STANDARD INSURANCE COMPANY

A Stock Life Insurance Company
PO Box 4744
Portland, Oregon 97208
(800) 522-0406

CERTIFICATE AND SUMMARY PLAN DESCRIPTION: GROUP DISABILITY INSURANCE

Policyholder:	California Teachers Association Economic Benefits Trust
Group Policy Number:	501000-P
Group Policy Effective Date:	September 1, 2007

The Group Policy has been issued to the Policyholder. We certify that you will be insured as provided by the terms of your Employer's coverage under the Group Policy. If the terms of this Certificate and Summary Plan Description differ from the terms of your Employer's coverage under the Group Policy, the latter will govern. If your coverage is changed by an amendment to the Group Policy, we will provide the Employer with a revised Certificate and Summary Plan Description or other notice to be given to you.

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

"You" and "your" mean the Participant. "We", "us", and "our" mean Standard Insurance Company. Other defined terms appear with their initial letters capitalized, and where they are defined, appear in boldface type. Additionally, section headings, and references to them, appear in boldface type

Chairman, President and CEO

GC190–LTD/S399/CTA.1

CALIFORNIA LIFE AND HEALTH INSURANCE GUARANTEE ASSOCIATION ACT
SUMMARY DOCUMENT AND DISCLAIMER

Residents of California who purchase life and health insurance and annuities should know that the insurance companies licensed in this state to write these types of insurance are members of the California Life and Health Insurance Guarantee Association ("CLHIGA"). 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 Guarantee Association will assess its other member insurance companies for the money to pay the claims of the 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 Guarantee Association is not unlimited, however, as noted below, and is not a substitute for consumers' care in selecting insurers.

The California Life and Health Insurance Guarantee 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 California. You should not rely on coverage by the 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 guarantee association to induce you to purchase any kind of insurance policy.**

Policyholders with additional questions should first contact their insurer or agent or may then contact:

The California Life and Health Insurance Guarantee Association

PO Box 17319

Beverly Hills CA 90209-3319

OR

Consumer Services Division

California Department of Insurance

300 South Spring St, South Tower

Los Angeles CA 90013

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

COVERAGE

Generally, individuals will be protected by the California Life and Health Insurance Guarantee Association if they live in this state and hold a life or health 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 this Guarantee Association if:

Their insurer was not authorized to do business in this state when it issued the policy or contract;

Their policy was issued by a health care service plan (HMO, Blue Cross, Blue Shield), a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society;

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.

The Guarantee Association also does not provide coverage for:

Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which guarantee rights to group contract holders, not individuals;

Employer or association plans, to the extent they are self-funded or uninsured;

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;

Any portion of a contract that provides dividends or experience rating credits.

LIMITS ON AMOUNT OF COVERAGE

The Act limits the Association to pay benefits as follows:

LIFE AND ANNUITY BENEFITS

80% of what the insurance company would owe under a policy or contract up to $100,000 in cash surrender values,

$100,000 in present value of annuities, or

$250,000 in life insurance death benefits.

A maximum of $250,000 for any one insured life no matter how many policies and contracts there were with the same company, even if the policies provided different types of coverages.

HEALTH BENEFITS

A maximum of $200,000 of the contractual obligations that the health insurance company would owe were it not insolvent. The maximum may increase or decrease annually based upon changes in the health care cost component of the consumer price index.

PREMIUM SURCHARGE

Member insurers are required to recoup assessments paid to the Association by way of a surcharge on premiums charged for health insurance policies to which the Act applies.

CALIFORNIA NOTICE OF COMPLAINT PROCEDURE

Should any dispute arise about your premium or about a claim that you have filed, write to the company that issued the group policy. If the problem is not resolved, you may also write to the State of California, Department of Insurance, Consumer Services Division, 300 S. Spring Street, South Tower, Los Angeles, CA 90013, or call toll-free 1-800-927-HELP, or (213) 897-8921 outside of California. This notice of complaint procedure is for information only and does not become a part or condition of this group policy/certificate.

Table of Contents

Index of Defined Terms

COVERAGE FEATURES

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

GENERAL POLICY INFORMATION

Group Policy Number:	501000-P
Policyholder:	California Teachers Association Economic Benefits Trust
Group ID Number:	10115778
Employer(s):	Any division of the California Public Schools Any non-public school in California Any state college in California Any state university in California An institution of higher education in California
Group Policy Effective Date:	September 1, 2007
Policy Issued in:	California

BECOMING INSURED

To become insured you must: (a) Be a Participant; (b) Be eligible; and (c) Meet the requirements in **Active Work Provisions** and **When Your Insurance Becomes Effective**.

Definition of Participant:

You are a Participant if you are an active classified employee of an Employer who is:

1. A CTA Education Support Professional (CTA ESP) in good standing of California Teachers Association (CTA);
2. Regularly working for an Employer(s) at least 20 hours per week for at least 180 days per year under the terms of your employment with the Employer(s); and
3. A citizen or resident of the United States or Canada.

You may not be a Participant if you are:

A. A student member of California Teachers Association.
B. An agency fee member of California Teachers Association.
C. A retired member of California Teachers Association.
D. A full time member of the armed forces of any country.

Eligibility Date:

You are eligible on the later of the following dates:

1. The Group Policy Effective Date; and
2. The date you become or return as a Participant.

Evidence Of Insurability: Required in all of the following instances:

a. If you apply more than 180 days after you become eligible for insurance under the Policyholder's group disability plan, or if you fail to make the required premium contribution by the third month following the date you apply for insurance.

b. If you apply more than 180 days after becoming employed in an occupation in which you are eligible to be a CTA Education Support Professional (CTA ESP) in good standing of California Teachers Association (CTA), while meeting items 2. and 3. of the Definition of Participant.

c. For reinstatements if required.

Note: Evidence Of Insurability will not be required to become insured under the Group Policy as described below, unless Evidence Of Insurability is required under **Reinstatement Of Insurance**.

1. Evidence Of Insurability will not be required if you apply within 180 days after you become eligible, provided Evidence of Insurability is not required under item b. above, and you make the required premium contribution by the third month following the date you apply for insurance.
2. Evidence Of Insurability will not be required to become insured on September 1, 2007, if you were insured on August 31, 2007 under the Prior Plan.
3. If you were receiving benefits or were serving the benefit waiting period on August 31, 2007 under the Prior Plan, Evidence Of Insurability will not be required for an amount of insurance not exceeding the amount for which you were insured under the Prior Plan if you apply within 120 days after you become eligible under the Group Policy, provided you make the required premium contribution by the third month following the date you apply for insurance.
4. Evidence Of Insurability will not be required to become insured under the Group Policy if you apply within 60 days following a Family Status Change and make the required premium contribution by the third month following the date you apply, unless Evidence Of Insurability was submitted to us previously and was not approved by us.
5. Evidence Of Insurability will not be required to become insured under the Group Policy on September 1, 2007 if you were insured under the Policyholder's group voluntary life insurance plan on August 31, 2007, you apply for insurance under the Group Policy by October 31, 2007, and you make the required premium contribution by the third month following the date you apply.
6. If you are covered under a disability insurance plan provided by another insurance carrier, Evidence Of Insurability will not be required if you apply for insurance under the Group Policy during a Transfer Enrollment Period, provided you make the required premium contribution by the third month following the date you apply, and your coverage under the other disability insurance policy has ended immediately prior to the scheduled effective date of your coverage under the Group Policy.
7. Evidence Of Insurability will not be required for you to become insured under the Group Policy if you apply during a Direct Enrollment Campaign. During a Direct Enrollment Campaign, you will receive written notification from us, regarding your eligibility to apply without submitting Evidence Of Insurability.

Transfer Enrollment Period means period(s) agreed upon between the Policyholder and us during which Participants may transfer coverage into the Group Policy from another disability insurance plan provided by another insurance carrier, and Evidence Of Insurability may be waived.

