YOUR BENEFIT PLAN

TR. OF HAWAII STATE TEACHERS ASSOCIATION VOLUNTARY EMPLOYEES BENEFICIARY TRUST

Long Term Disability

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Maryland

The group insurance policy providing coverage under this certificate was issued in a jurisdiction other than Maryland and may not provide all of the benefits required by Maryland law.

State Notices

IMPORTANT INFORMATION FOR RESIDENTS OF CERTAIN STATES: There are state-specific requirements that may change the provisions described in the group insurance certificate. If you live in a state that has such requirements, those requirements will apply to your coverage. State-specific requirements that may apply to your coverage are summarized below. In addition, updated state-specific requirements are published on our website. You may access the website at www.thehartford.com. If you are unable to access this website, want to receive a printed copy of these requirements, or have any questions or complaints regarding any of these requirements or any aspect of your coverage, please contact your Employee Benefits Manager; or you may contact us as follows:

The Hartford
Group Benefits Division, Customer Service
P.O. Box 2999
Hartford, CT 06104-2999
1-800-523-2233

If you have a complaint and contacts between you, us, your agent, or another representative have failed to produce a satisfactory solution to the problem, some states require we provide you with additional contact information. If your state requires such disclosure, the contact information is listed below with the other state requirements and notices.

We are providing notice that Hartford Life and Accident Insurance Company is subject to economic and trade sanctions laws and regulations. These laws and regulations, including the laws and regulations administered and enforced by the United States Department of the Treasury's Office of Foreign Assets Control ("OFAC"), prevent Hartford Life and Accident from providing coverage to, and from paying benefits to, entities and individuals where prohibited by applicable law. In addition, these laws and regulations prohibit certain activities with respect to certain countries.

We have included this information to make you aware of the existence and potential impact of these economic and trade sanctions programs on your benefit program.

The Hartford complies with applicable Federal civil rights laws and does not unlawfully discriminate on the basis of race, color, national origin, age, disability, or sex. The Hartford does not exclude or treat people differently for any reason prohibited by law with respect to their race, color, national origin, age, disability, or sex.

If your policy is governed under the laws of Maryland, any of the benefits, provisions or terms that apply to the state you reside in as shown below will apply only to the extent that such state requirements are more beneficial to you.

Alaska:

1. The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable to you.

Arizona:

1. **NOTICE:** The Certificate may not provide all benefits and protections provided by law in Arizona. Please read the Certificate carefully.

Arkansas:

1. **NOTICE:** You have the right to file a complaint with the Arkansas Insurance Department (AID). You may call AID to request a complaint form at (800) 852-5494 or (501) 371-2640 or write the Department at:
   Arkansas Insurance Department
   1 Commerce Way, Suite 102
   Little Rock, AR 72202
2. The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable to you.

California:

1. **NOTICE:** READ YOUR CERTIFICATE CAREFULLY
   You have a 30 day right from Your original Certificate Effective Date to examine Your certificate. If You are not satisfied, You may return it to Us within 30 days of Your original Certificate Effective Date. In that event, We will consider it void from its Effective Date and any premiums paid will be refunded. Any claims paid under The Policy during the initial 30 day period will be deducted from the refund.

PLEASE BE ADVISED THAT YOU RETAIN ALL RIGHTS WITH RESPECT TO YOUR POLICY/CERTIFICATE AGAINST YOUR ORIGINAL INSURER IN THE EVENT THE ASSUMING INSURER IS UNABLE TO FULFILL ITS OBLIGATIONS. IN SUCH EVENT YOUR ORIGINAL INSURER REMAINS LIABLE TO YOU NOTWITHSTANDING THE TERMS OF ITS ASSUMPTION AGREEMENT.

2. The **Policy Interpretation** provision, if shown in the General Provisions section of the Certificate, does not apply to you. The following requirement applies to you:

   Eligibility Determination: *How will We determine Your eligibility for benefits?*
   We, and not Your Employer or plan administrator, have the responsibility to fairly, thoroughly, objectively and timely investigate, evaluate and determine Your eligibility or Your beneficiaries for benefits for any claim You or Your beneficiaries make on The Policy. We will:
   1) obtain with Your cooperation and authorization if required by law, only such information that is necessary to evaluate Your claim and decide whether to accept or deny Your claim for benefits. We may obtain this information from Your Notice of Claim, submitted proofs of loss, statements, or other materials provided by You or others on Your behalf; or, at Our expense We may obtain necessary information, or have You physically examined when and as often as We may reasonably require while the claim is pending. In addition, and at Your option and at Your expense, You may provide Us and We will consider any other information, including but not limited to, reports from a Physician or other expert of Your choice. You should provide Us with all information that You want Us to consider regarding Your claim;
   2) as a part of Our routine operations, We will apply the terms of The Policy for making decisions, including decisions on eligibility, receipt of benefits and claims, or explaining policies, procedures and processes;
   3) if We approve Your claim, We will review Our decision to approve Your claim for benefits as often as is reasonably necessary to determine Your continued eligibility for benefits;
   4) if We deny Your claim, We will explain in writing to You or Your beneficiaries the basis for an adverse determination in accordance with The Policy as described in the provision entitled **Claim Denial**.

   In the event We deny Your claim for benefits, in whole or in part, You can appeal the decision to Us. If You choose to appeal Our decision, the process You must follow is set forth in The Policy provision entitled **Claim Appeal.** If You do not appeal the decision to Us, then the decision will be Our final decision.

3. **For Your Questions and Complaints:**
   State of California Insurance Department
   Consumer Communications Bureau
   300 South Spring Street, South Tower
   Los Angeles, CA 90013
   Toll Free: 1(800) 927-HELP
   TDD Number: 1(800) 482-4833
   Web Address: www.insurance.ca.gov

Colorado:

1. The **Surviving Children** definition within the **Survivor Income Benefit** will always include children related to You by civil union.
2. The **Surviving Spouse** definition within the **Survivor Income Benefit** will always include civil unions.
3. Entering a civil union, terminating a civil union, the death of a party to a civil union or a party to a civil union losing employment, which results in a loss of group insurance, will all constitute as a **Change in Family Status.**
4. **Complications of Pregnancy**, if shown in the **Definitions** section of the certificate, will always include acute nephritis or nephrosis, cardiac decompensation, missed abortion or any similar medical and surgical conditions of comparable severity regardless of hospital confinement.
5. The **Claim Appeal** provision will always include the following:

   In addition, if a claim for benefits is wholly or partially denied and all administrative remedies have been exhausted, You are entitled to pursue such claim anew, from the beginning, in a court with jurisdiction and entitled to a trial by jury.
6. The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.

Florida:

1. **NOTICE:** The benefits of the policy providing you coverage may be governed primarily by the laws of a state other than Florida.

Georgia:

1. **NOTICE:** The laws of the state of Georgia prohibit insurers from unfairly discriminating against any person based upon his or her status as a victim of family abuse.

Idaho:

1. **For Your Questions and Complaints:**
   Idaho Department of Insurance
   Consumer Affairs
   700 W State Street, 3rd Floor
   PO Box 83720
   Boise, ID 83720-0043
   Toll Free: 1-800-721-3272
   Web Address: www.DOI.Idaho.gov
2. **Notice to Buyer: This is a disability income protection policy**.
3. The **Benefits Commence** provision, shown in the **Schedule of Insurance** section of the Certificate, cannot exceed:
   1) 90 days for plan designs with a **Maximum Duration of Benefits Payable** of 1 year or less;
   2) 180 days for plan designs with a **Maximum Duration of Benefits Payable** of more than 1 year but less than 2 years; or
   3) 365 days for plan designs with a **Maximum Duration of Benefits Payable** of 2 years or more.
4. The **Maximum Duration of Benefits Payable** provision, shown in the **Schedule of Insurance** section of the Certificate, cannot be less than 6 months.

Illinois:

1. You may file a consumer complaint online at the Illinois Department of Insurance's website or by mail. The Department maintains a Consumer Division in Chicago at 115 S. Lasalle Street, 13th Floor, Chicago, Illinois 60603; and in Springfield at 320 West Washington Street, Springfield, Illinois 62767.

   This notice is to advise you that should any complaints arise regarding this insurance, you may contact the following:
   Illinois Department of Insurance
   320 W. Washington Street
   Springfield, Illinois 62767-0001

   Illinois Department of Insurance
   115 S. LaSalle Street
   13th Floor
   Chicago, Illinois 60603

   Consumer Complaints: DOI.Complaints@illinois.gov; toll-free: 1(866) 445-5364
   Officer of Consumer Health Insurance: DOI.Complaints@illinois.gov; toll-free: 1(877) 527-9431

2. The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable to you.

3. In accordance with Illinois law, insurers are required to provide the following **NOTICE** to applicants of insurance policies issued in Illinois.

STATE OF ILLINOIS
The Religious Freedom Protection and Civil Union Act
Effective June 1, 2011

The Religious Freedom Protection and Civil Union Act ("the Act") creates a legal relationship between two persons of the same or opposite sex who form a civil union. The Act provides that the parties to a civil union are entitled to the same legal obligations, responsibilities, protections and benefits that are afforded or recognized by the laws of Illinois to spouses. The law further provides that a party to a civil union shall be included in any definition or use of the terms "spouse," "family," "immediate family," "dependent," "next of kin," and other terms descriptive of spousal relationships as those terms are used throughout Illinois law. This includes the terms "marriage" or "married," or variations thereon. Insurance policies are required to provide identical benefits and protections to both civil unions and marriages. If policies of insurance provide coverage for children, the children of civil unions must also be provided coverage. The Act also requires recognition of civil unions or same sex civil unions or marriages legally entered into in other jurisdictions.

For more information regarding the Act, refer to 750 ILCS 75/1 *et seq*. Examples of the interaction between the Act and existing law can be found in the Illinois Insurance Facts, Civil Unions and Insurance Benefits document available on the Illinois Department of Insurance's website at https://idoi.illinois.gov.

