

NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS UNDER THE HAWAII LIFE AND DISABILITY INSURANCE GUARANTY ASSOCIATION ACT

Residents of Hawaii who purchase life insurance, annuities or disability insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Hawaii Life and Disability Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state, and in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however. And, as noted below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

DISCLAIMER

The Hawaii Life and Disability Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Hawaii. You should not rely on coverage by the Hawaii Life and Disability Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.

**The Hawaii Life and Disability Insurance Guaranty Association
1132 Bishop Street, Suite 1590
Honolulu, Hawaii 96813**

**Department of Commerce and Consumer Affairs
Insurance Division
P.O. Box 3614
Honolulu, Hawaii 96811**

The state law that provides for this safety-net is called the Hawaii Life and Disability Insurance Guaranty Association Act. Below is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Hawaii Life and Disability Insurance Guaranty Association if they live in this state and hold a life or disability insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by the Guaranty Association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state); or
- the insurer was not a member of the Guaranty Association. A nonprofit hospital or medical service organization (the "Blues"), an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange are examples of nonmember insurers.

The Guaranty Association also does not provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed an average rate;
- dividends;
- credits given in connection with the administration of a policy by a group contractholder;
- employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- unallocated annuity contracts (which give rights to group contractholders, not individuals).

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the Guaranty Association is obligated to pay out: The basic protections provided by the Association are:

- Life Insurance
- \$300,000 in death benefits
- \$100,000 in cash surrender or withdrawal values
- Health Insurance
- \$500,000 in hospital, medical and surgical insurance benefits
- \$300,000 in disability insurance benefits
- \$300,000 in long-term care insurance benefits
- \$100,000 in other types of health insurance benefits
- Annuities
- \$250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is \$300,000. Special rules apply with regard to hospital, medical and surgical insurance benefits and with regard to one owner or multiple non-group policies of life insurance.



STANDARD INSURANCE COMPANY

A Stock Life Insurance Company
900 SW Fifth Avenue
Portland, Oregon 97204-1282
(503) 321-7000

CERTIFICATE

GROUP LIFE INSURANCE

| | |
|-----------------|---|
| Policyholder: | HSTA Voluntary Employees Beneficiary Assn Trust |
| Policy Number: | 763948-A |
| Effective Date: | September 1, 2025 |
| Revision Date: | Not applicable |

The Group Policy has been issued to the Policyholder.

We certify that you will be insured as provided by the terms of the Policyholder's coverage under the Group Policy. If the terms of this Certificate differs from the terms of the Policyholder's coverage under the Group Policy, the latter will govern. If your coverage is changed by an amendment to the Group Policy, we will provide the Policyholder with a revised Certificate or other notice to be given to you.

Possession of this Certificate does not necessarily mean you are insured. You are insured only if you meet the requirements set out in this Certificate.

Unless defined differently within a particular provision, the terms "you" and "your" mean the Member. "We", "us", and "our" mean Standard Insurance Company. Other defined terms appear with their initial letters capitalized. Section headings, and references to them, appear in bold face type.

A handwritten signature in black ink, appearing to read "David Klein".

President and CEO

GC1219-LIFE

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COVERAGE FEATURES

This section contains many of the features of your group life insurance. Other provisions, including exclusions and limitations, appear in other sections. Please refer to the text of each section for full details. The Table of Contents and the Index of Defined Terms help locate sections and definitions.

GENERAL POLICY INFORMATION

| | |
|---|---|
| Group Policy Number: | 763948-A |
| Type of Insurance Provided: | |
| Life Insurance: | Yes |
| Accidental Death And Dismemberment (AD&D) Insurance: | Not applicable |
| Dependent Life Insurance: | Not applicable |
| Policyholder: | HSTA Voluntary Employees Beneficiary Assn Trust |
| Group Policy Effective Date: | September 1, 2025 |
| Revision Date: | Not applicable |
| State of Issue: | Hawaii |

BECOMING INSURED

To become insured for Life Insurance you must: (a) Be a Member; (b) Complete your Eligibility Waiting Period; and (c) Meet the requirements in **Life Insurance**. The requirements for becoming insured for coverages other than Life Insurance are set out in the text.