Direct Enrollment Campaign means a period designated by the Policyholder and agreed to by us during which Participants who are selected to receive a direct marketing solicitation may apply for insurance under the Group Policy and Evidence Of Insurability may be waived as provided above. Campaign criteria are subject to change at renewal.

PREMIUM CONTRIBUTIONS

Insurance is:	Contributory

SCHEDULE OF DISABILITY INSURANCE

Disability Benefits may be payable if you have met all the requirements to become insured and have completed the Benefit Waiting Period.

Disability Benefit:	66 2/3% of your Regular Daily Contract Salary, reduced by Deductible Income, payable for all Required Days Of Attendance on which you are Disabled in each calendar month. However, during periods for which you are eligible to receive Restored Sick Leave, no Disability Benefit will be payable.
Benefit Waiting Period:	The longer of (a) 7 consecutive Required Days Of Attendance, or (b) the expiration of Fully Paid Sick Leave.
Maximum Benefit Period:	One Benefit Year

DISABILITY PROVISIONS

Usual Occupation Period:	One Benefit Year
Partial Disability:	Covered

See **Definition of Disability** for more information.

DISABILITY EXCLUSIONS AND LIMITATIONS

Exclusions:

Preexisting Condition Exclusion:	Yes
Preexisting Condition Period:	The 30-calendar day period just before your insurance becomes effective.
Exclusion Period:	10 consecutive Required Days Of Attendance following the effective date of your insurance under the Group Policy.

The Group Policy also includes War, Intentionally Self-Inflicted Injury, and Felony exclusions. See **Disabilities Excluded From Coverage** for an explanation of all exclusions.

The Group Policy also includes a Care Of A Physician Limitation. See **Disabilities Subject To Limitations** for an explanation of all limitations.

OTHER PROVISIONS

Survivors Benefit Amount:	A lump sum equal to 3 times your Disability Benefit without reduction by Deductible Income.
Continuity of Coverage:	Yes

SCHEDULE OF ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE

AD&D Insurance Benefit:	$50,000
Seat Belt Benefit:	The amount of the Seat Belt Benefit is the lesser of (1) $10,000, or (2) the AD&D Insurance Benefit payable for the Loss.
Air Bag Benefit:	The amount of the Air Bag Benefit is the lesser of (1) $5,000, or (2) the AD&D Insurance Benefit payable for Loss of your life.
Higher Education Benefit:	The tuition expenses incurred per Child within 48 months after the date of Loss of your life at a licensed or accredited institution of higher education, exclusive of room and board, books, fees, supplies and other expenses, but not to exceed $1,000 per year per qualified Child.
Career Adjustment Benefit:	The tuition expenses for training incurred by your Spouse/Domestic Partner within 48 months after the date of Loss of your life, exclusive of room and board, books, fees, supplies and other expenses, but not to exceed $1,000 per year.
Child Care Benefit:	The total child care expense incurred by a Guardian within 36 months after the date of Loss of your life for all Children under age 13, but not to exceed $1,000 per year.

AD&D Table Of Losses:

The amount payable is a percentage of the AD&D Insurance Benefit in effect on the date of the accident and is determined by the Loss suffered as shown in the following table:

Loss:	Percentage Payable:
a. Life	100%
b. One hand, one foot, or sight of one eye	50%
c. Two or more of the Losses listed in b. above	100%

No more than 100% of your AD&D Insurance Benefit will be paid for all Losses resulting from one accident.

ERISA SUMMARY PLAN DESCRIPTION INFORMATION

Name of Plan:	Disability Insurance
Name, Address of Plan Sponsor:	California Teachers Association P.O. Box 921 Burlingame CA 94011-0921
Plan Sponsor Tax ID Number:	94-0362310
Plan Number:	590
Type of Plan:	Group Insurance Plan
Type of Administration:	Contract Administration
Name, Address, Phone Number of Plan Administrator:	California Teachers Association Economic Benefits Trust P.O. Box 921 Burlingame CA 94011-0921 (650) 697-1400
Name, Address of Registered Agent for Service of Legal Process:	Schwartz, Steinsapir, Dohrmann & Sommers 6300 Wilshire Boulevard Suite 2000 Los Angeles, CA 90048-5202 (323) 655-4700
If Legal Process Involves Claims For Benefits Under The Group Policy, Additional Notification of Legal Process Must Be Sent To:	Standard Insurance Company 1100 SW 6th Ave Portland OR 97204-1093
Sources of Contributions:	Participant
Funding Medium:	Standard Insurance Company - Fully Insured
Plan Fiscal Year End:	August 31

INSURING CLAUSE

If you become Disabled while insured under the Group Policy, we will pay benefits after we receive written proof that you are entitled to such benefits according to the terms of the Group Policy.

DEFINITION OF DISABILITY

You are Disabled if you meet the Usual Occupation Definition of Disability.

During the Benefit Waiting Period and the Usual Occupation Period you are required to be Totally Disabled from your Usual Occupation or Partially Disabled from your Usual Occupation.

1. **Total Disability Definition**: You are Totally Disabled from your Usual Occupation if, as a result of Sickness or Injury, you are unable to perform with reasonable continuity the Substantial And Material Acts necessary to pursue your Usual Occupation and you are not working in your Usual Occupation.
2. **Partial Disability Definition**: You are Partially Disabled from your Usual Occupation if you are not Totally Disabled and you are actually working in your Usual Occupation but, as a result of Sickness or Injury, you are unable to earn 80% or more of your Indexed Regular Daily Contract Salary.

Note: The loss of a professional or occupational license or certification does not constitute Disability unless the loss was and continues to be caused or substantially contributed to by a Disability. The duration of Disability Benefits will remain subject to any applicable limitations (see **Disabilities Subject To Limitations**).

During the Usual Occupation Period you may work in another occupation while you meet the Usual Occupation definition of Disability. However, your Work Earnings may be Deductible Income and Disability Benefits will end when your Work Earnings meet or exceed 80% of your Indexed Regular Monthly Contract Salary. See **Return To Work Incentive**, **Reduction Of Benefits**, and **When Benefits End**.

Usual Occupation may be interpreted to mean the employment, business, trade or profession that involves the Substantial And Material Acts of the occupation you are regularly performing for your Employer when Disability begins. Usual Occupation is not necessarily limited to the specific job you perform for your Employer.

Substantial And Material Acts means the important tasks, functions and operations generally required by employers from those engaged in your Usual Occupation that cannot be reasonably omitted or modified. In determining what Substantial And Material Acts are necessary to pursue your Usual Occupation, we will first look at the specific duties required by your job. If you are unable to perform one or more of these duties with reasonable continuity, we will then determine whether those duties are customarily required of other individuals engaged in your Usual Occupation. If any specific, material duties required of you by your job differ from the material duties customarily required of other individuals engaged in your Usual Occupation, then we will not consider those duties in determining what Substantial And Material Acts are necessary to pursue your Usual Occupation.

Your Usual Occupation Period is shown in the **Coverage Features**.

TEMPORARY RECOVERY

You may temporarily recover from your Disability and then become Disabled again from the same cause or causes without having to serve a new Benefit Waiting Period. **Temporary Recovery** means you cease to be Disabled for no longer than the applicable Allowable Period.

A. Allowable Periods during the Maximum Benefit Period

During the Maximum Benefit Period, the Allowable Period is a total of 60 consecutive Required Days Of Attendance for each period of recovery.

B. Effect Of Temporary Recovery

If your Temporary Recovery does not exceed the Allowable Periods, 1 through 5 below will apply.

1. The Regular Contract Salary and the number of Required Days Of Attendance used to determine your benefits will not change.
2. The period of Temporary Recovery will not count toward your Maximum Benefit Period.
3. No benefits will be payable for the period of Temporary Recovery.
4. No benefits will be payable after benefits become payable to you under any other group disability insurance policy under which you become insured during your period of Temporary Recovery.
5. Except as stated above, the provisions of the Group Policy will be applied as if there had been no interruption of your Disability.