Indiana:

1. **For Your Questions and Complaints:**
   Public Information/Market Conduct
   Indiana Department of Insurance
   311 W. Washington St. Suite 300
   Indianapolis, IN 46204-2787
   1(317) 232-2395

Kansas:

1. The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is amended to read as follows:
   Policy Interpretation: *Who interprets Policy terms and conditions?*
   Pursuant to the Employee Retirement Income Security Act of 1974, as amended (ERISA), Your Employer has delegated to Us the fiduciary responsibility to determine eligibility for benefits and to construe and interpret all terms and provisions of The Policy. Therefore, We are a fiduciary for The Policy and We have the continuing duty to act prudently and in the interest of You, Your beneficiaries and the other plan participants. If You have a claim for benefits which is denied or ignored, in whole or in part, then You may file suit in state or federal court for a review of Your eligibility or entitlement to benefits under The Policy. This provision only applies where the interpretation of The Policy is governed by ERISA.

Louisiana:

1. You are entitled to have your coverage reinstated after release from active military service; subject to the terms of the policy.

Maine:

1. **NOTICE:** The benefits under the policy are subject to reduction due to other sources of income.

   This means that your benefits will be reduced by the amount of any other benefits for loss of time provided to you or for which you are eligible as a result of the same period of disability for which you claim benefits under the policy.

   Other sources of income are plans or arrangements of coverage that provide disability-related benefits such as Worker's Compensation or other similar governmental programs or laws, or disability-related benefits received from your employer or as the result of your employment, membership or association with any group, union, association or other organization. Other sources of income include disability-related benefits under the United States Social Security Act or an alternate governmental plan, the Railroad Retirement Act, and other similar plans or acts. Other sources of income may also include certain disability-related or retirement benefits that you receive because of your retirement unless you were receiving them prior to becoming disabled.

   What comprises other sources of income under the policy is determined by the nature of the policyholder. Therefore, we strongly urge you to **Read Your Certificate Carefully.** A full description of the plans and types of plans considered to be other sources of income under the policy will be found in the definition of "Other Income Benefits" located in the Definitions section of your certificate.
2. **NOTICE:** The laws of the State of Maine require notification of the right to designate a third party to receive notice of cancellation, to change such a designation and, to have the Policy reinstated if the insured suffers from cognitive impairment or functional incapacity and the ground for cancellation was the insured's nonpayment of premium or other lapse or default on the part of the insured.

   Within 10 days after a request by an insured, a Third Party Notice Request Form shall be mailed or personally delivered to the insured.
3. You are entitled to have your coverage reinstated within 90 days from the date of cancellation; subject to premium payment. We have the right to require a medical demonstration of cognitive and/or functional capacity at your expense.

Maryland:

1. **NOTICE:** The group insurance Policy providing coverage under the Certificate may have been issued in a jurisdiction other than Maryland and may not provide all of the benefits required by Maryland law.

Massachusetts:

1. The **Surviving Children** definition in the **Survivor Income Benefit** will also include a child in the process of adoption.
2. You have the right to continue your coverage for up to 31 days should your employment terminate or you cease to be a member of an eligible class; subject to our receipt of the required premium payment.
3. You have the right to continue your coverage for a maximum of 90 days should your employment terminate due to a plant or partial plant closing. Premium payment must be received in order for coverage to continue.

Michigan:

1. The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable to you.

Minnesota:

1. The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable to you.

Montana:

1. **NOTICE:** Conformity with Montana statutes: The provisions of the certificate conform to the minimum requirements of Montana law and control over any conflicting statutes of any state in which the insured resides on or after the effective date of the certificate.
2. Pregnancy will be covered, the same as any other sickness, anything in The Policy to the contrary notwithstanding.

New Hampshire:

1. If Your claim is denied, You may appeal to Us within 180 days of receipt of the claim denial, subject to the other terms of the **Claim Appeal** provision.
2. The time period stated for legal action to start in the **Legal Actions** provision shown in the **General Provisions** section can not be less than 3 years after the time **Proof of Loss** is required to be given.

New Jersey:

1. The **Surviving Children** definition within the **Survivor Income Benefit** will always include children related to You by civil union.
2. The **Surviving Spouse** definition within the **Survivor Income Benefit** will always include civil unions and domestic partners, provided You continue to meet the requirements described in the domestic partner affidavit, civil union license or civil union certificate or as required by law. Same sex relationships entered into under the laws of another State or Country, which closely approximate a civil union or a domestic partnership under New Jersey law, will be recognized as civil unions or domestic partners under New Jersey law.

New Mexico:

1. The **Surviving Children** definition within the **Survivor Income Benefit**, if included in Your Certificate, will include children up to age 26.

New York:

1. We will not offset settlements or judgments from any lawsuit that represents or compensates you for a loss of earnings, if shown in the **Other Income Benefits** provision in the **Definitions** section of the certificate.
2. The **Conversion Right** provision, if shown in the **Period of Coverage** section of the Certificate, is not applicable.
3. The **Subrogation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable to you.
4. The **Reimbursement** provision, if shown in the **General Provisions** section of the Certificate, is not applicable to you.
5. If the definition of **Surviving Spouse** within the **Survivor Income Benefit** requires the completion of a domestic partner affidavit, the following requirement applies to you:

   The domestic partner affidavit must be notarized and requires that You and Your domestic partner meet all of the following criteria:

   1) you are both are legally and mentally competent to consent to contract in the state in which you reside;

2) you are not related by blood in a manner that would bar marriage under laws of the state in which you reside;
3) you have been living together on a continuous basis prior to the date of the application;
4) neither of you have been registered as a member of another domestic partnership within the last six months; and
5) you provide proof of cohabitation (e.g., a driver's license, tax return or other sufficient proof).

The domestic partner affidavit further requires that You and Your domestic partner provide proof of financial interdependence in the form of at least two of the following:

1) a joint bank account;
2) a joint credit card or charge card;
3) joint obligation on a loan;
4) status as an authorized signatory on the partner's bank account, credit card or charge card;
5) joint ownership of holdings or investments, residence, real estate other than residence, major items of personal property (e.g., appliances, furniture), or a motor vehicle;
6) listing of both partners as tenants on the lease of the shared residence;
7) shared rental payments of residence (need not be shared 50/50);
8) listing of both partners as tenants on a lease, or shared rental payments, for property other than residence;
9) a common household and shared household expenses (e.g., grocery bills, utility bills, telephone bills, etc. and need not be shared 50/50);
10) shared household budget for purposes of receiving government benefits;
11) status of one as representative payee for the other's government benefits;
12) joint responsibility for child care (e.g., school documents, guardianship);
13) shared child-care expenses (e.g., babysitting, day care, school bills, etc. and need not be shared 50/50);
14) execution of wills naming each other as executor and/or beneficiary;
15) designation as beneficiary under the other's life insurance policy;
16) designation as beneficiary under the other's retirement benefits account;
17) mutual grant of durable power of attorney;
18) mutual grant of authority to make health care decisions (e.g., health care power of attorney);
19) affidavit by creditor or other individual able to testify to partners' financial interdependence;
20) other item(s) of proof sufficient to establish economic interdependency under the circumstances of the particular case.

North Carolina:

1. The **Subrogation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable to you.
2. We will not offset for income received from a mandatory "no-fault" automobile insurance plan; if included in the **Other Income Benefits** provision in the **Definitions** section of the certificate.
3. You are not required to be under the **Regular Care of a Physician** in order to continue to receive benefit payments provided qualified medical professionals have determined that further medical care and treatment would be of no benefit to You.
4. The **Exclusions** provision shall only exclude for Workers' Compensation if the final adjudication of the Worker's Compensation claim determined that benefits are paid, or may be paid, if duly claimed.
5. No statements will be used to reduce or deny a claim if the insured person has been covered under the Policy for at least 2 years. Prior to 2 years, such statement must be in writing and signed by the insured person in order to be used.
6. The **Sending Proof of Loss** provision is amended to state that written **Proof of Loss** must be sent to Us within 180 days following the completion of the **Elimination Period**.
7. The **Claims to be Paid** provision is amended to state that We may pay up to $3,000 to a person who is Related to You and who, at Our sole discretion, is entitled to it. Any such payment shall fulfill Our responsibility for the amount paid.
8. **Notice of Claim** may also be given to Our representative, if applicable.
9. **NOTICE:** UNDER NORTH CAROLINA GENERAL STATUTE SECTION 58-50-40, NO PERSON, EMPLOYER, FINANCIAL AGENT, TRUSTEE, OR THIRD PARTY ADMINISTRATOR, WHO IS RESPONSIBLE FOR THE PAYMENT OF GROUP LIFE INSURANCE, GROUP HEALTH OR GROUP HEALTH PLAN

PREMIUMS, SHALL:

1. CAUSE THE CANCELLATION OR NONRENEWAL OF GROUP LIFE INSURANCE, GROUP HEALTH INSURANCE, HOSPITAL, MEDICAL, OR DENTAL SERVICE CORPORATION PLAN, MULTIPLE EMPLOYER WELFARE ARRANGEMENT, OR GROUP HEALTH PLAN COVERAGES AND THE CONSEQUENTIAL LOSS OF THE COVERAGES OF THE PERSON INSURED, BY WILLFULLY FAILING TO PAY THOSE PREMIUMS IN ACCORDANCE WITH THE TERMS OF THE INSURANCE OR PLAN CONTRACT; AND
2. WILLFULLY FAIL TO DELIVER, AT LEAST 45 DAYS BEFORE THE TERMINATION OF THOSE COVERAGES, TO ALL PERSONS COVERED BY THE GROUP POLICY WRITTEN NOTICE OF THE PERSON'S INTENTION TO STOP PAYMENT OF PREMIUMS. VIOLATION OF THIS LAW IS A FELONY. ANY PERSON VIOLATING THIS LAW IS ALSO SUBJECT TO A COURT ORDER REQUIRING THE PERSON TO COMPENSATE PERSONS INSURED FOR EXPENSES OR LOSSES INCURRED AS A RESULT OF THE TERMINATION OF THE INSURANCE.

IMPORTANT TERMINATION INFORMATION

YOUR INSURANCE MAY BE CANCELLED BY THE COMPANY. PLEASE READ THE TERMINATION PROVISION IN THE CERTIFICATE.

THE CERTIFICATE OF INSURANCE PROVIDES COVERAGE UNDER A GROUP MASTER POLICY. THE CERTIFICATE PROVIDES ALL OF THE BENEFITS MANDATED BY THE NORTH CAROLINA INSURANCE CODE, BUT YOU MAY NOT RECEIVE ALL OF THE PROTECTIONS PROVIDED BY A POLICY ISSUED IN NORTH CAROLINA AND GOVERNED BY ALL OF THE LAWS OF NORTH CAROLINA.