Member means a member in good standing of the Policyholder who is eligible for coverage as determined by Hawaii State Teachers Association.

Class Definition:

| | |
|----------|---|
| Class 1: | All active Members who have Active or Associate membership in the Hawaii State Teachers Association |
| Class 2: | All retired Members who have Retiree or Associate membership in the Hawaii State Teachers Association-Retired |

Eligibility Waiting Period: You are eligible on the date you become a Member, but not before the Group Policy Effective Date.

PREMIUM CONTRIBUTIONS

| | |
|-------------------------|--------------|
| Life Insurance (Basic): | Contributory |
|-------------------------|--------------|

ERISA SUMMARY PLAN DESCRIPTION INFORMATION

Name of Plan: Life Insurance

Name, Address of Plan Sponsor: Board of Trustees
HSTA Voluntary Employees Beneficiary Assn Trust
1259 Aala St. Ste 202
Honolulu HI 96817

Plan Sponsor Tax ID Number: 23-7296050

Plan Number: 505

Type of Plan: Group Insurance Plan

Type of Administration: Contract Administration

Name, Address of Plan Administrator: Board of Trustees
HSTA Voluntary Employees Beneficiary Assn Trust
1259 Aala St. Ste 202
Honolulu HI 96817

Name, Address of Registered Agent for Service of Legal Process: Board of Trustees
HSTA Voluntary Employees Beneficiary Assn Trust
1259 Aala St. Ste 202
Honolulu HI 96817

If Legal Process Involves Claims For Benefits Under The Group Policy, Additional Notification of Legal Process Must Be Sent To: Standard Insurance Company
1100 SW 6th Ave
Portland OR 97204-1093

Sources of Contributions: Employer/Member

Funding Medium: Standard Insurance Company - Fully Insured

Plan Fiscal Year End: August 31

INSURING CLAUSE

If you die while insured under the Group Policy, we will pay benefits according to the terms of the Group Policy after we receive Proof Of Loss satisfactory to us, subject to the **Claims** provision.

LI.IC.OT.1

EVIDENCE OF INSURABILITY

Evidence of Insurability will be required as follows:

1. If you apply for Contributory Life Insurance for yourself more than 60 days after you become eligible.
2. For reinstatements, if required.
3. For Members eligible, but not insured under the Prior Plan.

LI.EOI.OT.1

LIFE INSURANCE

A. Amount Of Life Insurance

See **Coverage Features** for the Life Insurance schedule.

B. When Life Insurance Becomes Effective

Your Life Insurance becomes effective as follows:

1. Life Insurance Subject To Evidence Of Insurability

Life Insurance subject to **Evidence Of Insurability** becomes effective on the first day of the calendar month following the date we approve your Evidence Of Insurability.

2. Life Insurance Not Subject To Evidence Of Insurability

You must apply in Writing for Contributory Life Insurance and agree to pay premiums.

Contributory Life Insurance not subject to **Evidence Of Insurability** becomes effective on:

- i. The first day of the calendar month following the date you become eligible if you apply on or before that date.
- ii. The first day of the calendar month following the date you apply if you apply within 60 days after you become eligible.

C. Changes In Life Insurance

1. A decrease in your Life Insurance because of a change in your classification becomes effective on the first day of the calendar month following the date of the change.
2. A decrease in your Life Insurance because of a change in your age becomes effective on the first day of the calendar month following the date of the change.

D. Suicide Exclusion: Life Insurance

The **Coverage Features** states which Life Insurance plan is subject to this suicide exclusion.

If your death results from suicide or other intentionally self-inflicted injury, while sane or insane, 1 and 2 below apply.