BENEFITS FOR DISABILITY

Subject to the terms of the Group Policy, we will pay you the following benefits if you become Disabled while insured under the Group Policy.

If you become Disabled, we will pay you a Disability Benefit according to the terms of the Group Policy.

The amount of the Disability Benefit is shown in the **Coverage Features**.

RETURN TO WORK INCENTIVE

A. During The Benefit Waiting Period

You may serve your Benefit Waiting Period while working, if you meet the Usual Occupation Definition of Disability.

B. After The Benefit Waiting Period

You are eligible for the Return To Work Incentive on the first day you work after the Benefit Waiting Period if Disability Benefits are payable on that date.

Your Work Earnings will be Deductible Income as determined below:

a. For each calendar month, we will determine the amount of your Disability Benefit as if there were no Deductible Income, and add your Work Earnings to that amount.

b. Determine 100% of the amount of your Indexed Regular Daily Contract Salary and multiply that by the number of Required Days Of Attendance for that same calendar month.

c. If a. is greater than b., the difference will be Deductible Income.

Days in which you receive Fully Paid Sick Leave do not count as Required Days Of Attendance.

C. Work Earnings Definition

Work Earnings means your gross monthly earnings from work you perform while Disabled. Work Earnings includes:

1. Earnings from your Employer.
2. Earnings from any other employer or self-employment for which you become employed on or after the date of your Disability.

3. Any increases in earnings from employment from any other employer or self-employment in which you were engaged prior to the date of your Disability.

4. Any sick pay, vacation pay, annual or personal leave pay, substitute differential pay, or other salary continuation earned or accrued while working.

Earnings from work you perform will be included in Work Earnings when you have the right to receive them. If you are paid in a lump sum or on a basis other than monthly, we will prorate your Work Earnings over the period of time to which they apply. If no period of time is stated, we will use a reasonable one.

In determining your Work Earnings we:

1. Will use the financial accounting method you use for income tax purposes, if you use that method on a consistent basis.

2. Will not be limited to the taxable income you report to the Internal Revenue Service.

3. May ignore expenses under section 179 of the IRC as a deduction from your gross earnings.

4. May ignore depreciation as a deduction from your gross earnings.

5. May adjust the financial information you give us in order to clearly reflect your Work Earnings.

D. Family Care Expenses Adjustment

If you must pay Family Care Expenses in order to work, we will reduce the amount of the Work Earnings used in determining your Deductible Income, subject to the following:

1. Your Work Earnings will be reduced by the first $250 per Family Member of the monthly Family Care Expenses you pay, but not to exceed a total of $500 for all Family Members.

2. The Work Earnings and the Family Care Expenses must be for the same period.

3. You must give us satisfactory proof of the Family Care Expenses you pay.

4. The Work Earnings reduction by Family Care Expenses will end 12 months after it begins.

Family Care Expenses means the amount you pay to a licensed care provider for the care of your Family Member which is necessary in order for you to work.

Family Member means your Spouse/Domestic Partner, parent, grandparent, sibling, or other close family member, residing in your home who, because of mental or physical incapacity, is chiefly dependent upon you for support and maintenance, or your Child.

Child means, for the purposes of the Family Care Expenses Adjustment:

1. Your child residing in your home (including the child of your Spouse/Domestic Partner and an adopted child), from live birth through age 12; or

2. Your child, age 13 or older, residing in your home (including the child of your Spouse/Domestic Partner and an adopted child) who is:

   a. Continuously incapable of self-sustaining employment because of mental retardation or physical handicap; and

   b. Chiefly dependent upon you for support and maintenance.

REGULAR CONTRACT SALARY

Regular Contract Salary means your annual salary from the Employer(s) under the terms of your employment contract with the Employer(s) in effect for the contract year in which you become Disabled. Regular Contract Salary does not include any additional compensation, such as overtime pay, weekend or summer school work compensation, bonuses or district-funded fringe benefits.

Regular Daily Contract Salary means your Regular Contract Salary, divided by the number of your Required Days Of Attendance for the contract year in which you become Disabled.

Regular Monthly Contract Salary means your Regular Contract Salary, divided by 12.

The Regular Contract Salary and the number of Required Days Of Attendance will not change after your date of Disability.

COORDINATION OF BENEFITS

Your Disability Benefit is reduced by benefits payable under any other group disability insurance policy that insures the same Regular Contract Salary. If the other group policy has a disability benefit which is reduced by all or part of your Disability Benefit under this Group Policy, then the following formula will be used to compute your Disability Benefit:

Disability Benefit = A divided by (A + B), times C

In this formula,

A = The Disability Benefit which would be payable under this Group Policy if you were not insured under the other group policy.

B = The disability benefit which would be payable by the other group policy if you were not insured under this Group Policy.

C = A or B, whichever is higher.

The resulting Disability Benefit is our pro rata share of the higher of the benefits which would be payable if you were not insured under both group policies. If necessary, the same principles will be applied to coordinate benefits among three or more group disability insurance policies issued by us.

REDUCTION OF BENEFITS

Subject to the terms of the Group Policy, your Disability Benefits will be reduced by Deductible Income.

A. Definition Of Deductible Income

Deductible Income means:

1. Annual or personal leave pay, severance pay, substitute differential pay, and other salary continuation, including donated amounts and donated sick pay (but not vacation pay), paid to you by your Employer.
2. Your Work Earnings, as described in **Return To Work Incentive**.
3. Any amount you receive or are eligible to receive because of your Disability, including amounts for partial or total disability, whether permanent, temporary, or vocational, under any of the following:
   a. A workers' compensation law;
   b. The Jones Act;
   c. Maritime Doctrine of Maintenance, Wages or Cure;
   d. Longshoremen's and Harbor Worker's Act; or
   e. Any similar act or law.

   Deductible Income does not include California Workers' Compensation benefits for permanent total or permanent partial disability.

4. Any amount you receive or are eligible to receive because of your Disability or any amount you actually receive because of your retirement under:

   a. The Federal Social Security Act;

   b. The Canada Pension Plan;

   c. The Quebec Pension Plan;

   d. The Railroad Retirement Act; or

   e. Any similar plan, act, or law.

   Primary offset: Primary benefits are Deductible Income, but dependents benefits are not.

5. Any amount you receive or are eligible to receive because of your disability under any state disability income benefit law or similar law.

6. Any earnings or compensation included in Regular Contract Salary which you receive or have a right to receive while Disability Benefits are payable.

7. Any amount you receive because of your disability under any other insurance coverage not sponsored by an Employer (which is not already subject to the **Coordination Of Benefits** provision).

   Deductible Income does not include:

   a. Reimbursement for hospital, medical, or surgical expense.

   b. Group credit or mortgage disability insurance benefits.

   c. Accelerated death benefits or qualified disability benefits paid under a life insurance policy.

8. Any disability or retirement benefits you receive or are eligible to receive because of your Disability or retirement under your Employer's retirement plan, including a public employee retirement system, a state teacher retirement system, and a plan arranged and maintained by a union or employee association for the benefit of its members.

   Retirement benefits will not include amounts rolled over or transferred to any eligible retirement plan as defined by the Internal Revenue Code, nor will they include any amount of service retirement benefits attributable to your contributions.

   You are not required to apply for disability or early retirement benefits under your Employer's retirement plan if the receipt of such benefits would reduce the benefit you would be eligible to receive at normal retirement age. However, disability or early retirement benefits you do receive will be Deductible Income.

   Deductible Income does not include benefits from a. through i. below.

   a. Profit sharing plan.

   b. Thrift or savings plan.

   c. Deferred compensation plan.

   d. Plan under IRC Section 401(k), 408(k), 408 (p) or 457.

   e. Individual Retirement Account (IRA).

   f. Tax Sheltered Annuity (TSA) under IRC Section 403(b).

   g. Stock ownership plan.

   h. Keogh (HR-10) plan.

i. Public Employee Retirement System (PERS) or State Teachers Retirement Service (STRS) benefits under the Defined Benefit Supplement Program.