PRE-EXISTING LIMITATION
READ CAREFULLY
NO BENEFITS WILL BE PAYABLE UNDER THIS PLAN FOR PRE-EXISTING CONDITIONS WHICH ARE NOT COVERED UNDER THE PRIOR PLAN. PLEASE READ THE LIMITATIONS IN THE CERTIFICATE.

READ YOUR CERTIFICATE CAREFULLY.

Oregon:

1. The definition of **Surviving Spouse** within the **Survivor Income Benefit** will include Your domestic partner provided You have registered as domestic partners with a government agency or office where such registration is available. You will not be required to provide proof of such registration.
2. The **Surviving Children** definition within the **Survivor Income Benefit** will include children related to You by domestic partnership.
3. You are entitled to have your coverage continue while you are scheduled or required to serve as a juror for jury duty.

Rhode Island:

1. The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable to you.

South Carolina:

1. The **Physical Examinations and Autopsy** provision will state that such autopsy must be performed during the period of contestability and must take place in the state of South Carolina.
2. If You become insured under The Policy on the Policy Effective Date and were insured under the Prior Policy within 30 days of being covered under The Policy, the **Pre-existing Condition Limitation** will end on the earliest of:
    1) the Policy Effective date, if Your coverage for the Disability was not limited by a pre-existing condition restriction under the Prior Policy; or
    2) the date the restriction would have ceased to apply had the Prior Policy remained in force, if Your coverage was limited by a pre-existing condition limitation under the Prior Policy.

   This is subject to the other terms and conditions of the **Continuity From a Prior Policy** provision.

South Dakota:

1. The definition of **Physician** may include the insured person or a person related to the insured person by blood or marriage provided that the he/she is the only such physician in the area and provided that he/she is acting within the scope of their normal employment.
2. We will not offset against the amount of any benefit for loss of income, provided to Your family, Your Spouse or Your Spouse's family.

Texas:

1. The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable to you.
2. **NOTICE:**

Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company. If you don't, you may lose your right to appeal.

Hartford Life and Accident Insurance Company
To get information or file a complaint with your insurance company:

Call: Customer Service at 860-547-5000

Toll-free: 1-800-523-2233

Online: https://www.thehartford.com/contact-the-hartford
Email: gbdcustomerservice@thehartford.com
Mail: The Hartford, Group Benefits Division, P.O. Box 2999, Hartford, CT 06104-2999

The Texas Department of Insurance
To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439

File a complaint: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov
Mail: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros. Si no lo hace, podría perder su derecho para apelar.

Hartford Life and Accident Insurance Company
Para obtener información o para presentar una queja ante su compañía de seguros:

Llame a: servicio al cliente al 860-547-5000

Teléfono gratuito: 1-800-523-2233

En línea: https://www.thehartford.com/contact-the-hartford
Correo electrónico: gbdcustomerservice@thehartford.com
Dirección postal: The Hartford, Group Benefits Division, P.O. Box 2999, Hartford, CT 06104-2999

El Departamento de Seguros de Texas

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439

Presente una queja en: www.tdi.texas.gov
Correo electrónico: ConsumerProtection@tdi.texas.gov
Dirección postal: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

Utah:

1. If the **Sending Proof of Loss** provision provides a timeframe in which proof must be submitted before it affects Your claim, this time limitation shall not apply to You.

Vermont:

1. The following requirement applies:

Purpose: Vermont law requires that health insurers offer coverage to parties to a civil union that is equivalent to coverage provided to married persons.

Definitions, Terms, Conditions and Provisions: The definitions, terms, conditions or any other provisions of the policy, contract, certificate and/or riders and endorsements are hereby superseded as follows:

1) Terms that mean or refer to a marital relationship, or that may be construed to mean or refer to a marital relationship, such as "marriage", "spouse", "husband", "wife", "dependent", "next of kin", "relative", "beneficiary", "survivor", "immediate family" and any other such terms, include the relationship created by a civil union established according to Vermont law.
2) Terms that mean or refer to the inception or dissolution of a marriage, such as "date of marriage", "divorce decree", "termination of marriage" and any other such terms include the inception or dissolution of a civil union established according to Vermont law.
3) Terms that mean or refer to family relationships arising from a marriage, such as “family”, “immediate family”, “dependent”, “children”, “next of kin”, “relative”, “beneficiary”, “survivor” and any other such terms include family relationships created by a civil union established according to Vermont law.
4) "Dependent" means a spouse, a party to a civil union established according to Vermont law, and a child or children (natural, stepchild, legally adopted or a minor or disabled child who is dependent on the insured for support and maintenance) who is born to or brought to a marriage or to a civil union established according to Vermont law.
5) "Child or covered child" means a child (natural, step-child, legally adopted or a minor or disabled child who is dependent on the insured for support and maintenance) who is born to or brought to a marriage or to a civil union established according to Vermont law.

CAUTION: FEDERAL LAW RIGHTS MAY OR MAY NOT BE AVAILABLE

Vermont law grants parties to a civil union the same benefits, protections and responsibilities that flow from marriage under state law. However, some or all of the benefits, protections and responsibilities related to health insurance that are available to married persons under federal law may not be available to parties to a civil union. For example, federal law, the Employee Income Retirement Security Act of 1974 known as “ERISA”, controls the employer/employee relationship with regard to determining eligibility for enrollment in private employer health benefit plans. Because of ERISA, Act 91 does not state requirements pertaining to a private employer’s enrollment of a party to a civil union in an ERISA employee welfare benefit plan. However, governmental employers (not federal government) are required to provide health benefits to the dependents of a party to a civil union if the public employer provides health benefits to the dependents of married persons. Federal law also controls group health insurance continuation rights under COBRA for employers with 20 or more employees as well as the Internal Revenue Code treatment of health insurance premiums. As a result, parties to a civil union and their families may or may not have access to certain benefits under the policy, contract, certificate, rider or endorsement that derive from federal law. You are advised to seek expert advice to determine your rights under this contract.

Virginia:

1. **For Your Questions and Complaints:**
   State Corporation Commissions
   Life and Health Division
   Bureau of Insurance
   P.O. Box 1157

Richmond, VA 23218
1(804) 371-9691 (inside Virginia)
1(877) 310-6560 (outside Virginia)

Washington:

1. You are entitled to continue your insurance for a period of up to six months should your employment terminate as a result of a general work stoppage.

Wisconsin:

1. **For Your Questions and Complaints:**
   To request a Complaint Form:
   Office of the Commissioner of Insurance
   Complaints Department
   P.O. Box 7873
   Madison, WI 53707-7873
   1(800) 236-8517 (within Wisconsin)
   1(608) 266-0103 (outside of Wisconsin)

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Group Disability Income Insurance

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

One Hartford Plaza

Hartford, Connecticut 06155

(A stock insurance company)

The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries.

CERTIFICATE OF INSURANCE

Policyholder: TR. OF HAWAII STATE TEACHERS ASSOCIATION VOLUNTARY ***
Policy Number: GLT-204902
Policy Effective Date: May 1, 2022
Policy Anniversary Date: September 1

We have issued The Policy to the Policyholder. Our name, the Policyholder's name and the Policy Number are shown above. The provisions of The Policy, which are important to You, are summarized in this certificate consisting of this form and any additional forms which have been made a part of this certificate. This certificate replaces any other certificate We may have given to You earlier under The Policy. The Policy alone is the only contract under which payment will be made. Any difference between The Policy and this certificate will be settled according to the provisions of The Policy on file with Us at Our home office. The Policy may be inspected at the office of the Policyholder.

Signed for the Company

Kevin Barnett, *Secretary*

Michael J. Fish, *President*

A note on capitalization in this certificate:

Capitalization of a term, not normally capitalized according to the rules of standard punctuation, indicates a word or phrase that is a defined term in The Policy or refers to a specific provision contained herein.

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SCHEDULE OF INSURANCE

The Policy of long term Disability insurance provides You with long term income protection if You become Disabled from a covered injury, sickness or pregnancy.

The benefits described herein are those in effect as of May 1, 2026.

Cost of Coverage:
You must contribute toward the cost of coverage.

Disclosure of Fees:
We may reduce or adjust premiums, rates, fees and/or other expenses for programs under The Policy.

Disclosure of Services:
In addition to the insurance coverage, We may offer noninsurance benefits and services to Active Employees.

Eligible Class(es) For Coverage:
All Full-time and Half-time Active Employees who are Hawaii State Teachers Association members, associate Hawaii State Teachers Association members, and regularly scheduled employees of Hawaii State Teachers Association, who are classified eligible by The Trust, who are citizens or legal residents of the United States, its territories and protectorates; excluding temporary, leased or seasonal employees.

Full-time Employment: at least 35 hours weekly
Half-time Employment: at least 17.5 hours weekly

Eligibility Waiting Period for Coverage:
None

Elimination Period:
Option 1: 6 month(s)
Option 2: 9 month(s)
Option 3: 18 month(s)
Option 4: 24 month(s)

Maximum Monthly Benefit: $7,000

Minimum Monthly Benefit: $50

Benefit Percentage:

Option 1: 50%

Option 2: 60%

Option 3: 66 2/3%

Maximum Duration of Benefits

Maximum Duration of Benefits Table

Age When Disabled	Benefits Payable
Prior to Age 63	To Normal Retirement Age or 42 months, if greater
Age 63	To Normal Retirement Age or 36 months, if greater
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

Normal Retirement Age means the Social Security Normal Retirement Age as stated in the 1983 revision of the United States Social Security Act. It is determined by Your date of birth as follows:

Year of Birth	Normal Retirement Age
1937 or before	65
1938	65 + 2 months
1939	65 + 4 months
1940	65 + 6 months
1941	65 + 8 months
1942	65 + 10 months
1943 thru 1954	66
1955	66 + 2 months
1956	66 + 4 months
1957	66 + 6 months
1958	66 + 8 months
1959	66 + 10 months
1960 or after	67

ELIGIBILITY AND ENROLLMENT

Eligible Persons: *Who is eligible for coverage?*
All persons in the class or classes shown in the Schedule of Insurance will be considered Eligible Persons.