1. The amount payable will exclude the amount of your Life Insurance which is subject to this suicide exclusion and which has not been continuously in effect for at least 2 years on the date of your death. In computing the 2-year period, we will include time you were insured under the Prior Plan.
2. We will refund all premiums paid for that portion of your Life Insurance which is excluded from payment under this suicide exclusion.

E. When Life Insurance Ends

Your Life Insurance ends automatically on the earliest of:

1. The date the last period ends for which a premium was paid for your Life Insurance.
2. The date the Group Policy terminates.
3. The first day of the calendar month following the date you cease to be a Member.

F. Reinstatement Of Life Insurance

If your Life Insurance ends, you may become insured again as a new Member. However, the following will apply:

1. If your Life Insurance ends because you cease to be a Member, and if you become a Member again within 90 days, the Eligibility Waiting Period will be waived.
2. If your Life Insurance ends because you fail to make a required premium contribution, you must provide Evidence Of Insurability to become insured again.
3. If you exercised your Right To Convert, you must provide Evidence Of Insurability to become insured again.
4. If your Life Insurance ends because you are on a federal or state-mandated family or medical leave of absence, and you become a Member again immediately following the period allowed, your insurance will be reinstated pursuant to the federal or state-mandated family or medical leave act or law.

LI.LF.OT.1

RIGHT TO CONVERT

A. Right To Convert

You may buy an individual policy of life insurance without Evidence Of Insurability if all of the following requirements are met:

1. Your Insurance ends or is reduced due to a Qualifying Event.
2. You apply in Writing and pay us the first premium during the Conversion Period.

The maximum amount you have a Right To Convert is the amount of your Insurance which ended, except as limited under C. Limits On Right To Convert.

B. Definitions For Right To Convert

1. Conversion Period means the 60-day period after the date of any Qualifying Event.
2. Insurance means your Life Insurance under the Group Policy.
3. Qualifying Event means termination or reduction of your Insurance for any reason except the Member's failure to make a required premium contribution.

C. Limits On Right To Convert

If your Insurance ends or is reduced because of termination or amendment of the Group Policy, the following will apply.

1. You may not convert Insurance which has been in effect for less than 5 years.
2. The maximum amount that may be converted is the lesser of:
 - a. The amount of Insurance which ended, minus any other group life insurance for which you become eligible during the Conversion Period.
 - b. \$10,000

D. The Individual Policy

You may select an individual whole life insurance policy we issue to persons of your age, except:

1. A policy with disability, accidental death, or other additional benefits.
2. A policy in an amount less than the minimum amount we issue.

The individual policy of life insurance will become effective on the day after the end of the Conversion Period. We will use our published rates for standard risks to determine the premium.

E. Death During The Conversion Period

If you die during the Conversion Period, we will pay a death benefit equal to the maximum amount you had a Right To Convert, whether or not you applied for an individual policy. In no event will the benefits paid exceed the amount in effect under the Group Policy on the day before your Qualifying Event.

If you apply for an individual policy of life insurance, and death occurs during the Right To Convert Period, and if you name a Beneficiary in your application that is different from the last Beneficiary you or named under the Group Policy, then it will be considered a change of Beneficiary to the person named in the application. The change will take effect on the date of the application.

LI.RC.OT.1

CLAIMS

A. Filing A Claim

Claims should be filed on our forms. If we do not provide our forms within 15 days after they are requested, the claim may be submitted in a letter to us.

B. Time Limits On Filing Proof Of Loss

Proof Of Loss must be provided within 90 days after the date of the loss. If that is not possible, it must be provided as soon as reasonably possible, but not later than one year after the 90-day period.

If Proof Of Loss is filed outside these time limits, the claim will be denied. These limits will not apply while the Member or Beneficiary lacks legal capacity.

C. Proof Of Loss

Proof Of Loss means Written proof that a loss occurred:

1. For which the Group Policy provides benefits;
2. Which is not subject to any exclusions; and
3. Which meets all other conditions for benefits.