9. Any amount you receive by compromise, settlement, or other method as a result of a claim for any of the above, whether disputed or undisputed.

10. Deductible Income does not include:

    a. Any cost of living increase in any Deductible Income other than Work Earnings, if the increase becomes effective while you are Disabled and while you are eligible for the Deductible Income.

    b. Reasonable attorneys' fees incurred in connection with a claim for Deductible Income.

B. Rules Used To Determine Monthly Equivalents Of Deductible Income

Each month we will determine your Disability Benefit using the Deductible Income for the same monthly period, even if you actually receive the Deductible Income in another month.

Deductible Income for each month will be calculated as follows:

1. With respect to disability and retirement benefits under your Employer's retirement plan or the Federal Social Security Act, or similar plan, act or law, which are Deductible Income, your Disability Benefit will be reduced by the following:

    a. Determine the monthly amount of the Deductible Income and multiply that amount by 12.

    b. Divide the amount in a. above by the annual number of your Required Days Of Attendance.

    c. Multiply the amount in b. above by the number of Required Days Of Attendance applicable to that calendar month.

2. With respect to all other Deductible Income, your Disability Benefit will be reduced each month by the amount of the Deductible Income for that month.

If you are paid Deductible Income in a lump sum or by a method other than monthly, we will determine your Disability Benefit using a prorated amount.

If you receive a lump sum refund, withdrawal or distribution of contributions and earnings from your Employer's retirement plan, we will determine your Disability Benefit using a lifetime monthly annuity amount, with no survivor income. The annuity will be based on the amount you receive, and on the life expectancy of a person your age on the later of:

a. The date the lump sum is paid; and

b. The date Disability Benefits become payable.

For amounts under a workers' compensation law, the Jones Act, the Maritime Doctrine of Maintenance, Wages or Cure, the Longshoremen's and Harbor Worker's Act, or any similar act or law, the period of time used to prorate the amount cannot exceed the first to occur of the following:

a. The date you reach age 65, or the end of the Maximum Benefit Period, if later; and

b. The end of the stated period.

C. Your Duty To Pursue Deductible Income

You must pursue Deductible Income for which you may be eligible. We may ask for written documentation of your pursuit of Deductible Income. You must provide it within 60 days after we mail you our request.

D. Estimating And Deducting

For any item of Deductible Income that includes amounts you are eligible to receive, we will reduce your Disability Benefits by the amount we estimate you would be eligible to receive if:

1. You have failed to pursue the Deductible Income with reasonable diligence;
2. We have a reasonable, good faith belief that you are eligible for the Deductible Income; and
3. We are able to reasonably estimate the amount that would be payable.

We will not estimate and deduct amounts with respect to a claim for Deductible Income that is pending, so long as you continue to pursue the claim with reasonable diligence.

E. Pending Deductible Income

We will not deduct pending Deductible Income until it becomes payable. You must notify us of the amount of the Deductible Income when it is approved. You must repay us for the resulting overpayment of your claim.

F. Overpayment Of Claim

We will notify you of the amount of any overpayment of your claim under any group disability insurance policy issued by us. If the overpayment was due to your receipt of Deductible Income, you have an immediate obligation to repay us. If the overpayment was due to an error and not due to receipt of Deductible Income, our right to reimbursement is subject to the standard set forth in Title 10 of the California Code of Regulations § 2695.11, including:

1. The error was not due to a mistake of law;
2. We notify you of the overpayment within six months of the date of the error or within 15 calendar days after the date of discovery if due to your or a third parties representation or nondisclosure;
3. The notification clearly states the cause of the error and the overpayment amount; and
4. The overpayment is not subject to a reasonable dispute as to the facts.

You may not receive any benefits until we have been repaid in full. In the meantime, any benefits paid, will be applied to reduce the amount of the overpayment.

ADDITIONAL BENEFITS FOR DISABILITY

Subject to the terms of the Group Policy, we will pay you the following benefits if you become Disabled while insured under the Group Policy.

A. Dependent Education Benefit

1. Dependent Education Benefit Requirements

We will pay a Dependent Education Benefit if you meet all of the requirements below:

a. You are Disabled and Disability Benefits are payable to you.

b. You have an Eligible Student.

Eligible Student means:

a. Your Child, who is registered and in full-time attendance at a licensed or accredited educational institution beyond high school.

b. Your Spouse/Domestic Partner, who is registered and in full-time attendance at a licensed or accredited educational institution beyond high school for the purpose of obtaining employment or increasing earnings.

For each Eligible Student, written proof of registration and full-time attendance satisfactory to us must be submitted at the start of each term or semester and as often as we may reasonably require thereafter.

Child means, for the purposes of the Dependent Education Benefit, your unmarried child from age 17 through age 24. Child includes any of the following, if they otherwise meet the definition of Child: (a) your natural or adopted child; or (b) the child of your Spouse/Domestic Partner, if living in your home.

2. Dependent Education Benefit Amount

   The amount of the Dependent Education Benefit will be $150 per month for each Eligible Student. We will not pay more than a total of $600 per month for all Eligible Students.

3. Payment Of Dependent Education Benefits

   Dependent Education Benefits will be paid directly to you at the end of each calendar month you qualify for them. The Dependent Education Benefit will first be applied to reduce any overpayment of your claim. If Disability Benefits are payable to both you and your Spouse/Domestic Partner, we will pay a Dependent Education Benefit for either you or your Spouse/Domestic Partner, but not both. The Dependent Education Benefit is payable for a maximum of 48 months for each Eligible Student. The Dependent Education Benefit ends when you no longer meet the requirements in item A.1. above.

B. Survivors Benefit

   If you die after Disability Benefits have become payable and before the end of the Maximum Benefit Period, we will pay a Survivors Benefit according to 1 through 4 below.

   1. The amount of the Survivors Benefit is shown in the **Coverage Features**.
   2. The Survivors Benefit will first be applied to reduce any overpayment of your claim.
   3. The Survivors Benefit will be paid as provided in the **Beneficiary Provisions For AD&D Insurance And Survivors Benefit**.
   4. For the purpose of calculating the Survivor Benefit, the Disability Benefit will be based on 22 Required Days Of Attendance.

DISABILITIES EXCLUDED FROM COVERAGE

A. War

   You are not covered for a Disability caused or contributed to by War or any act of War. **War** means declared or undeclared war, whether civil or international, that involves nations and/or sovereigns. This exclusion does not include acts of terrorism, so long as they are isolated in nature and unrelated to and not arising from War as defined above.

B. Intentionally Self-Inflicted Injury

   You are not covered for a Disability caused or contributed to by an intentionally self-inflicted Injury, while sane.

C. Preexisting Condition

   1. Definition

      Preexisting Condition means a diagnosed mental or physical condition for which you have received medical treatment, care or services or have taken prescribed medication at any time during the Preexisting Condition Period shown in the **Coverage Features**.

   2. Exclusion

      You are not covered for a Disability caused or substantially contributed to by a Preexisting Condition or medical or surgical treatment of a Preexisting Condition unless, on the date you become Disabled, you have been continuously insured under the Group Policy and Actively At Work for the entire Exclusion Period shown in the **Coverage Features**.

D. Felony

You are not covered for a Disability caused or contributed to by your committing or attempting to commit an assault or felony.

DISABILITIES SUBJECT TO LIMITATIONS

During the Benefit Waiting Period, you must be receiving care by a Physician which is appropriate for the condition or conditions causing the Disability. No Disability Benefits will be paid for any period of Disability when you are not receiving care by a Physician which is appropriate for the condition or conditions causing the Disability. Appropriate care is the treatment a patient would make a reasonable decision to accept after duly considering the opinions of medical professionals. This limitation will not apply after you reach your maximum point of recovery.

WHEN BENEFITS END

Your Disability Benefits end automatically on the earliest of 1 through 5 below.