Eligibility for Coverage: *When will I become eligible?*
You will become eligible for coverage on the later of:
1) the Policy Effective Date; or
2) the date on which You complete the Eligibility Waiting Period for Coverage shown in the Schedule of Insurance, if applicable.

Enrollment: *How do I enroll for coverage?*
To enroll for coverage You must:
1) complete and sign a group insurance enrollment form which is satisfactory to Us; and
2) deliver it to Your Employer.

If You do not enroll within 60 days after becoming eligible under The Policy, or if You were eligible to enroll under the Prior Policy and did not do so, and later choose to enroll:
1) You must give Us Evidence of Insurability satisfactory to Us; and
2) You may enroll at any time.

Evidence of Insurability: *What is Evidence of Insurability and what happens if Evidence of Insurability is not satisfactory to Us?*
Evidence of Insurability must be satisfactory to Us and may include, but will not be limited to:
1) a completed and signed application approved by Us;
2) a medical examination;
3) attending Physicians' statements; and
4) any additional information We may require.

All Evidence of Insurability will be furnished at Your expense. We will then determine if You are insurable under The Policy.

If Your Evidence of Insurability is not satisfactory to Us:
1) Your Monthly Benefit will equal the amount for which You were eligible without providing Evidence of Insurability, provided You enrolled within 60 days of the date You were first eligible to enroll; and
2) You will not be covered under The Policy if You enrolled more than 60 days after the date You were first eligible to enroll.

PERIOD OF COVERAGE

Effective Date: *When does my coverage start?*
Your coverage will start on the earliest of:
1) the date You become eligible, if You enroll or have enrolled by then;
2) the first day of the month following the date on which You enroll, if You do so within 60 days after the date You are eligible; or
3) the date We approve Your Evidence of Insurability, for benefit amounts requiring Evidence of Insurability.

Deferred Effective Date: *When will my effective date for coverage or a change in my coverage be deferred?*
If You are absent from work due to:
1) accidental bodily injury;
2) sickness;
3) Mental Illness;
4) Substance Abuse; or
5) pregnancy;

on the date Your insurance, or increase in coverage, would otherwise have become effective, Your insurance, or increase in coverage will not become effective until You are Actively at Work one full day.

Changes in Coverage: *Can I change my benefit options?*
You may change Your benefit option at any time.
You may decrease coverage, or increase coverage to a higher option. An increase in coverage will be subject to Your submission of an application that meets Our approval.

When will a requested change in benefit option take effect?
Any such increase in coverage is subject to the following provisions:
1) Deferred Effective Date; and
2) Pre-existing Conditions Limitation.

Do coverage amounts change if there is a change in my class or my rate of pay?
Your coverage may increase or decrease on the date there is a change in Your class or Pre-disability Earnings. However, no increase in coverage will be effective unless on that date You:
1) are an Active Employee; and
2) are not absent from work due to being Disabled. If You were so absent from work, the effective date of such increase will be deferred until You are Actively at Work for one full day.

No change in Your Pre-disability Earnings will become effective until the date We receive notice of the change.

What happens if the Employer changes The Policy?
Any increase or decrease in coverage because of a change in The Policy will become effective on the date of the change, subject to the following provisions:
1) the Deferred Effective Date provision; and
2) Pre-existing Conditions Limitation.

Termination: *When will my coverage end?*
Your coverage will end on the earliest of the following:
1) the date The Policy terminates;
2) the date The Policy no longer insures Your class;
3) the date premium payment is due but not paid;
4) the last day of the period for which You make any required premium contribution;
5) the date Your Employer terminates Your employment; or
6) the date You cease to be aFull-time or Half-time Active Employee in an eligible class for any reason;

unless continued in accordance with any of the Continuation Provisions.

Continuation Provisions: *Can my coverage be continued beyond the date it would otherwise terminate?*
Coverage can be continued by Your Employer beyond a date shown in the Termination provision, if Your Employer provides a plan of continuation which applies to all employees the same way. Continued coverage:
1) is subject to any reductions in The Policy;
2) is subject to payment of premium; and
3) terminates if:
   a) The Policy terminates; or
   b) coverage for Your class terminates.

In any event, Your benefit level, or the amount of earnings upon which Your benefits may be based, will be that in effect on the day before Your coverage was continued. Coverage may be continued in accordance with the above restrictions and as described below:

Military Leave of Absence: If You enter active military service and are granted a military leave of absence in writing, Your coverage may be continued for up to 12 weeks, or longer if required by other applicable law. If the leave ends prior to the agreed upon date, this continuation will cease immediately.

Family and Medical Leave: If You are granted a leave of absence, in writing, according to the Family and Medical Leave Act of 1993, or other applicable state or local law, Your coverage may be continued for up to 12 weeks, or 26 weeks if You qualify for Family Military Leave, or longer if required by other applicable law, following the date Your leave commenced. If the leave terminates prior to the agreed upon date, this continuation will cease immediately.

Coverage while Disabled: *Does my insurance continue while I am Disabled and no longer an Active Employee?*
If You are Disabled and You cease to be an Active Employee, Your insurance will be continued:

1) during the Elimination Period while You remain Disabled by the same Disability; and
2) after the Elimination Period for as long as You are entitled to benefits under The Policy.

Waiver of Premium: *Am I required to pay premiums while I am Disabled?*
No premium will be due for You:

1) after the Elimination Period; and
2) for as long as benefits are payable.

Extension of Benefits for Disability: *Do my benefits continue if The Policy terminates?*
If You are entitled to benefits while Disabled and The Policy terminates, benefits:

1) will continue as long as You remain Disabled by the same Disability; but
2) will not be provided beyond the date We would have ceased to pay benefits had the insurance remained in force.

Termination of The Policy for any reason will have no effect on Our liability under this provision.

BENEFITS

Disability Benefit: *What are my Disability Benefits under The Policy?*
We will pay You a Monthly Benefit if You:

1) become Disabled while insured under The Policy;
2) are Disabled throughout the Elimination Period;
3) remain Disabled beyond the Elimination Period; and
4) submit Proof of Loss to Us.

Benefits accrue as of the first day after the Elimination Period and are paid monthly. However, benefits will not exceed the Maximum Duration of Benefits.

Mental Illness and Substance Abuse Benefits: *Are benefits limited for Mental Illness or Substance Abuse?*
If You are Disabled because of:

1) Mental Illness that results from any cause;
2) any condition that may result from Mental Illness;
3) alcoholism; or
4) the non-medical use of narcotics, sedatives, stimulants, hallucinogens, or any other such substance;

then, subject to all other provisions of The Policy, We will limit the Maximum Duration of Benefits.

Benefits will be payable:

1) for as long as You are confined in a hospital or other place licensed to provide medical care for the disabling condition; or
2) if not confined, or after You are discharged and still Disabled, for a total of 24 months for all such disabilities during Your lifetime.

Recurrent Disability: *What happens if I Recover but become Disabled again?*
Periods of Recovery during the Elimination Period will not interrupt the Elimination Period, if the number of days You return to work as an Active Employee are less than 30 days.

Any day within such period of Recovery, will not count toward the Elimination Period.

After the Elimination Period, if You return to work as an Active Employee and then become Disabled and such Disability is:

1) due to the same cause; or
2) due to a related cause; and
3) within 6 months of the return to work,

the Period of Disability prior to Your return to work and the recurrent Disability will be considered one Period of Disability, provided The Policy remains in force.

If You return to work as an Active Employee for 6 months or more, any recurrence of a Disability will be treated as a new Disability. The new Disability is subject to a new Elimination Period and a new Maximum Duration of Benefits.

Period of Disability means a continuous length of time during which You are Disabled under The Policy.

Recover or Recovery means that You are no longer Disabled and have returned to work with The Employer and premiums are being paid for You.

Calculation of Monthly Benefit:
Return to Work Incentive: *How are my Disability benefits calculated?*
If You remain Disabled after the Elimination Period, but work while You are Disabled, We will determine Your Monthly Benefit for a period of up to 12 consecutive months as follows:

1) multiply Your Pre-disability Earnings by the Benefit Percentage for which You enrolled;
2) compare the result with the Maximum Benefit for which You enrolled; and
3) from the lesser amount, deduct Other Income Benefits.

The result is Your Monthly Benefit. Current Monthly Earnings will not be used to reduce Your Monthly Benefit. However, if the sum of Your Monthly Benefit and Your Current Monthly Earnings exceeds 100% of Your Pre-disability Earnings, We will reduce Your Monthly Benefit by the amount of excess.

The 12 consecutive month period will start on the last to occur of:

1) the day You first start work; or
2) the end of the Elimination Period.

If You are Disabled and not receiving benefits under the Return to Work Incentive, We will calculate Your Monthly Benefit as follows:

1) multiply Your Monthly Income Loss by the Benefit Percentage for which You enrolled;
2) compare the result with the Maximum Benefit for which You enrolled; and
3) from the lesser amount, deduct Other Income Benefits.

The result is Your Monthly Benefit.

Calculation of Monthly Benefit: *What happens if the sum of my Monthly Benefit, Current Monthly Earnings, and Other Income Benefits exceeds 100% of my Pre-disability Earnings?*
If the sum of Your Monthly Benefit, Current Monthly Earnings, and Other Income Benefits exceeds 100% of Your Pre-disability Earnings, We will reduce Your Monthly Benefit by the amount of the excess. However, Your Monthly Benefit will not be less than the Minimum Monthly Benefit.

If an overpayment occurs, We may recover all or any portion of the overpayment, in accordance with the Overpayment Recovery provision.

Minimum Monthly Benefit: *Is there a Minimum Monthly Benefit?*
Your Monthly Benefit will not be less than the Minimum Monthly Benefit shown in the Schedule of Insurance.

Partial Month Payment: *How is the benefit calculated for a period of less than a month?*
If a Monthly Benefit is payable for a period of less than a month, We will pay 1/30 of the Monthly Benefit for each day You were Disabled.