Proof Of Loss includes any other information we may reasonably require in support of a claim. Proof Of Loss must be in Writing and must be provided at the expense of the claimant.

D. Investigation Of Claim

We may have you examined at our expense at reasonable intervals. Any such examination will be conducted by specialists of our choice.

We may have an autopsy performed at our expense, except where prohibited by law.

E. Time Of Payment

We will pay benefits within 60 days after the latest date shown below:

1. The date Proof Of Loss is satisfied.

2. The date we receive sufficient information to determine liability, the extent of liability and the appropriate payee legally entitled to benefits.
3. The date that legal impediments to payment of benefits that depend on the action of parties other than us are resolved and sufficient evidence of resolution is provided to us. Legal impediments to payment include, but are not limited to:
 - a. The establishment of guardianships or conservatorships.
 - b. The appointment and qualification of trustees, executors and administrators.
 - c. The submission of information required to satisfy state or federal reporting requirements.

Interest, if applicable, will accrue 30 days from the latest of the dates shown above, continuing up to the date of payment.

Payment made in good faith shall discharge us of liability to the extent of such payment.

F. Notice Of Decision On Claim

We will evaluate a claim for benefits promptly after we receive it. Within 90 days after we receive the claim we will send the claimant: (a) a Written decision on the claim; or (b) a notice that we are extending the period to decide the claim for an additional 90 days.

If we extend the period to decide the claim, we will notify the claimant of the following: (a) the reasons for the extension; (b) when we expect to decide the claim; (c) an explanation of the standards on which entitlement to benefits is based; (d) the unresolved issues preventing a decision; and (e) any additional information we need to resolve those issues.

If we request additional information, the claimant will have 45 days to provide the information. If the claimant does not provide the requested information within 45 days, we may decide the claim based on the information we have received.

If we deny any part of the claim, we will send the claimant a Written notice of denial containing the following:

1. The reasons for our decision.
2. Reference to the parts of the Group Policy on which our decision is based.
3. A description of any additional information needed to support the claim.
4. Information concerning the claimant's right to receive, free of charge, copies of non-privileged documents and records relevant to the claim.
5. Information concerning the claimant's right to a review of our decision.
6. Information concerning the right to bring a civil action for benefits under section 502(a) of ERISA if the claim is denied on review.

G. Review Procedure

If all or part of a claim is denied, the claimant may request a review. The claimant must request a review in Writing within 60 days after receiving notice of the denial of any other claim.

The claimant may send us Written comments or other items to support the claim. The claimant may review and receive copies of any non-privileged information that is relevant to the request for review. There will be no charge for such copies. Our review will include any Written comments or other items the claimant submits to support the claim.

We will review the claim promptly after we receive the request. Within 60 days after we receive the request for review we will send the claimant: (a) a Written decision on review; or (b) a notice that we are extending the review period for 60 days.

If an extension is due to the claimant's failure to provide information necessary to decide the claim on review, the extended time period for review of the claim will not begin until the claimant provides the information or otherwise responds.

If we extend the review period, we will notify the claimant of the following: (a) the reasons for the extension; (b) when we expect to decide the claim on review; and (c) any additional information we need to decide the claim.

If we request additional information, the claimant will have 45 days to provide the information. If the claimant does not provide the requested information within 45 days, we may conclude our review of the claim based on the information we have received.

If we deny any part of the claim on review, the claimant will receive a Written notice of denial containing the following:

1. The reasons for our decision.
2. Reference to the parts of the Group Policy on which our decision is based.
3. Information concerning the claimant's right to receive, free of charge, copies of non-privileged documents and records relevant to the claim.

LI.CL.HI.1

ASSIGNMENT

The rights and benefits under the Group Policy cannot be assigned.

LI.AS.OT.1

BENEFIT PAYMENT AND BENEFICIARY PROVISIONS

A. Payment Of Benefits

Benefits payable because of your death will be paid to the Beneficiary you named. See B through E of this section.