1. The date you are no longer Disabled.
2. The date your Maximum Benefit Period ends.
3. The date you die.
4. The date benefits become payable under any other group disability insurance policy under which you become insured during a period of Temporary Recovery.
5. The date you fail to provide proof of continued Disability and entitlement to benefits.

BENEFITS AFTER INSURANCE ENDS OR IS CHANGED

During each period of continuous Disability, we will pay benefits according to the terms of the Group Policy in effect on the date you become Disabled. Your right to receive benefits will not be affected by:

1. Termination of the Group Policy after you become Disabled; or
2. Any amendment to the Group Policy that is effective after you become Disabled.

EFFECT OF NEW DISABILITY

If a period of Disability is extended by a new cause while benefits are payable, benefits will continue while you remain Disabled. However, 1 and 2 apply.

1. Benefits will not continue beyond the end of the original Maximum Benefit Period.
2. All provisions of the Group Policy, including the **Disabilities Excluded From Coverage** and **Disabilities Subject To Limitations** sections, will apply to the new cause of Disability.

WAIVER OF PREMIUM

We will waive payment of premium for your insurance while Disability Benefits are payable.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

A. Insuring Clause

If you have an accident while insured under the Group Policy and the accident results in a Loss, we will pay benefits after we receive written proof that you are entitled to such benefits according to the terms of the Group Policy.

B. Definition Of Loss For AD&D Insurance

Loss means loss of life, hand, foot, or sight which meets all of the following requirements:

1. Is caused directly by an accident.
2. Occurs independently of all other causes.
3. Occurs within 365 days of the accident.
4. With respect to Loss of life, is evidenced by a certified copy of the death certificate.
5. With respect to all other Losses, is certified by a Physician.

With respect to a **hand** or **foot**, **Loss** means actual and permanent severance from the body at or above the wrist or ankle joint, whether or not surgically reattached.

With respect to **sight**, **Loss** means entire, uncorrectable, and irrecoverable loss of sight in one eye.

C. Amount Payable

See **Coverage Features** for the AD&D Insurance schedule. The amount payable is a percentage of the AD&D Insurance Benefit in effect on the date of the accident and is determined by the Loss suffered. See AD&D Table Of Losses in the **Coverage Features**.

D. AD&D Insurance Exclusions

No AD&D Insurance benefit is payable if the accident or Loss is caused or contributed to by any of the following:

1. War or act of War. **War** means declared or undeclared war, whether civil or international, that involves nations and/or sovereigns. This exclusion does not include acts of terrorism, so long as they are isolated in nature and unrelated to and not arising from War as defined above.
2. Suicide or other intentionally self-inflicted Injury, while sane or insane.
3. Committing or attempting to commit an assault or felony.
4. Sickness (including but not limited to heart attack or stroke).
5. Bacterial infections (except infections which occur with and through a cut or wound at the time of the accident).
6. Medical or surgical treatment (except surgical treatment required by the accident and performed within 90 days after the accident).

E. Additional AD&D Benefits

Seat Belt Benefit

The amount of the Seat Belt Benefit is shown in the **Coverage Features**.

We will pay a Seat Belt Benefit if all of the following requirements are met:

1. You suffer a Loss as a result of an Automobile accident for which an AD&D Insurance Benefit is payable; and
2. You are wearing and properly utilizing a Seat Belt System at the time of the accident, as evidenced by a police accident report.

Seat Belt System means a properly installed combination lap and shoulder restraint system that meets the Federal Vehicle Safety Standards of the National Highway Traffic Safety Administration. Seat Belt System will include a lap belt alone, but only if the Automobile did not have a combination lap and shoulder restraint system when manufactured. Seat Belt System does not include a shoulder restraint alone.

Automobile means a motor vehicle licensed for use on public highways.

Air Bag Benefit

The amount of the Air Bag Benefit is shown in the **Coverage Features**.

We will pay an Air Bag Benefit if all of the following requirements are met:

1. You die as a result of an Automobile accident for which a Seat Belt Benefit is payable for Loss of your life.
2. The Automobile is equipped with an Air Bag System that was installed as original equipment by the Automobile manufacturer and has received regular maintenance or scheduled replacement as recommended by the Automobile or Air Bag manufacturer.
3. You are seated in the driver's or a passenger's seating position intended to be protected by the Air Bag System and the Air Bag System deploys, as evidenced by a police accident report.

Air Bag System means an automatically inflatable passive restraint system that is designed to provide automatic crash protection in front or side impact Automobile accidents and meets the Federal Vehicle Safety Standards of the National Highway Traffic Safety Administration.

Automobile means a motor vehicle licensed for use on public highways.

Higher Education Benefit

The amount of the Higher Education Benefit is shown in the **Coverage Features**.

We will pay a Higher Education Benefit to your Child if all of the following requirements are met:

1. You die as a result of an accident for which an AD&D Insurance Benefit is payable for Loss of your life.
2. Your Child is, within 12 months after the date of Loss of your life, registered and in full-time attendance at a licensed or accredited institution of higher education beyond high school.

The Higher Education Benefit will be paid annually to each Child who meets the requirements of item 2 above, for a maximum of 48 consecutive months beginning on the date of Loss of your life. No Higher Education Benefit will be paid if there is no Child eligible to receive it.

Career Adjustment Benefit

The amount of the Career Adjustment Benefit is shown in the **Coverage Features**.

We will pay a Career Adjustment Benefit to your Spouse/Domestic Partner if all of the following requirements are met:

1. You die as a result of an accident for which an AD&D Insurance Benefit is payable for Loss of your life.
2. Your Spouse/Domestic Partner is, within 48 months after the date of Loss of your life, registered and in attendance at a professional or trades training program for the purpose of obtaining employment or increasing earnings.

The Career Adjustment Benefit will be paid annually to a Spouse/Domestic Partner who meets the requirements of item 2 above, for a maximum of 48 consecutive months beginning on the date of Loss of your life. No Career Adjustment Benefit will be paid if you have no surviving Spouse/Domestic Partner.

Child Care Benefit

The amount of the Child Care Benefit is shown in the **Coverage Features**.

We will pay a Child Care Benefit to a Guardian if all of the following requirements are met:

1. You die as a result of an accident for which an AD&D Insurance Benefit is payable for Loss of your life.
2. The Guardian pays a licensed child care provider who is not a member of your family or the Guardian's family for child care provided to your Child(ren) under age 13 within 36 months of Loss of your life.
3. The child care is necessary in order for the Guardian to work or to obtain training for work or to increase earnings.

No Child Care Benefit will be paid if there is no Guardian.

Guardian means a person with whom your Child(ren) live(s) who is (a) your Spouse/Domestic Partner, or (b) a court appointed legal guardian of your Child(ren).

F. Payment Of Benefits

1. Except as provided in item 3. below, benefits payable because of your death will be paid to the Beneficiary you name. See **Beneficiary Provisions For AD&D Insurance And Survivors Benefit**.
2. AD&D Insurance Benefits payable for Losses other than Loss of life will be paid to you. Any such benefits remaining unpaid at your death will be paid according to the provisions for payment of a death benefit.
3. Other Benefits will be paid as follows:

   The Child Care Benefit will be paid to a Guardian. No Child Care Benefit will be paid if there is no Guardian.

   The Career Adjustment Benefit will be paid to your surviving Spouse/Domestic Partner. No Career Adjustment Benefit will be paid if you have no Spouse/Domestic Partner.

   The Higher Education Benefit will be paid annually to each eligible Child. No Higher Education Benefit will be paid if there is no Child eligible to receive it.

G. Autopsy

With respect to claims for AD&D Insurance death benefits, we may have an autopsy performed at our expense, except where prohibited by law.

H. Definitions For AD&D Insurance

AD&D Insurance means accidental death and dismemberment insurance under the Group Policy.