Termination of Payment: *When will my benefit payments end?*
Benefit payments will stop on the earliest of:

1) the date You are no longer Disabled;
2) the date You fail to furnish Proof of Loss;
3) the date You are no longer under the Regular Care of a Physician;

4) the date You refuse Our request that You submit to an examination by a Physician or other qualified medical professional;
5) the date of Your death;
6) the date You refuse to receive recommended treatment that is generally acknowledged by Physicians to cure, correct or limit the disabling condition;
7) the last day benefits are payable according to the Maximum Duration of Benefits Table;
8) the date Your Current Monthly Earnings:
   a) are equal to or greater than 80% of Your Indexed Pre-disability Earnings if You are receiving benefits for being Disabled from Your Occupation; or
   b) are greater than the lesser of the product of Your Indexed Pre-disability Earnings and the Benefit Percentage for which You enrolled or the Maximum Monthly Benefit if You are receiving benefits for being Disabled from Any Occupation;
9) the date no further benefits are payable under any provision in The Policy that limits benefit duration; or
10) the date You refuse to participate in a Rehabilitation program, or refuse to cooperate with or try:
   a) modifications made to the work site or job process to accommodate Your identified medical limitations to enable You to perform the Essential Duties of Your Occupation;
   b) adaptive equipment or devices designed to accommodate Your identified medical limitations to enable You to perform the Essential Duties of Your Occupation;
   c) modifications made to the work site or job process to accommodate Your identified medical limitations to enable You to perform the Essential Duties of Any Occupation, if You were receiving benefits for being disabled from Any Occupation; or
   d) adaptive equipment or devices designed to accommodate Your identified medical limitations to enable You to perform the Essential Duties of Any Occupation, if You were receiving benefits for being disabled from Any Occupation;

   provided a qualified Physician or other qualified medical professional agrees that such modifications, Rehabilitation program or adaptive equipment accommodate Your medical limitation.

EXCLUSIONS AND LIMITATIONS

Exclusions: *What Disabilities are not covered?*
The Policy does not cover, and We will not pay a benefit for, any Disability:
1) unless You are under the Regular Care of a Physician;
2) that is caused or contributed to by war or act of war, whether declared or not;
3) caused by Your commission of or attempt to commit a felony;
4) caused or contributed to by Your being engaged in an illegal occupation; or
5) caused or contributed to by an intentionally self-inflicted injury.

Pre-existing Condition Limitation: *Are benefits limited for Pre-existing Conditions?*
We will not pay any benefit, or any increase in benefits, under The Policy for any Disability that results from, or is caused or contributed to by, a Pre-existing Condition, unless, at the time You become Disabled:
1) You have not received Medical Care for the condition for 12 consecutive months while insured under The Policy; or
2) You have been continuously insured under The Policy for 24 consecutive months.

Pre-existing Condition means:
1) any accidental bodily injury, sickness, Mental Illness, pregnancy, or episode of Substance Abuse; or
2) any manifestations, symptoms, findings, or aggravations related to or resulting from such accidental bodily injury, sickness, Mental Illness, pregnancy, or Substance Abuse;

for which You received Medical Care during the 90 consecutive day period that ends the day before:
1) Your effective date of coverage; or
2) the effective date of a Change in Coverage.

Medical Care is received when a Physician or other health care provider:
1) is consulted or gives medical advice; or
2) recommends, prescribes, or provides Treatment.

Treatment includes but is not limited to:
1) medical examinations, tests, attendance or observation; and
2) use of drugs, medicines, medical services, supplies or equipment.

GENERAL PROVISIONS

Notice of Claim: *When should I notify the Company of a claim?*
You must give Us written notice of a claim within 30 days after Disability occurs. Failure to give notice within such time shall not invalidate or reduce any claim if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible. Such notice must include Your name, Your address, and the Policy Number.

Claim Forms: *Are special forms required to file a claim?*
We will send forms to You to provide Proof of Loss, within 15 days of receiving a Notice of Claim. If We do not send the forms within 15 days, You may submit any other written proof which fully describes the nature and extent of Your claim.

Proof of Loss: *What is Proof of Loss?*
Proof of Loss may include but is not limited to the following:

1) documentation of:
    a) the date Your Disability began;
    b) the cause of Your Disability;
    c) the prognosis of Your Disability;
    d) Your Pre-disability Earnings, Current Monthly Earnings or any income, including but not limited to copies of Your filed and signed federal and state tax returns; and
    e) evidence that You are under the Regular Care of a Physician;
2) any and all medical information, including x-ray films and photocopies of medical records, including histories, physical, mental or diagnostic examinations and treatment notes;
3) the names and addresses of all:
    a) Physicians or other qualified medical professionals You have consulted;
    b) hospitals or other medical facilities in which You have been treated; and
    c) pharmacies which have filled Your prescriptions within the past three years;
4) Your signed authorization for Us to obtain and release:
    a) medical, employment and financial information; and
    b) any other information We may reasonably require;
5) disclosure of all information and documentation required by Us relating to Other Income Benefits;
6) proof that You and Your dependents have applied for all Other Income Benefits which are available; and
7) disclosure of all information and documentation required by Us in order to exercise Our Subrogation or Reimbursement rights.

You will not be required to claim any retirement benefits which You may only get on a reduced basis. All proof submitted must be satisfactory to Us.

Additional Proof of Loss: *What Additional Proof of Loss is the Company entitled to?*
To assist Us in determining if You are Disabled, or to determine if You meet any other term or condition of The Policy, We have the right to require You to:

1) meet and interview with Our representative; and
2) be examined by a Physician, vocational expert, functional expert, or other medical or vocational professional of Our choice.

Any such interview, meeting or examination will be:

1) at Our expense; and
2) as reasonably required by Us.

Your Additional Proof of Loss must be satisfactory to Us. Unless We determine You have a valid reason for refusal, We may deny, suspend or terminate Your benefits if You refuse to be examined or meet to be interviewed by Our representative.

Sending Proof of Loss: *When must Proof of Loss be given?*
Written Proof of Loss must be sent to Us within 90 days following the completion of the Elimination Period. If proof is not given by the time it is due, it will not affect the claim if:

1) it was not reasonably possible to give proof within the required time; and
2) proof is given as soon as reasonably possible; but
3) not later than 15 months after it is due, unless You are not legally competent.

We may request Proof of Loss throughout Your Disability, as reasonably required. In such cases, We must receive the proof within 30 days of the request.

Claim Payment: *When are benefit payments issued?*
When We determine that You;

1) are Disabled; and
2) eligible to receive benefits;

We will pay accrued benefits at the end of each month that You are Disabled. We may, at Our option, make an advance benefit payment based on Our estimated duration of Your Disability. If any payment is due after a claim is terminated, it will be paid as soon as Proof of Loss satisfactory to Us is received.

Benefits may be subject to interest payments as required by applicable law.

Claims to be Paid: *To whom will benefits for my claim be paid?*
All payments are payable to You. Any payments owed at Your death may be paid to Your estate. If any payment is owed to:

1) Your estate;
2) a person who is a minor; or
3) a person who is not legally competent;

then We may pay up to $1,000 to a person who is Related to You and who, at Our sole discretion, is entitled to it. Any such payment shall fulfill Our responsibility for the amount paid.

Claim Denial: *What notification will I receive if my claim is denied?*
If a claim for benefits is wholly or partly denied, You will be furnished with written notification of the decision. This written notification will:

1) give the specific reason(s) for the denial;
2) make specific reference to The Policy provisions on which the denial is based;
3) provide a description of any additional information necessary to perfect a claim and an explanation of why it is necessary; and
4) provide an explanation of the review procedure.

Claim Appeal: *What recourse do I have if my claim is denied?*
On any claim, You or Your representative may appeal to Us for a full and fair review. To do so You:

1) must request a review upon written application within:
   a) 180 days of receipt of claim denial if the claim requires Us to make a determination of disability; or
   b) 60 days of receipt of claim denial if the claim does not require Us to make a determination of disability; and
2) may request copies of all documents, records, and other information relevant to Your claim; and
3) may submit written comments, documents, records and other information relating to Your claim.

We will respond to You in writing with Our final decision on the claim.

Social Security: *When must I apply for Social Security Benefits?*
You must apply for Social Security disability benefits when the length of Your Disability meets the minimum duration required to apply for such benefits. You must apply within 45 days from the date of Our request. If the Social Security Administration denies Your eligibility for benefits, You will be required:

1) to follow the process established by the Social Security Administration to reconsider the denial; and
2) if denied again, to request a hearing before an Administrative Law Judge of the Office of Hearing and Appeals.

Plan Offered by a State or Municipal Government: *When must I apply for benefits under a plan offered by a state or municipal government?*
You must apply for disability benefits under a plan offered by a state or municipal government, such as those offered by a public employee retirement system or state teacher retirement system, when the length of Your Disability meets the minimum duration required to apply for such benefits and You are eligible under the plan. You must apply within 45 days from the date of Our request. If the administrator of that alternative plan denies Your eligibility for benefits, You will be required to follow the process established by the administrator to reconsider the denial.

Benefit Estimates: *How does the Company estimate Disability benefits under the United States Social Security Act or an alternative plan offered by a state or municipal government?*
We reserve the right to reduce Your Monthly Benefit by estimating the Social Security disability benefits, or disability benefits under an alternative plan offered by a state or municipal government, that You or Your spouse and children may be eligible to receive.

When We determine that You or Your dependent may be eligible for benefits, We may estimate the amount of these benefits. We may reduce Your Monthly Benefit by the estimated amount.

Your Monthly Benefit will not be reduced by estimated Social Security disability benefits nor disability benefits under an alternative plan offered by a state or municipal government if:

1) You apply for Social Security disability benefits, or disability benefits under an alternative plan offered by a state or municipal government if applicable, and pursue all required appeals in accordance with the Social Security and Plan Offered by a State or Municipal Government provisions; and
2) You have signed a form authorizing the Social Security Administration, or the administrator of the alternative plan offered by a state or municipal government if applicable, to release information about awards directly to Us; and
3) You have signed and returned Our reimbursement agreement, which confirms that You agree to repay all overpayments.

If We have reduced Your Monthly Benefit by an estimated amount and:

1) You or Your dependent are later awarded Social Security disability benefits, or disability benefits under an alternative plan offered by a state or municipal government, We will adjust Your Monthly Benefit when We receive proof of the amount awarded, and determine if it was higher or lower than Our estimate; or
2) Your application for Social Security disability benefits, or disability benefits under an alternative plan offered by a state or municipal government, has been denied, We will adjust Your Monthly Benefit when You provide Us proof of final denial from which You cannot appeal from an Administrative Law Judge of the Office of Hearing and Appeals, or similar level under an alternative plan offered by a state or municipal government when available.