B. Naming A Beneficiary

Beneficiary means a person you name to receive your death benefits. You may name one or more Beneficiaries.

If you name two or more Beneficiaries in a class:

1. Two or more surviving Beneficiaries will share equally, unless you provide for unequal shares.
2. If you provide for unequal shares in a class, and two or more Beneficiaries in that class survive, we will pay each surviving Beneficiary his or her designated share. Unless you provided otherwise, we will then pay the share(s) otherwise due to any deceased Beneficiary(ies) to the surviving Beneficiaries pro rata based on the relationship that the designated percentage or fractional share of each surviving Beneficiary bears to the total shares of all surviving Beneficiaries.
3. If only one Beneficiary in a class survives, we will pay the total death benefits to that Beneficiary.

You may name or change Beneficiaries at any time without the consent of a Beneficiary.

Your designation must meet all of the following requirements:

1. You must name or change Beneficiaries in Writing. Writing includes a form Signed by you or a verification from us or our designated agent, the Policyholder or the Policyholder's designated agent, or the Employer or the Employer's designated agent of an electronic or telephonic designation made by you.
2. Must be dated.

3. Must be delivered to us or our designated agent, the Policyholder or the Policyholder's designated agent, or the Employer or the Employer's designated agent, during your lifetime.
4. Must relate to the insurance provided under the Group Policy.

Your designation will take effect on the date it is received by us or our designated agent, the Policyholder or the Policyholder's designated agent, or the Employer or the Employer's designated agent.

If we approve it, a designation which meets the requirements of a Prior Plan will be accepted as your Beneficiary designation under the Group Policy.

C. Simultaneous Death Provision

If a Beneficiary or a person in one of the classes listed in item D. No Surviving Beneficiary dies on the same day you die, or within 15 days thereafter, benefits will be paid as if that Beneficiary or person had died before you, unless Proof Of Loss with respect to your death is delivered to us before the date of the Beneficiary's death.

D. No Surviving Beneficiary

If you do not name a Beneficiary for each different insurance plan where you may elect a Beneficiary, or if you are not survived by one, benefits will be paid in equal shares to the first surviving class of the classes below.

1. Your spouse/Spouse.
2. Your children.
3. Your parents.
4. Your brothers and sisters.
5. Your estate.

E. Method Of Payment

Recipient means a person who is entitled to benefits under this **Benefit Payment and Beneficiary Provisions** section.

If the amount payable to a Recipient is less than \$25,000, we will pay it in a lump sum.

To the extent permitted by law, the amount payable to the Recipient will not be subject to any legal process or to the claims of any creditor or creditor's representative.

LI.BB.OT.1

RIGHT TO RECOVERY

If benefits have been overpaid on any claim then full reimbursement to us is required within 60 days of notification to you, your Beneficiary or your estate. If reimbursement is not made then we have the right to do any of the following:

1. Reduce future benefits until full reimbursement is made.
2. Recover such overpayments from you, your Beneficiary or your estate.

Such reimbursement is required whether the overpayment is due to fraud, our error in processing a claim or any other reason.

LI.RR.OT.1

CLAIMANT COOPERATION

If you or your Beneficiary fails to cooperate with us in the administration of your claim, we may close or deny the claim. Such cooperation includes, but is not limited to, providing any information or documentation needed to determine if benefits are payable or the actual benefit amount due.

LI.CLC.OT.1

AGENCY, RELEASE AND INDEMNIFICATION

Individuals selected by the Policyholder to secure coverage under the Group Policy or to perform their administrative function under it, represent and act on behalf of the person selecting them, and do not represent or act on behalf of Standard Insurance Company. The Policyholder and such individuals have no authority to alter, expand or extend our liability or to waive, modify or compromise any defense or right we may have under the Group Policy. The Policyholder hereby releases, holds harmless and indemnifies Standard Insurance Company from any liability arising from or related to any negligence, error, omission, misrepresentation or dishonesty of any of them or their representatives, agency or employees.