Child means:

1. For the purposes of the Higher Education Benefit, your unmarried child from age 17 through age 24. Child includes any of the following, if they otherwise meet the definition of Child: (a) your natural or adopted child; or (b) the child of your Spouse/Domestic Partner, if living in your home.
2. For the purposes of the Child Care Benefit:
   a. Your child residing in your home (including the child of your Spouse/Domestic Partner and an adopted child), from live birth through age 12; or
   b. Your child, age 13 or older, residing in your home (including the child of your Spouse/Domestic Partner and an adopted child) who is:
      i. Continuously incapable of self-sustaining employment because of mental retardation or physical handicap; and

ii. Chiefly dependent upon you for support and maintenance.

BENEFICIARY PROVISIONS FOR AD&D AND SURVIVORS BENEFITS

A. Naming A Beneficiary

Beneficiary means a person you name to receive AD&D Insurance death benefits and the Survivors Benefit. Your Beneficiary designation for AD&D Insurance and the Survivors Benefit may be different.

You may name one or more Beneficiaries. If you name two or more Beneficiaries in a class:

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

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

You must name or change Beneficiaries in writing. Writing includes a form signed by you or verification from us of an electronic designation made by you.

Your designation:

1. Must be dated;
2. Must be delivered to us during your lifetime;
3. Must relate to the insurance provided under the Group Policy; and
4. Will take effect on the date it is delivered to us.

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

B. Change Of Beneficiary

The right to change a Beneficiary is reserved to the Participant, and the consent of the Beneficiary or Beneficiaries shall not be requisite to any change in Beneficiary.

C. Simultaneous Death Provision

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

D. No Surviving Beneficiary

If you do not name a Beneficiary or if you are not survived by one, benefits will be paid in equal shares to the first surviving class of the classes below.

1. Your Spouse/Domestic Partner.
2. Your children.
3. Your parents.

4. Your brothers and sisters.

5. Your estate.

E. Method Of Payment

The benefit will be paid in a lump sum.

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

CLAIMS

A. Notice Of Claim

Written notice of claim must be given to us within 60 days after the occurrence or commencement of any loss covered by the Group Policy, or as soon thereafter as is reasonably possible.

B. Claim Forms

We, upon receipt of a notice of claim, will furnish you with such forms as are usually furnished by us for filing proof of claim. If such forms are not furnished within 15 days after the giving of such notice you shall be deemed to have complied with the requirements of this Group Policy as to proof of loss upon submitting, within the time fixed in the Group Policy for filing proof of loss. For purposes of this provision proof of loss means proof covering the occurrence, the character and the extent of the loss for which claim is made.

C. Documentation

It is the claimant's responsibility to provide us completed claim statements, a signed authorization to obtain information, and any other items we may reasonably require in support of a claim. If the required documentation is not provided within 45 days after we mail our request, the claim may be denied.

D. Time Limits On Filing Proof Of Loss

Written proof of loss must be furnished to us, in case of claim for loss for which this Group Policy provides any periodic payment contingent upon continuing loss, within 90 days after the termination of the period for which we are liable, and in case of claim for any other loss, within 90 days after the date of such loss. Failure to furnish such proof of loss within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof of loss within such time, provided such proof of loss is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the Participant or Beneficiary, later than one year from the time proof of loss is otherwise required.

E. Time Of Payment Of Claim

Disability Benefits will be paid to you at the end of each month upon receipt of due written proof of loss. Any balance remaining unpaid upon the termination of the period of liability will be paid immediately upon receipt of due written proof. All other benefits payable under the Group Policy will be paid (to the Participant) as they accrue immediately upon receipt of due written proof of loss.

F. Physical Examinations

We at our expense shall have the right and opportunity to examine the person of any individual whose Injury or Sickness is the basis of claim when and as often as it may reasonably require during the pendency of a claim hereunder.

G. Notice Of Decision On Claims For AD&D Insurance Benefits

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

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

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

If we deny any part of the claim, the claimant will receive a written notice of denial containing:

1. The reasons for our decision.
2. Reference to the parts of the Group Policy on which our decision is based.
3. A description of any additional information needed to support the claim.
4. Information concerning the claimant's right to a review of our decision.
5. Information regarding the claimant's rights to appeal under the CTA Advisory Panel on Endorsed Services.
6. Information concerning the right to bring a civil action for benefits under section 502(a) of ERISA if the claim is denied on review.

H. Review Procedures For AD&D Insurance Benefits

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

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

We will review the claim promptly after we receive the request. Within 60 days after we receive the request for review we will send the claimant: (a) a written decision on review; or (b) a notice that we are extending the review period for 60 days. If the extension is due to the claimant's failure to provide information necessary to decide the claim on review, the extended time period for review of the claim will not begin until the claimant provides the information or otherwise responds.

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

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

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

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

4. Information concerning the claimant's right to a review of our decision by the CTA Advisory Panel on Endorsed Services.

5. Information concerning the right to bring a civil action for benefits under section 502(a) of ERISA.

If you are a member of California Teachers Association whose claim was denied on review and you disagree or are dissatisfied with the decision on the claim, a written complaint may be filed with the CTA Advisory Panel on Endorsed Services. The complaint must be filed within 180 days after receiving notice of the denial upon review and in accordance with the CTA Advisory Panel on Endorsed Services' established procedures. The CTA Advisory Panel on Endorsed Services will investigate and review the member's request for review in accordance with its established procedures at the next scheduled meeting, and may uphold or reverse our decision.

The CTA Complaint Review Request Form for the CTA Advisory Panel on Endorsed Services may be obtained by contacting:

California Teachers Association
Member Benefits Department
P.O. Box 921
Burlingame CA 94011-0921

For further eligibility requirements and deadlines for submission, please contact CTA Member Benefits at: (650) 552-5200.

I. Notice Of Decision On Claims For All Other Benefits

We will evaluate your claim promptly after you file it. Within 45 days after we receive your claim we will send you: (a) a written decision on your claim; or (b) a notice that we are extending the period to decide your claim for 30 days. Before the end of this extension period we will send you: (a) a written decision on your claim; or (b) a notice that we are extending the period to decide your claim for an additional 30 days. If an extension is due to your failure to provide information necessary to decide the claim, the extended time period for deciding your claim will not begin until you provide the information or otherwise respond.

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

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

If we deny any part of your claim, you will receive a written notice of denial containing:

1. The reasons for our decision.

2. Reference to the parts of the Group Policy on which our decision is based.

3. Reference to any internal rule or guideline relied upon in making our decision.

4. A description of any additional information needed to support your claim.

5. Information concerning your right to a review of our decision.

6. Information regarding the claimant's right to appeal under the CTA Advisory Panel on Endorsed Services.

7. Information concerning your right to bring a civil action for benefits under section 502(a) of ERISA if your claim is denied on review.

J. Review Procedures For All Other Benefits

If all or part of a claim is denied, the claimant may request a review. The claimant must request a review in writing within 180 days after receiving notice of the denial.

The claimant may send us written comments or other items to support the claim. The claimant may review and receive copies of any non-privileged information that is relevant to the request for review. There will be no charge for such copies. The claimant may request the names of medical or vocational experts who provided advice to us about the claim.

The person conducting the review will be someone other than the person who denied the claim and will not be subordinate to that person. The person conducting the review will not give deference to the initial denial decision. If the denial was based on a medical judgement, the person conducting the review will consult with a qualified health care professional. This health care professional will be someone other than the person who made the original medical judgement and will not be subordinate to that person. Our review will include any written comments or other items the claimant submits to support the claim.

We will review the claim promptly after we receive the request. Within 45 days after we receive the request for review we will send the claimant: (a) a written decision on review; or (b) a notice that we are extending the review period for 45 days. If the extension is due to the claimant's failure to provide information necessary to decide the claim on review, the extended time period for review of the claim will not begin until the claimant provides the information or otherwise responds.