If Your Social Security benefits or disability benefits under an alternative plan offered by a state or municipal government were lower than We estimated, and We owe You a refund, We will make such refund in a lump sum. If Your Social Security benefits or disability benefits under an alternative plan offered by a state or municipal government were higher than We estimated, and if Your Monthly Benefit has been overpaid, You must make a lump sum refund to Us equal to all overpayments, in accordance with the Overpayment Recovery provision.

Overpayment: *When does an overpayment occur?*
An overpayment occurs:

1) when We determine that the total amount We have paid in benefits is more than the amount that was due to You under The Policy; or
2) when payment is made by Us that should have been made under another group policy.

This includes, but is not limited to, overpayments resulting from:

1) retroactive awards received from sources listed in the Other Income Benefits definition;
2) failure to report, or late notification to Us of any Other Income Benefit(s) or earned income;
3) misstatement;
4) fraud; or
5) any error We may make.

Overpayment Recovery: *How does the Company exercise the right to recover overpayments?*
We have the right to recover from You any amount that We determine to be an overpayment. You have the obligation to refund to Us any such amount. Our rights and Your obligations in this regard may also be set forth in the reimbursement agreement You will be required to sign when You become eligible for benefits under The Policy.

If benefits are overpaid on any claim, You must reimburse Us within 30 days.

If reimbursement is not made in a timely manner, We have the right to:

1) recover such overpayments from:
   a) You;
   b) any other organization;
   c) any other insurance company;
   d) any other person to or for whom payment was made; and
   e) Your estate;
2) reduce or offset against any future benefits payable to You or Your survivors, including the Minimum Monthly Benefit, until full reimbursement is made. Payments may continue when the overpayment has been recovered;
3) refer Your unpaid balance to a collection agency; and
4) pursue and enforce all legal and equitable rights in court.

Subrogation: *What are Our subrogation rights?*
If You:

1) suffer a Disability caused, in full or in part, by the act or omission of any person or legal entity;

2) become entitled to and are paid benefits under The Policy in compensation for lost wages; and
3) do not initiate legal action for the recovery of such benefits from a Third Party in a reasonable period of time or notify Us that You do not intend to do so;

then We will be subrogated to any rights You may have against a Third Party and may, at Our option, bring legal action against or otherwise pursue a Third Party to recover any payments made by Us in connection with the Disability.

Third Party as used in this provision, means:

1) any person or legal entity whose act or omission, in full or in part, causes You to suffer a Disability for which benefits are paid or payable under The Policy; or
2) any insurer, including Your own, that provides benefits to You as a result of the act or omission which causes You to suffer a Disability for which benefits are paid or payable under The Policy.

Reimbursement: *What are Our reimbursement rights?*

We have the right to be reimbursed for any benefit payments made or required to be made under The Policy for a Disability for which You recover any funds from a Third Party.

If You recover any funds from a Third Party as:

1) a legal judgment;
2) an arbitration award; or
3) a settlement or otherwise;

You or Your attorney shall hold in constructive trust the lesser of:

1) the entire amount of the benefit payment(s) made or required to be made by Us; or
2) the total amount of the recovered funds;

less Our pro rata share of any reasonable attorneys' fees and court costs associated with the recovered funds. We have the right of first reimbursement regardless of:

1) whether You are made whole;
2) how the recovered funds are characterized; or
3) whether the particular funds recovered are still in Your possession.

By accepting benefit payment(s) under The Policy, You:

1) agree to cooperate fully with Our reimbursement rights, including disclosure of all information and documentation required by Us in order to exercise Our reimbursement rights; and
2) will not do anything to prejudice Our reimbursement rights.

You or Your attorney's failure to cooperate fully with Our reimbursement rights may result in denial or termination of Your benefits under The Policy.

Third Party as used in this provision, means:

1) any person or legal entity whose act or omission, in full or in part, causes You to suffer a Disability for which benefits are paid or payable under The Policy; or
2) any insurer, including Your own, that provides benefits to You as a result of the act or omission which causes You to suffer a Disability for which benefits are paid or payable under The Policy.

Legal Actions: *When can legal action be taken against Us?*

Legal action cannot be taken against Us:

1) sooner than 60 days after the date Proof of Loss is given; or
2) more than 3 years after the date Proof of Loss is required to be given according to the terms of The Policy.

Insurance Fraud: *How does the Company deal with fraud?*

Insurance Fraud occurs when You and/or Your Employer provide Us with false information or file a claim for benefits that contains any false, incomplete or misleading information with the intent to injure, defraud or deceive Us. It is a crime if You and/or Your Employer commit Insurance Fraud. We will use all means available to Us to detect, investigate, deter and prosecute those who commit Insurance Fraud. We will pursue all available legal remedies if You and/or Your Employer perpetrate Insurance Fraud.

Misstatements: *What happens if facts are misstated?*

If material facts about You were not stated accurately:

1) Your premium may be adjusted; and
2) the true facts will be used to determine if, and for what amount, coverage should have been in force.

No statement, except fraudulent misstatements, made by You relating to Your insurability will be used to contest the insurance for which the statement was made after the insurance has been in force for two years during Your lifetime. In order to be used, the statement must be in writing and signed by You.

All statements made by the Policyholder, the Employer or You under The Policy will be deemed representations and not warranties. No statement made to affect this insurance will be used in any contest unless it is in writing and a copy of it is given to the person who made it, or to his or her beneficiary or Your representative.

Policy Interpretation: *Who interprets the terms and conditions of The Policy?*
The Policyholder hereby designates Us to be a fiduciary under The Policy solely for the purposes of:

(a) determining all questions of eligibility that pertain to You;
(b) determining the amount and type of benefits payable to You in accord with The Policy; and
(c) interpreting The Policy provisions including those necessary to determine benefits. Our determinations and interpretations, and Our decisions on these matters are subject to de novo review by an impartial reviewer as provided in The Policy or as allowed by law.

Physical Examinations and Autopsy: *Will I be examined during the course of my claim?*
While a claim is pending We have the right at Our expense:

1) to have the person who has a loss examined by a Physician when and as often as reasonably necessary; and
2) to make an autopsy in case of death where it is not forbidden by law.

DEFINITIONS

Actively at Work means at work with the Employer on a day that is one of the Employer's scheduled workdays. On that day, You must be performing for wage or profit all of the regular duties of Your Occupation:

1) in the usual way; and
2) for Your usual number of hours.

We will consider You Actively at Work on a day that is not a scheduled work day only if You were Actively at Work on the preceding scheduled work day.

Active Full-time or Active Half-time Employee means an employee who works for the Employer on a regular basis in the usual course of the Employer's business. This must be at least the number of hours shown in the Schedule of Insurance.

Any Occupation means any occupation for which You are qualified by education, training or experience, and that has an earnings potential greater than the lesser of:

1) the product of Your Indexed Pre-disability Earnings and the Benefit Percentage; or
2) the Maximum Monthly Benefit.

Current Monthly Earnings means monthly earnings You receive from:

1) Your Employer; and
2) other employment;

while You are Disabled.

However, if the other employment is a job You held in addition to Your job with Your Employer, then during any period that You are entitled to benefits for being Disabled from Your Occupation, only the portion of Your earnings that exceeds Your average earnings from the other employer over the 6 month period just before You became Disabled will count as Current Monthly Earnings.

Current Monthly Earnings also includes the pay You could have received for another job or a modified job if:

1) such job was offered to You by Your Employer, or another employer, and You refused the offer; and
2) the requirements of the position were consistent with:
   a) Your education, training and experience; and
   b) Your capabilities as medically substantiated by Your Physician.

Disability or Disabled means You are prevented from performing one or more of the Essential Duties of:

1) Your Occupation during the Elimination Period;

2) Your Occupation, for the 2 years following the Elimination Period, and as a result Your Current Monthly Earnings are less than 80% of Your Indexed Pre-disability Earnings; and
3) after that, Any Occupation.

If at the end of the Elimination Period, You are prevented from performing one or more of the Essential Duties of Your Occupation, but Your Current Monthly Earnings are equal to or greater than 80% of Your Pre-disability Earnings, Your Elimination Period will be extended for a total period of 12 months from the original date of Disability, or until such time as Your Current Monthly Earnings are less than 80% of Your Pre-disability Earnings, whichever occurs first. For the purposes of extending Your Elimination Period, Your Current Monthly Earnings will not include the pay You could have received for another job or a modified job if such job was offered to You by Your Employer, or another employer, and You refused the offer.

Your Disability must result from:
1) accidental bodily injury;
2) sickness;
3) Mental Illness;
4) Substance Abuse; or
5) pregnancy.

Your failure to pass a physical examination required to maintain a license to perform the duties of Your Occupation, alone, does not mean that You are Disabled.

Elimination Period means the longer of the number of consecutive days at the beginning of any one period of Disability which must elapse before benefits are payable or the expiration of any Employer sponsored short term Disability benefits or salary continuation program, excluding benefits required by state law.

Employer means the Policyholder.

Essential Duty means a duty that:
1) is substantial, not incidental;
2) is fundamental or inherent to the occupation; and
3) cannot be reasonably omitted or changed.

Your ability to work the number of hours in Your regularly scheduled workweek is an Essential Duty.

Indexed Pre-disability Earnings means Your Pre-disability Earnings adjusted annually by adding the lesser of:
1) 10%; or
2) the percentage change in the Consumer Price Index (CPI-W).

The percentage change in the CPI-W means the difference between the current year's CPI-W as of July 31, and the prior year's CPI-W as of July 31, divided by the prior year's CPI-W. The adjustment is made January 1st each year after You have been Disabled for 12 consecutive month(s), provided You are receiving benefits at the time the adjustment is made.

The term Consumer Price Index (CPI-W) means the index for Urban Wage Earners and Clerical Workers published by the United States Department of Labor. It measures on a periodic (usually monthly) basis the change in the cost of typical urban wage earners' and clerical workers' purchase of certain goods and services. If the index is discontinued or changed, We may use another nationally published index that is comparable to the CPI-W.

Mental Illness means a mental disorder as listed in the current version of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association. A Mental Illness may be caused by biological factors or result in physical symptoms or manifestations.