LI.AR.OT.1

TIME LIMITS ON LEGAL ACTIONS

No action at law or in equity may be brought until 60 days after we have been given Proof Of Loss. No such action may be brought more than three years after the adverse decision date.

LI.TL.OT.1

INCONTESTABILITY OF INSURANCE

Any statement made to obtain or to increase insurance is a representation and not a warranty.

No misrepresentation will be used to reduce or deny a claim unless all of the following requirements are met:

1. The insurance would not have been approved for you if we had known the truth.
2. We have given you or any other person claiming benefits a copy of the Signed Written instrument which contains the misrepresentation.

We will not use a misrepresentation to reduce or deny a claim after your insurance has been in effect for two years during the lifetime of the insured.

LI.IN.OT.1

CLERICAL ERROR, MISSTATEMENT AND AGENCY

A. Clerical Error And Agency

Clerical error by us, the Policyholder, your employer or their respective employees or representatives will not:

1. Cause a person to become insured.
2. Invalidate insurance under the Group Policy otherwise validly in force.
3. Continue insurance under the Group Policy otherwise validly terminated.

The Policyholder and your employer act on their own behalf as your agent, and not as our agent. The Policyholder and your employer have no authority to alter, expand or extend our liability or to waive, modify or compromise any defense or right we may have under the Group Policy.

B. Misstatement Of Age

If a person's age has been misstated, we will make an equitable adjustment of premiums, benefits, or both. The adjustment will be based on:

1. The amount of insurance based on the correct age.
2. The difference between the premiums paid and the premiums which would have been paid if the age had been correctly stated.

LI.CE.OT.1

DEFINITIONS

Annual Earnings means your annual rate of earnings from your employer. Your Annual Earnings will be based on your earnings in effect on your last full day of active work.

Annual Earnings includes:

1. Commissions averaged over the preceding 12 calendar months or over the period of your employment if less than 12 months.
2. Shift differential pay.
3. Contributions you make through a salary reduction agreement with your employer to:
 - a. An IRC Section 401(k), 403(b), 408(k) or 457 deferred compensation arrangement.
 - b. An executive nonqualified deferred compensation arrangement.
4. Amounts contributed to your fringe benefits according to a salary reduction agreement under an IRC Section 125 plan.

Annual Earnings does not include:

1. Bonuses.
2. Overtime pay.
3. Your employer's contributions on your behalf to any deferred compensation arrangement or pension plan.
4. Stock options or stock bonuses.
5. Any other extra compensation.

Child means:

1. Your child from live birth through age 18, (through age 22 if a registered student in full time attendance at an accredited educational institution).
2. Your disabled child who is 19 years of age or older, is your qualifying child as defined by the Internal Revenue Service for whom you or your Spouse claims as a dependent on Federal Income Taxes filed for the preceding calendar year and meets one of the following requirements:
 - a. Has been insured continuously under the Group Policy prior to reaching age 19.
 - b. Who is 19 years of age or older at the time of your initial eligibility under the Group Policy.
3. Child includes any of the following, if they otherwise meet the definition of Child:
 - a. Your adopted child.
 - b. Your stepchild if living in your home.

Contributory means you pay all or part of the premium for insurance.

Eligibility Waiting Period means the period you must be a Member before you become eligible for insurance. See **Coverage Features**.

Evidence Of Insurability means an applicant must do all of the following:

1. Complete and sign our medical history statement.
2. Sign our form authorizing us to obtain information about the applicant's health.
3. Undergo a physical examination, if required by us, which may include blood testing.
4. Provide any additional information about the applicant's insurability that we may reasonably require.

Group Policy means this group life insurance policy issued by us to the Policyholder and identified by the Group Policy Number, the Policyholder's attached application, group life insurance Certificates with the same Group Policy Number, and any amendments to the Group Policy or Certificates.

Hospital means a legally operated hospital providing full-time medical care and treatment under the direction of a full-time staff of licensed Physicians.