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

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

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

1. The reasons for our decision.
2. Reference to the parts of the Group Policy on which our decision is based.
3. Reference to any internal rule or guideline relied upon in making our decision.
4. Information concerning your right to receive, free of charge, copies of non-privileged documents and records relevant to your claim.
5. Information concerning the claimant's right to a review of our decision by the CTA Advisory Panel on Endorsed Services.
6. Information concerning your right to bring a civil action for benefits under section 502(a) of ERISA.

If you are a member of California Teachers Association whose claim was denied on review and you disagree or are dissatisfied with the decision on the claim, a written complaint may be filed with the CTA Advisory Panel on Endorsed Services. The complaint must be filed within 180 days after receiving notice of the denial upon review and in accordance with the CTA Advisory Panel on Endorsed Services' established procedures. The CTA Advisory Panel on Endorsed Services will investigate and review the member's request for review in accordance with its established procedures at the next scheduled meeting, and may uphold or reverse our decision.

The CTA Complaint Review Request Form for the CTA Advisory Panel on Endorsed Services may be obtained by contacting:

California Teachers Association
Member Benefits Department
P.O. Box 921

Burlingame CA 94011-0921

For further eligibility requirements and deadlines for submission, please contact CTA Member Benefits at: (650) 552-5200.

K. Entire Contract

This Group Policy and the application of the Policyholder constitute the entire contract between the parties, and any statement made by the Policyholder or by any Participant shall, in the absence of fraud, be deemed a representation and not a warranty. No such statement shall be used in defense to a claim hereunder unless it is contained in a written application, nor shall any such statement of the Policyholder, except a fraudulent misstatement, be used at all to void this policy after it has been in force for three years from the date of its issue, nor shall any such statement of any Participant eligible for coverage under the policy, except a fraudulent misstatement, be used at all in defense to a claim for loss incurred or disability (as defined in the Group Policy) commencing after the insurance coverage with respect to which claim is made has been in effect for three years from the date it became effective.

No change in this Group Policy shall be valid unless approved by an executive officer of us and unless such approval be endorsed herein or attached hereto. No agent has authority to change this Group Policy or waive any of its provisions.

L. Time Limit On Certain Defenses

After two years from the date of issue of this Group Policy, no misstatement of the Policyholder, except a fraudulent misstatement, made in his application shall be used to void the Group Policy; and after two years from the effective date of the coverage with respect to which any claim is made no misstatement of any Participant eligible for coverage under the Group Policy, except a fraudulent misstatement, made in an application under the policy shall be used to deny a claim for loss incurred or disability (as defined in the Group Policy) commencing after expiration of such three years.

M. Legal Actions

No action at law or in equity shall be brought to recover on this Group Policy prior to the expiration of 60 days after proof of loss has been furnished in accordance with the requirements of this Group Policy. No such action shall be brought after the expiration of three years after the time proof of loss is required to be furnished.

N. Grace Period

A grace period of 60 days will be granted for the payment of premiums accruing after the first premium, during which grace period the Group Policy shall continue in force.

If premium equal to at least 50% of the amount due on any Premium Due Date under all group voluntary disability policies issued by us to the Policyholder is not paid during the Grace Period, the Group Policy will terminate automatically on the second August 31st next following the end of the Grace Period.

O. Assignment

The rights and benefits under the Group Policy are not assignable.

CONTINUITY OF COVERAGE

A. Waiver Of Active Work Requirement

If you were insured under the Prior Plan on the day before the Group Policy Effective Date, you can become insured on the Group Policy Effective Date without meeting the Active Work requirement. See **Active Work Provisions**.

The Disability Benefit payable for a period of continuous Disability beginning before you meet the Active Work requirement will be:

1. The monthly benefit which would have been payable under the terms of the Prior Plan if it had remained in force; reduced by
2. Any benefits payable under the Prior Plan.

B. Effect Of Preexisting Conditions

If your Disability is subject to the Preexisting Condition Exclusion, Disability Benefits will be payable if:

1. You were insured under the Prior Plan on the day before the Group Policy Effective Date;
2. You became insured under the Group Policy when your insurance under the Prior Plan ceased;
3. You were continuously insured under the Group Policy from the effective date of your insurance under the Group Policy through the date you became Disabled from the Preexisting Condition; and
4. Benefits would have been payable under the Prior Plan if you had remained insured under the Prior Plan, taking into account the preexisting condition exclusion, if any, of the Prior Plan.

Your monthly benefit will be the Disability Benefit payable under the Group Policy.

WHEN YOUR INSURANCE BECOMES EFFECTIVE

You must apply in writing for insurance and agree to pay premiums. Subject to the **Active Work Provisions**, your insurance becomes effective on the following applicable date:

1. If you are not required to submit Evidence Of Insurability, your insurance will become effective on the later of (a) the date you become eligible, and (b) the first day of the calendar month following the date you apply.
2. If you are required to submit Evidence Of Insurability (as shown in the **Coverage Features**), your insurance will become effective on the later of (a) the date you become eligible, and (b) the first day of the calendar month following the date we approve your Evidence Of Insurability.

Note: Insurance will not become effective if the required premium contribution has not been made for that month. If a premium contribution was not made because your Employer makes payroll deductions only 10 months each year, your insurance will become effective as if the premium contribution had been made. However, premium contributions must begin the next following month in which employee payroll deductions are made by your Employer.

ACTIVE WORK PROVISIONS

A. Active Work Requirement

You must be capable of Active Work on the scheduled effective date of your insurance or your insurance will not become effective as scheduled. If you are incapable of Active Work because of Sickness or Injury on the scheduled effective date of your insurance, your insurance will not become effective until you have been Actively At Work for ten full consecutive Required Days Of Attendance.

Active Work and **Actively At Work** mean performing with reasonable continuity the Substantial And Material Acts of your Usual Occupation at your Employer's usual place of business.

B. Changes In Insurance

This Active Work requirement also applies to any increase in your insurance.

WHEN YOUR INSURANCE ENDS

Your insurance ends automatically on the earliest of:

1. The date the last period ends for which a premium was paid for your insurance.
2. The date the Group Policy terminates.
3. The date you are no longer employed with an Employer. However, insurance will continue for up to 90 days following the date employment terminates, provided insurance premiums continue to be paid and termination of your employment occurs due to any of the following, as determined by the Employer:
   a. Budgetary constraints
   b. Decline in student attendance
   c. Reduction or discontinuance of a service
   d. Curriculum modification
4. The first day of the calendar month following the date you cease to be a Participant, unless:
   a. You cease to be a Participant because you are not working the required minimum number of hours. In this case, unless it ends under 1 through 3 above, your insurance will be continued during the following periods:
      i. During the Benefit Waiting Period.
      ii. During a leave of absence if continuation of your insurance under the Group Policy is required by federal or a state-mandated family or medical leave act or law.
      iii. During the first 90 days of a temporary layoff.
      iv. Through the last day of the calendar month in which you are absent from Active Work due to a labor dispute (See Strike Continuation).
      v. Through the last day of the first calendar month for which you are absent from Active Work due to a leave of absence.
      vi. During a Scheduled Vacation Period; or
   b. You cease to be a Participant because you are no longer a CTA Education Support Professional (CTA ESP) member in good standing of California Teachers Association. In this case, unless it ends under 1 through 3 above, your insurance will continue through the first day of the calendar month following the date of the termination letter.

STRIKE CONTINUATION

Insurance may be continued for up to 6 months while you are absent from Active Work because of a strike, lockout or other general work stoppage caused by a labor dispute. Rules 1 through 3 below will apply.

1. You must pay the entire premium for your insurance on or before each Premium Due Date.
2. The premiums for your insurance during the work stoppage will equal the premium rate in effect on the date the work stoppage began. We may change premium rates during the work stoppage according to the terms of the Group Policy.
3. Insurance continued under this provision will end on the earliest of:

a. Any Premium Due Date if you fail to make the required premium contribution on or before that date.

b. The date you have been absent from Active Work for 6 months.

c. On the date you begin full-time employment with another employer.

d. At our option, on any Premium Due Date if less than 75% of the Participants eligible to continue insurance under this provision make the required premium payment.