For the purpose of The Policy, Mental Illness does not include the following mental disorders outlined in the Diagnostic and Statistical Manual of Mental Disorders:
1) Mental Retardation;
2) Pervasive Developmental Disorders;
3) Motor Skills Disorder;
4) Substance-Related Disorders;
5) Delirium, Dementia, and Amnesic and Other Cognitive Disorders; or
6) Narcolepsy and Sleep Disorders related to a General Medical Condition.

Monthly Benefit means a monthly sum payable to You while You are Disabled, subject to the terms of The Policy.

Monthly Income Loss means Your Pre-disability Earnings minus Your Current Monthly Earnings.

Other Income Benefits means the amount of any benefit for loss of income, provided to You or Your family, as a result of the period of Disability for which You are claiming benefits under The Policy. This includes any such benefits for which You or Your family are eligible or that are paid to You or Your family, or to a third party on Your behalf, pursuant to any:

1) temporary, permanent disability, or impairment benefits under a Workers' Compensation Law, the Jones Act, occupational disease law, similar law or substitutes or exchanges for such benefits;
2) governmental law or program that provides disability or unemployment benefits as a result of Your job with Your Employer;
3) plan or arrangement of coverage, whether insured or not, which is received from Your Employer as a result of employment by or association with Your Employer or which is the result of membership in or association with any group, association, union or other organization;
4) individual insurance policy where the premium is wholly or partially paid by the Employer;
5) mandatory “no fault” automobile insurance plan;
6) disability benefits under:
    a) the United States Social Security Act or alternative plan offered by a state or municipal government;
    b) the Railroad Retirement Act;
    c) the Canada Pension Plan, the Canada Old Age Security Act, the Quebec Pension Plan or any provincial pension or disability plan; or
    d) similar plan or act;

    that You, Your spouse and/or children, are eligible to receive because of Your Disability; or
7) disability benefit from the Department of Veterans Affairs, or any other foreign or domestic governmental agency:
    a) that begins after You become Disabled; or
    b) that You were receiving before becoming Disabled, but only as to the amount of any increase in the benefit attributed to Your Disability.

Other Income Benefits also means the amount of any payments that are made to You or to Your family, or to a third party on Your behalf, pursuant to any:

1) disability benefit under Your Employer's Retirement Plan;
2) temporary, permanent disability or impairment benefits under a Workers' Compensation Law, the Jones Act, occupational disease law, similar law or substitutes or exchanges for such benefits;
3) portion of a judgment or settlement of a claim or lawsuit that represents or compensates for Your loss of earnings, less Our pro rata share of any associated reasonable attorneys’ fees and court costs;
4) retirement benefit from a Retirement Plan that is wholly or partially funded by employer contributions, unless:
    a) You were receiving it prior to becoming Disabled; or
    b) You immediately transfer the payment to another plan qualified by the United States Internal Revenue Service for the funding of a future retirement;

    (Other Income Benefits will not include the portion, if any, of such retirement benefit that was funded by Your after-tax contributions.); or
5) retirement benefits under:
    a) the United States Social Security Act or alternative plan offered by a state or municipal government;
    b) the Railroad Retirement Act;
    c) the Canada Pension Plan, the Canada Old Age Security Act, the Quebec Pension Plan or any provincial pension or disability plan;
    d) similar plan or act;

    that You and Your spouse and children receive because of Your retirement, unless You were receiving them prior to becoming Disabled.

If You are paid Other Income Benefits in a lump sum or settlement, You must provide proof satisfactory to Us of:

1) the amount attributed to loss of income; and
2) the period of time covered by the lump sum or settlement.

We will pro-rate the lump sum or settlement over this period of time. If You cannot or do not provide this information, We will assume the entire sum to be for loss of income, and the time period to be 24 month(s). We may make a retroactive allocation of any retroactive Other Income Benefit. A retroactive allocation may result in an overpayment of Your claim.

The amount of any increase in Other Income Benefits will not be included as Other Income Benefits if such increase:

1) takes effect after the date benefits become payable under The Policy; and
2) is a general increase which applies to all persons who are entitled to such benefits.

Physician means a person who is:

1) a doctor of medicine, osteopathy, psychology or other legally qualified practitioner of a healing art that We recognize or are required by law to recognize;
2) licensed to practice in the jurisdiction where care is being given;
3) practicing within the scope of that license; and
4) not You or Related to You by blood or marriage.

Pre-disability Earnings means Your regular monthly rate of pay, not counting commissions, bonuses, tips and tokens, overtime pay or any other fringe benefits or extra compensation, in effect on the last day You were Actively at Work before You became Disabled.

However, if You were an hourly paid Active Employee before You became Disabled, Pre-disability Earnings means the product of:

1) the average number of hours You worked per month, not including overtime, over the most recent 12 month period immediately prior to the last day You were Actively at Work before You became Disabled, multiplied by:
2) Your hourly wage in effect immediately prior to the last day You were Actively at Work before You became Disabled.

Regular Care of a Physician means that You are being treated by a Physician:

1) whose medical training and clinical experience are suitable to treat Your disabling condition; and
2) whose treatment is:
   a) consistent with the diagnosis of the disabling condition;
   b) according to guidelines established by medical, research, and rehabilitative organizations; and
   c) administered as often as needed;

   to achieve the maximum medical improvement.

Rehabilitation means a process of Our working together with You in order for Us to plan, adapt, and put into use options and services to meet Your return to work needs. A Rehabilitation program may include, when We consider it to be appropriate, any necessary and feasible:

1) vocational testing;
2) vocational training;
3) alternative treatment plans such as:
   a) support groups;
   b) physical therapy;
   c) occupational therapy; or
   d) speech therapy;
4) work-place modification to the extent not otherwise provided;
5) job placement;
6) transitional work; and
7) similar services.

Related means Your spouse, or other adult living with You, or Your sibling, parent, step-parent, grandparent, aunt, uncle, niece, nephew, son, daughter, or grandchild.

Retirement Plan means a defined benefit or defined contribution plan that provides benefits for Your retirement and which is not funded wholly by Your contributions. It does not include:

1) a profit sharing plan;
2) thrift, savings or stock ownership plans;
3) a non-qualified deferred compensation plan; or
4) an individual retirement account (IRA), a tax sheltered annuity (TSA), Keogh Plan, 401(k) plan, 403(b) plan or 457 deferred compensation arrangement.

Substance Abuse means the pattern of pathological use of alcohol or other psychoactive drugs and substances characterized by:

1) impairments in social and/or occupational functioning;
2) debilitating physical condition;
3) inability to abstain from or reduce consumption of the substance; or
4) the need for daily substance use to maintain adequate functioning.

Substance includes alcohol and drugs but excludes tobacco and caffeine.

The Policy means the Policy which We issued to the Policyholder under the Policy Number shown on the face page.

We, Our, or Us means the insurance company named on the face page of The Policy.

Your Occupation means Your Occupation as it is recognized in the general workplace. Your Occupation does not mean the specific job You are performing for a specific employer or at a specific location.

You or Your means the person to whom this certificate is issued.

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 in the box below, this protection is not a substitute for consumers' care in selecting companies that are well managed and financially stable.

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 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 Guaranty Association
P.O. Box 4068
Honolulu, Hawaii 96812

Department of Commerce and Consumer Affairs
P.O. Box 3814
Honolulu, Hawaii 96811

The state law that provides for this safety net coverage is called the Hawaii Life and Disability Insurance Guaranty Association Act. On the next page 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.

(please turn to next page)

COVERAGE

Generally, individuals will be protected by the Hawaii Life and Disability Insurance Guaranty Association if they live in Hawaii 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 insurer 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 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 Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Association will pay a maximum of $300,000 - no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall $300,000 limit, the Association will not pay more than $100,000 in cash surrender values, $100,000 in health insurance benefits, $100,000 in present value of annuities, or $300,000 in life insurance death benefits - again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages.

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ERISA INFORMATION
THE FOLLOWING NOTICE
CONTAINS IMPORTANT INFORMATION

This employee welfare benefit plan (Plan) is subject to certain requirements of the Employee Retirement Income Security Act of 1974 (ERISA), as amended. ERISA requires that you receive a Statement of ERISA Rights, a description of Claim Procedures, and other specific information about the Plan. This document serves to meet ERISA requirements and provides important information about the Plan.

The benefits described in your booklet-certificate (Booklet) are provided under a group insurance policy (Policy) issued by the Hartford Life and Accident Insurance Company (Insurance Company) and are subject to the Policy's terms and conditions. The Policy and Booklet are incorporated into, and form a part of, the Plan. The Plan has designated and named the Insurance Company as the claims fiduciary for benefits provided under the Policy. The Plan has granted the Insurance Company full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Policy, to the extent permitted by applicable state law.

A copy of the Plan is available for your review during normal working hours in the office of the Plan Administrator.

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1. **Plan Name**

   For employees of TR. OF HAWAII STATE TEACHERS ASSOCIATION VOLUNTARY EMPLOYEES BENEFICIARY TRUST:

   Group Long Term Disability Plan

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2. **Plan Number**

   Group Long Term Disability - 505

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3. **Employer/Plan Sponsor**

   TR. OF HAWAII STATE TEACHERS ASSOCIATION VOLUNTARY EMPLOYEES BENEFICIARY TRUST
   1259 AALA STREET
   SUITE 202
   HONOLULU, HI 96817

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4. **Employer Identification Number**

   23-7296050

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5. **Type of Plan**

   Welfare Benefit Plan providing:

   Group Long Term Disability Insurance

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6. **Plan Administrator**

   TR. OF HAWAII STATE TEACHERS ASSOCIATION VOLUNTARY EMPLOYEES BENEFICIARY TRUST
   1259 AALA STREET
   SUITE 202
   HONOLULU, HI 96817

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7. **Agent for Service of Legal Process**

For the Plan

TR. OF HAWAII STATE TEACHERS ASSOCIATION VOLUNTARY EMPLOYEES BENEFICIARY TRUST
1259 AALA STREET
SUITE 202
HONOLULU, HI 96817

For the Policy:

Hartford Life and Accident Insurance Company
One Hartford Plaza
Hartford, Connecticut 06155

In addition to the above, Service of Legal Process may be made on a plan trustee or the plan administrator.