Injury means an injury to the body.

Life Insurance means life insurance under the Group Policy.

Nursing Home means a licensed institution operated for the purpose of providing nursing care and treatment for individuals which provides 24-hour nursing services under the direction and supervision of a Physician.

Physician means a licensed M.D. or D.O., acting within the scope of the license. Physician does not include you or your Spouse, or the brother, sister, parent or child of either you or your Spouse.

Pregnancy means your pregnancy, childbirth, or related medical conditions, including complications of pregnancy.

Prior Plan means the Policyholder's group life insurance plan in effect on the day before the effective date of the Policyholder's coverage under the Group Policy and which is replaced by the Group Policy.

Sickness means your sickness, illness or disease.

Signed means any symbol or method executed or adopted by you with the present intention to authenticate a record, and which is on or transmitted by paper, electronic or telephonic media, and which is consistent with applicable law, and authorized or accepted by us.

Spouse means:

1. A person to whom you are legally married; or
2. A person who is party to a Civil Union with you. Civil Union means a civil union established according to applicable law.

However, for the purposes of insurance under the Group Policy, Spouse does not include a person who is a full-time member of the armed forces of any country or a person from whom you are divorced or legally separated.

Writing or Written means a record which is on or transmitted by paper, electronic or telephonic media, and which is consistent with applicable law, and authorized or accepted by us.

LI.DF.OT.1

ERISA INFORMATION AND NOTICE OF RIGHTS

The following information and notice of rights and protections is furnished by the Plan Administrator as required by the Employee Retirement Income Security Act of 1974 (ERISA).

A. General Plan Information

The General Plan Information required by ERISA is shown in the **Coverage Features**.

B. Statement Of Your Rights Under ERISA

1. Right To Examine Plan Documents

You have the right to examine all Plan documents, including any insurance contracts or collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. These documents may be examined free of charge at the Plan Administrator's office.

2. Right To Obtain Copies Of Plan Documents

You have the right to obtain copies of all Plan documents, including any insurance contracts or collective bargaining agreements, a copy of the latest annual report (Form 5500 Series), and updated summary plan description upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for these copies.

3. Right To Receive A Copy Of Annual Report

The Plan Administrator must give you a copy of the Plan's summary annual financial report, if the Plan was required to file an annual report. There will be no charge for the report.

4. Right To Review Of Denied Claims

If your claim for a Plan benefit is denied or ignored, in whole or in part, you have the right: a) to know why this was done; b) to obtain copies of documents relating to the decision, without charge; and c) to have your claim reviewed and reconsidered, all within certain time schedules.

C. Obligations Of Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of all 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 Plan benefit or exercising your rights under ERISA.

D. Enforcing ERISA Rights

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request 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 Plan 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. 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.

E. Additional Procedures For Claims Based on Disability Determinations Filed on or after April 1, 2018

If we deny any part of your claim for a benefit that relies on a disability determination, you will receive a written notice of denial containing a copy of any internal rule or guideline relied upon in making the decision, or a statement that no such rules or guidelines exist. The notice of denial will also include information concerning your right to receive, free of charge, copies of non-privileged documents and records relevant to your claim.

If all or part of a claim is denied, you may request a review. Before we issue a decision on review for a benefit that relies on a disability decision, we will provide you, free of charge, with any new evidence or rationale considered, relied upon, or generated by us in connection with the claim, and we will provide such new evidence or rationale sufficiently in advance of the decision deadline date to give you a reasonable opportunity to respond prior to that date.

If our review results in a denial of any part of your claim for a benefit that relies on a disability decision, your written notice of denial will contain a copy of any internal rule or guideline relied upon in making the decision, or a statement that no such rules or guidelines exist. The notice of denial will also include information concerning your right to bring a civil action for benefits under section 502(a) of ERISA and a description of any applicable contractual limitations period that applies to your right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim.

F. Plan And ERISA Questions

If you have any questions about the 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, DC 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.

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