Contract Administrator of the HSTA Voluntary Employees Beneficiary Association Trust and maintains the records regarding your eligibility for benefits described in this booklet. Questions regarding enrollment, change in employee status, or change in dependent coverage should be directed to the Trust Office. Any disagreement regarding your eligibility status or the status of your dependent that cannot be resolved by the Trust Office may be submitted to the Board of Trustees for review.

You (or your authorized representative) may appeal any decision based on Plan rules adopted by the Board of Trustees (e.g., denial of eligibility or loss of eligibility) by filing a written request for review with the Board of Trustees at the following address:

Board of Trustees
HSTA Voluntary Employees Beneficiary Association Trust
1259 Aala Street, Suite 202
Honolulu, Hawaii 96817

Or, send a fax to: (808) 440-6941

Your written request must be filed within 60 days after receipt of the Plan's decision and describe the reasons why you feel the Plan's decision was not proper. You should also submit any documents, records, and other information in support of your claim not already furnished to the Plan. Upon your request, you (or your authorized representative) may review and obtain copies of all Plan documents, records, and other information relevant to your claim, free of charge.

Upon receipt of your written request for review, the Board of Trustees (or a sub-committee thereof) will review your claim and take into account all evidence submitted by you (or your authorized representative), without regard to whether such evidence was submitted or considered in the initial claim determination. The Board of Trustees (or a subcommittee thereof) will determine whether or not a hearing will be held on your claim. If a hearing is to be held, you will be notified of the time and place at least two weeks in advance of the hearing (unless you agree in writing to a shorter notice period). You and/or your authorized representative may appear at the hearing.

The Board of Trustees (or sub-committee thereof) will render its decision within 60 days after receipt of your written request, unless special circumstances require an extension of time for processing your request, in which case the decision shall be rendered as soon as possible, but not later than 120 days after receipt of your written request. If an extension is required, the Board of Trustees (or sub-committee thereof) will notify you, in writing, prior to the end of the initial 60-day review period and indicate the special circumstances that make the extension necessary and the date by which a decision is expected.

The decision of the Board of Trustees (or sub-committee thereof) will be written in clear, easily understood language and provide the reasons for their decision and the specific Plan provisions that support it.

If you disagree with the decision on appeal, you may file suit in Federal or state court. If your suit is successful, the court may award you legal costs, including attorneys' fees.

The preceding is for informational purposes only and is a summary of the Plan's claims and appeals procedure. This summary is subject to the provisions of the Plan Documents and all amendments made thereto, which are on file with the HSTA Voluntary Employees Beneficiary Association Trust Office. In the event of a conflict between the information contained in this booklet and the Plan Documents, the Plan Document will control. Please refer to these documents for specific questions about claims and appeals procedure.

STATEMENT OF ERISA RIGHTS

As a participant in the HSTA Voluntary Employees Beneficiary Association Trust, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

ENFORCE YOUR RIGHTS

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.