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8. **Sources of Contributions**

   (Group Long Term Disability) The Employer pays the premium for the insurance, but may allocate part of the cost to the employee, or the employee may pay the entire premium. The Employer determines the portion of the cost to be paid by the employee. The insurance company/provider determines the cost according to the rate structure reflected in the Policy of Incorporation.

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9. **Type of Administration** The plan is administered by the Plan Administrator with benefits provided in accordance with the provisions of the applicable group plan.

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10. The Plan and its records are kept on a Policy Year basis.

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11. **Labor Organizations**

    None

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12. **Names and Addresses of Trustees**

    None

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13. **Plan Amendment Procedure**

    The Plan Administrator reserves full authority, at its sole discretion, to terminate, suspend, withdraw, reduce, amend or modify the Plan, in whole or in part, at any time, without prior notice.

    The Employer also reserves the right to adjust your share of the cost to continue coverage by the same procedures.

STATEMENT OF ERISA RIGHTS

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

1. Receive Information About Your Plan and Benefits

a) 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.
b) 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.
c) 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.

2. 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.

3. 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. If the Plan requires you to complete administrative appeals prior to filing in court, your right to file suit in state or Federal court may be affected if you do not complete the required appeals. 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.

4. 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 (formerly known as the Pension and Welfare Benefits 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.

CLAIM PROCEDURES

The Plan has designated and named the Insurance Company as the claims fiduciary for benefits provided under the Policy. The Plan has granted the Insurance Company full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Policy, to the extent permitted by applicable state law.

Claim Procedures for Claims Requiring a Determination of Disability

Claims and appeals for disability benefits will be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to any individual (such as a claims adjudicator or medical or vocational expert) shall not be made based upon the likelihood that the individual will support the denial of benefits.

If the Insurance Company fails to strictly adhere to all the requirements of ERISA with respect to a claim, you are deemed to have exhausted the administrative remedies available under the Plan, with certain exceptions. Accordingly, you are entitled to bring a civil action to pursue any available remedies under section 502(a) of ERISA on the basis that the Insurance Company has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim. If you choose to bring a civil action to pursue remedies under section 502(a) of ERISA under such circumstances, your claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary. However, the administrative remedies available under the Plan will not be deemed exhausted based on *de minimis* violations that do not cause, and are not likely to cause, prejudice or harm to you so long as the Insurance Company demonstrates that the violation was for good cause or due to matters beyond the control of the Insurance Company and that the violation occurred in the context of an ongoing, good faith exchange of information between the Insurance Company and you. This exception is not available if the violation is part of a pattern or practice of violations by the Insurance Company. Before filing a civil action, you may request a written explanation of the violation from the Insurance Company, and the Insurance Company must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the administrative remedies available under the Plan to be deemed exhausted. If a court rejects your request for immediate review on the basis that the Insurance Company met the standards for the exception, your claim shall be considered as re-filed on appeal upon the Insurance Company's receipt of the decision of the court. Within a reasonable time after the receipt of the decision, the Insurance Company shall provide you with notice of the resubmission.

Claims for Benefits

If you or your authorized representative would like to file a claim for benefits for yourself or your insured dependents, you or your authorized representative should obtain a claim form(s) from your Employer or Plan Administrator. The applicable section of such form(s) must be completed by (1) you, (2) the Employer or Plan Administrator and (3) the attending physician or hospital. Following completion, the claim form(s) must be forwarded to the Insurance Company's claim representative. The Insurance Company will evaluate your claim and determine if benefits are payable.

The Insurance Company will make a decision no more than 45 days after receipt of your properly filed claim. The time for decision may be extended for two additional 30 day periods provided that, prior to any extension period, the Insurance Company notifies you in writing that an extension is necessary due to matters beyond the control of the Insurance Company, identifies those matters and gives the date by which it expects to render its decision. If your claim is extended due to your failure to submit information necessary to decide your claim, the time for decision may be tolled from the date on which the notification of the extension is sent to you until the date the Insurance Company receives your response to our request. If the Insurance Company approves your claim, the decision will contain information sufficient to reasonably inform you of that decision.

Any adverse benefit determination will be in writing and include: 1) the specific reason or reasons for the decision; 2) specific references to the Policy provisions on which the decision is based; 3) a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary; 4) a description of the Insurance Company's review procedures and time limits applicable to such procedures; 5) a statement that you have the right to bring a civil action under section 502(a) of ERISA after you appeal the decision and after you receive a written denial on appeal; 6) a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (a) the views presented by you to the Insurance Company of health care professionals treating you and vocational professionals who evaluated you, (b) the views of medical or vocational experts whose advice was obtained on behalf of the Insurance Company in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and (c) a disability determination regarding you presented by you to the Insurance Company made by the Social Security Administration; 7) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; 8) either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Insurance Company relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Insurance Company do not exist; 9) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits; and

10) a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Insurance Company.

Appealing Denials of Claims for Benefits

On any wholly or partially denied claim, you or your representative must appeal once to the Insurance Company for a full and fair review. You must complete this claim appeal process before you file an action in court, with the exception of an action under the deemed exhausted process described above. Your appeal request must be in writing and be received by the Insurance Company no later than the expiration of 180 days from the date you received your claim denial. As part of your appeal:

1. you may request, free of charge, copies of all documents, records, and other information relevant to your claim; and
2. you may submit written comments, documents, records and other information relating to your claim.

The Insurance Company's review on appeal shall take into account all comments, documents, records and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

Before the Insurance Company can issue an adverse benefit determination on review, the Insurance Company shall provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Insurance Company (or at the direction of the Insurance Company) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give you a reasonable opportunity to respond prior to that date.

Before the Insurance Company can issue an adverse benefit determination on review based on a new or additional rationale, the Insurance Company shall provide you, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give you a reasonable opportunity to respond prior to that date.

The Insurance Company will make a final decision no more than 45 days after it receives your timely appeal. The time for final decision may be extended for one additional 45 day period provided that, prior to the extension, the Insurance Company notifies you in writing that an extension is necessary due to special circumstances, identifies those circumstances and gives the date by which it expects to render its decision. If your claim is extended due to your failure to submit information necessary to decide your claim on appeal, the time for decision shall be tolled from the date on which the notification of the extension is sent to you until the date the Insurance Company receives your response to the request.

The individual reviewing your appeal shall give no deference to the initial benefit decision and shall be an individual who is neither the individual who made the initial benefit decision, nor the subordinate of such individual. The review process provides for the identification of the medical or vocational experts whose advice was obtained in connection with an initial adverse decision, without regard to whether that advice was relied upon in making that decision. When deciding an appeal that is based in whole or part on medical judgment, the Insurance Company will consult with a medical professional having the appropriate training and experience in the field of medicine involved in the medical judgment and who is neither an individual consulted in connection with the initial benefit decision, nor a subordinate of such individual. If the Insurance Company grants your claim appeal, the decision will contain information sufficient to reasonably inform you of that decision.

However, any final adverse benefit determination on review will be in writing and include: 1) the specific reason or reasons for the decision; 2) specific references to the Policy provisions on which the decision is based; 3) a statement that you are entitled to receive, upon request and free of charge, copies of all documents, records, and other information relevant to your claim; 4) a statement (a) that you have the right to bring a civil action under section 502(a) of ERISA, and (b) describing 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; 5) a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (a) the views presented by you to the Insurance Company of health care professionals treating you and vocational professionals who evaluated you, (b) the views of medical or vocational experts whose advice was obtained on behalf of the Insurance Company in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and (c) a disability determination regarding you presented by you to the Insurance Company made by the Social Security Administration; 6) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; 7) either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Insurance

Company relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; 8) a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Insurance Company; and 9) any other notice(s), statement(s) or information required by applicable law.

Claim Procedures for Claims Not Requiring a Determination of Disability

Claims and appeals for benefits will be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) shall not be made based upon the likelihood that the individual will support the denial of benefits.

Claims for Benefits

If you or your authorized representative would like to file a claim for benefits for yourself or your insured dependents, you or your authorized representative should obtain a claim form(s) from your Employer or Plan Administrator. The applicable section of such form(s) must be completed by (1) you, (2) the Employer or Plan Administrator and (3) the attending physician or hospital. Following completion, the claim form(s) must be forwarded to the Insurance Company's claim representative. The Insurance Company will evaluate your claim and determine if benefits are payable.

The Insurance Company will make a decision no more than 90 days after receipt of your properly filed claim. However, if the Insurance Company determines that special circumstances require an extension, the time for its decision will be extended for an additional 90 days, provided that, prior to the beginning of the extension period, the Insurance Company notifies you in writing of the special circumstances and gives the date by which it expects to render its decision. If extended, a decision shall be made no more than 180 days after your claim was received. If the Insurance Company approves your claim, the decision will contain information sufficient to reasonably inform you of that decision.

However, any adverse benefit determination will be in writing and include: 1) specific reasons for the decision; 2) specific references to Policy provisions on which the decision is based; 3) a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary; 4) a description of the review procedures and time limits applicable to such, and 5) a statement that you have the right to bring a civil action under section 502(a) of ERISA after you appeal our decision and after you receive a written denial on appeal.

Appealing Denials of Claims for Benefits

On any wholly or partially denied claim, you or your representative must appeal once to the Insurance Company for a full and fair review. You must complete this claim appeal process before you file an action in court. Your appeal request must be in writing and be received by the Insurance Company no later than the expiration of 60 days from the date you received your claim denial. As part of your appeal:

1. you may request, free of charge, copies of all documents, records, and other information relevant to your claim; and
2. you may submit written comments, documents, records and other information relating to your claim.

The Insurance Company's review on appeal shall take into account all comments, documents, records and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

The Insurance Company will make a final decision no more than 60 days after it receives your timely appeal. However, if the Insurance Company determines that special circumstances require an extension, the time for its decision will be extended for an additional 60 days, provided that, prior to the beginning of the extension period, the Insurance Company notifies you in writing of the special circumstances and gives the date by which it expects to render its decision. If extended, a decision shall be made no more than 120 days after your appeal was received. If the Insurance Company grants your claim appeal, the decision will contain information sufficient to reasonably inform you of that decision.

However, any final adverse benefit determination on review will be in writing and include: 1) specific reasons for the decision and specific references to the Policy provisions on which the decision is based, 2) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim, 3) a statement of your right to bring a civil action under section 502(a) of ERISA, and 4) any other notice(s), statement(s) or information required by applicable law.