REINSTATEMENT OF INSURANCE

If your insurance ends, you may become insured again as a new Participant. However, the following will apply.

1. If you cease to be a Participant because of a covered Disability, your insurance will end; however, if you become a Participant again immediately after Disability Benefits end, the Preexisting Condition Exclusion will be applied as if your insurance had remained in effect during that period of Disability.
2. If your insurance ends because you fail to make a required premium contribution, you must provide Evidence Of Insurability to become insured again. This requirement will not apply to you if your coverage ended involuntarily during an approved leave of absence not due to Disability, a period you were temporarily laid off, or a labor dispute, and you apply for coverage within 120 days after you return to Active Work and you make the required premium contributions by the third month following the date you apply.
3. If your insurance ends because you are on a federal or state mandated family or medical leave of absence, and you become a Participant again immediately following the period allowed, your insurance will be reinstated pursuant to the federal or state mandated family or medical leave act or law.
4. The Preexisting Conditions Exclusion will be applied as if there had been no break in coverage, if required by federal or state mandated family or medical leave act or law and you become insured again immediately following the period allowed under the family or medical leave act or law.
5. In no event will insurance be retroactive.

CONTINUATION OF INSURANCE AFTER TRANSFERRING OF EMPLOYMENT

If you transfer employment to another Employer or to an institution whose primary purpose is research or development of public education in California, your insurance under the Group Policy may be continued at its current level, subject to the following:

1. You must apply in writing to continue your insurance and make the first premium payment to us at our Home Office within 180 days after the date of your transfer. Thereafter, premium payments must be made semi-annually, by March 1 and September 1 of each year. If you have the ability to pay for insurance through payroll deduction, premium payments must be made through payroll deduction.
2. Your insurance continued under this provision will be subject to all other terms of the Group Policy.

CLERICAL ERROR AND MISSTATEMENT

A. Clerical Error

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

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

B. Misstatement Of Age

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

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

C. Agency

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

TERMINATION OR AMENDMENT OF THE GROUP POLICY

The Group Policy may be terminated by us or the Policyholder according to its terms. The Policyholder may terminate the Group Policy in whole, and may terminate insurance for any class or group of Participants, at any time by giving us written notice.

Benefits under the Group Policy are limited to its terms, including any valid amendment. No change or amendment will be valid unless it is approved in writing by one of our executive officers and given to the Policyholder for attachment to the Group Policy. If the terms of the Certificate differ from the Group Policy, the terms stated in the Group Policy will govern. The Policyholder, your Employer and their respective employees or representatives have no right or authority to change or amend the Group Policy or to waive any of its terms or provisions without our signed written approval.

We may change the Group Policy in whole or in part when any change or clarification in law or governmental regulation affects our obligations under the Group Policy, or with the Policyholder's consent.

Any such change or amendment of the Group Policy may apply to current or future Participants or to any separate classes or groups of Participants.

DEFINITIONS

Benefit Waiting Period means the period you must be continuously Disabled before Disability Benefits become payable. No Disability Benefits are payable during the Benefit Waiting Period. See **Coverage Features**.

Benefit Year means (a) a period equal to the number of your Required Days Of Attendance under the terms of your employment contract with the Employer for the contract year in which you become Disabled, plus (b) any additional periods of Restored Sick Leave.

Contributory means insurance is elective and Participants pay all of the premiums for insurance.

CPI-W means the Consumer Price Index for Urban Wage Earners and Clerical Workers published by the United States Department of Labor. If the CPI-W is discontinued or changed, we may use a comparable index. Where required, we will obtain prior state approval of the new index.

Disability Benefit means the monthly benefit payable to you under the terms of the Group Policy.

Domestic Partner means:

1. A person recognized as your domestic partner under California state law; or
2. An individual over the age of 18 whom you consider to be a life partner, provided that the individual: (a) is capable of consenting to a domestic partnership; (b) is not related by blood in a way that would prevent him or her from marrying you; and (c) is living with you in a condition of financial interdependence, in that you and the individual are liable to third parties for any obligations incurred by one or the other for the common necessities of life, such as food, shelter and medical care.

   Neither you nor your Domestic Partner may have a similar relationship with any other person, nor be legally married to another person.

Eligibility Date means the date you become eligible for insurance under the Group Policy. See **Coverage Features**.

Providing **Evidence Of Insurability** means you must:

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

Family Status Change means any of the following events:

1. Your marriage, divorce or legal separation; or initiation or dissolution of a Domestic Partner relationship.
2. The birth of your Child.
3. The adoption of a Child by you.
4. The death of your Spouse/Domestic Partner and/or Child.
5. The commencement or termination of your Spouse/Domestic Partner's employment.
6. A change in employment from full-time to part-time by you or your Spouse/Domestic Partner.

Fully Paid Sick Leave means sick pay you are eligible to receive from your Employer as of the date of Disability, excluding Restored Sick Leave.

Group Policy means the group disability insurance policy issued by us to the Policyholder and identified by the Group Policy Number.

Indexed Regular Contract Salary means your Regular Contract Salary adjusted by the rate of increase in the CPI-W. During your first year of Disability, your Indexed Regular Contract Salary is the same as your Regular Contract Salary. Thereafter, your Indexed Regular Contract Salary is determined on each anniversary of your Disability by increasing the previous year's Indexed Regular Contract Salary by the rate of increase in the CPI-W for the prior calendar year. The maximum adjustment in any year is 10%. Your Indexed Regular Contract Salary will not decrease, even if the CPI-W decreases.

Indexed Regular Daily Contract Salary means your Indexed Regular Contract Salary, divided by the number of your Required Days Of Attendance for the contract year in which you became Disabled.

Indexed Regular Monthly Contract Salary means your Indexed Regular Contract Salary, divided by 12.

Injury means an injury to your body.

Maximum Benefit Period means the longest period for which Disability Benefits are payable for any one period of continuous Disability, whether from one or more causes. It begins at the end of the Benefit Waiting Period. No Disability Benefits are payable after the end of the Maximum Benefit Period, even if you are still Disabled. See **Coverage Features**.

Physician means a licensed medical professional, diagnosing and treating individuals within the scope of the license. The term includes a legally licensed physician, dentist, optometrist, podiatrist, psychologist or chiropractor. Physician does not include you or your Spouse/Domestic Partner, or the brother, sister, parent or child of either you or your Spouse/Domestic Partner.

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

Required Day(s) Of Attendance means any day(s) you are required to be Actively At Work under the terms of your employment on the date you become Disabled. The calendar dates in a subsequent employment contract year may not fall on the same days of the week as the employment calendar in effect on your date of Disability.

Restored Sick Leave means sick pay that is accrued through your employment with your Employer after your date of Disability, excluding Fully Paid Sick Leave.

Scheduled Vacation Period means a vacation period, other than a leave of absence, for which you are scheduled to be away from work for at least 2 but less than 14 consecutive weeks.

Sickness means an illness or disease, a Mental Disorder, a pregnancy, or the donation of your kidney, skin, lung, or bone marrow for transplantation into another person.

Spouse means a person to whom you are legally married.

ERISA INFORMATION AND NOTICE OF RIGHTS

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

A. General Plan Information

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

B. Statement Of Your Rights Under ERISA

1. Right To Examine Plan Documents

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

2. Right To Obtain Copies Of Plan Documents

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

3. Right To Receive A Copy Of Annual Report

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

4. Right To Review Of Denied Claims

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

C. Obligations Of Fiduciaries

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

D. Enforcing ERISA Rights

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

E. Plan And ERISA Questions

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

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

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

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

If our review results in a denial of any part of your claim for a benefit that relies on a disability decision, your written notice of denial will contain a copy of any internal rule or guideline relied upon in making the decision, or a statement that no such rules or guidelines exist. The notice of denial will also include information concerning your right to bring a civil action for benefits under

section 502(a) of ERISA and a description of any applicable contractual limitations period that applies to your right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim.

ERISA.90.01