

Notice of Limited Benefits

This coverage does not constitute comprehensive health insurance coverage (often referred to as “major medical coverage”) and does not satisfy the requirement of minimum essential coverage under the Affordable Care Act.

AMERICAN HERITAGE LIFE INSURANCE COMPANY

HOME OFFICE:

4920 SAN PABLO ROAD S, SUITE 200C

JACKSONVILLE, FLORIDA 32224-1844

(800) 521-3535

A Stock Company

GROUP HOSPITAL INDEMNITY INSURANCE POLICY NON-PARTICIPATING

American Heritage Life Insurance Company will provide benefits under this policy. We make this promise subject to all of the provisions of this policy.

The policyholder should read this group policy carefully and contact us promptly with any questions. This group policy is delivered in and is governed by the laws of the governing jurisdiction and, to the extent applicable, by the Employee Retirement Income Security Act of 1974 (ERISA), and consists of:

1. all policy provisions and any amendments and/or attachments issued; and
2. the policyholder's signed application.

This policy may be changed in whole or in part. The approval must be in writing, signed by one of our executive officers and endorsed on or attached to this policy. No other person, including an agent, may change this policy or waive any part of it.

Signed for American Heritage Life Insurance Company at its Home Office in Jacksonville, Florida on the policy effective date.



Secretary



President

**THIS IS A GROUP HOSPITAL INDEMNITY ONLY POLICY WHICH PROVIDES
LIMITED BENEFITS AS STATED OR OTHER BENEFITS SPECIFICALLY
DESCRIBED WITHIN THIS POLICY**

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POLICY SPECIFICATIONS

POLICYHOLDER: Jefferson Parish School System.

POLICY NUMBER: G-87463-H

POLICY EFFECTIVE DATE: January 1, 2026

POLICY ANNIVERSARY DATE: January 1, 2027 and the first day of January each calendar year thereafter.

GOVERNING JURISDICTION: the state of Louisiana and subject to the laws of that jurisdiction.

ELIGIBLE CLASS(ES):

All full-time active employees or members working 20+ hours per week.

ELIGIBILITY WAITING PERIOD:

30 Days

Low Plan

First Day Hospital Confinement – \$1,000
Daily Hospital Confinement – \$100 per day
Hospital Intensive Care – \$100 per day
Fixed Wellness – \$50 per day

High Plan

First Day Hospital Confinement – \$2,000
Daily Hospital Confinement – \$200 per day
Hospital Intensive Care – \$200 per day
Fixed Wellness – \$50 per day

INITIAL RATE:

Low Plan

The following are the initial rates for all available coverage types:
Monthly rate of \$8.65 per insured employee or member for Individual Coverage; or
\$16.71 per insured employee or member for Individual and Spouse Coverage; or
\$11.44 per insured employee or member for Individual and Child(ren) Coverage; or
\$20.02 per insured employee or member for Family Coverage

High Plan

The following are the initial rates for all available coverage types:
Monthly rate of \$16.51 per insured employee or member for Individual Coverage; or
\$32.24 per insured employee or member for Individual and Spouse Coverage; or
\$22.10 per insured employee or member for Individual and Child(ren) Coverage; or
\$38.48 per insured employee or member for Family Coverage

RATE GUARANTEE DATE:

January 1, 2030

PREMIUM DUE:

January 1, 2026 and the first day of each calendar month thereafter.
All premiums must be sent to us on or before the premium due date. The premium must be paid in United States dollars.

COST OF COVERAGE:

The insured employee or member pays the cost of coverage.

DIVISIONS, SUBSIDIARIES OR AFFILIATED COMPANIES:

These are the policyholder’s divisions, subsidiaries, or affiliates listed below. The policyholder may act for and on behalf of any and all of these in all matters that pertain to this policy. Every act done by, agreement made with, or notice given to the policyholder will be binding on them.

Name

None

Location (City and State)

POLICYHOLDER PROVISIONS

RATE GUARANTEE

A change in premium rate will not take effect before the Rate Guarantee Date. However, we may change premiums at any time for reasons which affect the risk assumed including those reasons shown below:

1. a change occurs in this plan design; or
2. a division, subsidiary, or affiliated company is added or deleted; or
3. the number of insured employees or members changes by 25% or more; or
4. a new law or a change in any existing law is enacted which applies to this policy; or
5. less than 10% of those eligible for coverage are participating.

We will notify the policyholder in writing at least 45 days before a premium rate is changed. A change may take effect on an earlier date when both we and the policyholder agree in writing. Rates shall not increase in the first 12 months of coverage and shall not increase more than once in a 6 month period thereafter.

PREMIUM INCREASES OR DECREASES

Premium increases or decreases may take effect any time subject to the RATE GUARANTEE provision. If they take effect during a policy month, they are adjusted and due on the next premium due date following the change. Changes will not be pro-rated daily.

If premiums are paid on other than a monthly basis, premiums for increases and decreases will result in a monthly pro-rated adjustment on the next premium due date.

INFORMATION REQUIRED FROM THE POLICYHOLDER

The policyholder must provide us with the following on a regular basis:

1. information about employees or members:
 - a. who are eligible to become insured; and
 - b. whose coverage changes; and/or
 - c. whose coverage ends; and
2. any information that may be required to manage a claim; and
3. any other information that may be reasonably required.

Policyholder records that have a bearing, in our opinion, on this policy will be available for review by us at any reasonable time.

CANCELING POLICY

This policy can be canceled:

1. by us; or
2. by the policyholder.

We may cancel or offer to modify this policy, with at least 60 days written notice to the policyholder, if:

1. less than 10% of those eligible for coverage are participating; or
2. this policy has been in effect more than 12 months; or
3. the policyholder does not promptly provide us with information that is reasonably required; or
4. the policyholder fails to perform any of its obligations that relate to this policy; or
5. fewer than 10 employees or members are insured; or
6. premiums are not received within the 31 day grace period.

If the premiums are not received during the grace period, this policy will terminate automatically at the end of the grace period. Premiums are required for coverage during the grace period. All premiums due must be paid to us for the full period this policy is in force.

The policyholder may cancel this policy by written notice delivered to us at least 31 days prior to the cancellation date. When both the policyholder and we agree, this policy can be canceled on an earlier date. If canceled, coverage will end at 12:00 midnight on the last day of coverage.

If this policy is canceled, the cancellation will not affect a payable claim incurred prior to cancellation.

GENERAL PROVISIONS

EFFECTIVE DATE OF COVERAGE

Coverage to each eligible employee or member will be effective at 12:01 a.m. on the effective date shown on page 3 of the certificate of insurance issued to that employee or member provided he or she is actively employed on that date.

If the employee or member is not actively employed on that date due to temporary layoff, leave of absence or Family and Medical Leave of Absence, coverage begins on the date he or she returns to active employment. This applies to initial coverage, as well as any increase in coverage that occurs after the employee or member's initial coverage is effective.

For any change in coverage, the change is effective on the date we receive such request for change.

Any decrease in coverage will take effect on the first day of the calendar month that next follows the date the employee or member applies for the decrease, but will not affect a payable claim that occurs prior to the effective date of the decrease.

CERTIFICATES OF INSURANCE

We will furnish to the policyholder a certificate of insurance for delivery to each insured employee or member. The certificate will provide a description of the insurance provided by this policy and will state:

1. the essential features of the insurance coverage; and
2. to whom benefits are payable.

If there is any discrepancy between the provisions of any certificate and the provisions of this policy, the provisions of this policy govern.

WHEN AN ELIGIBLE EMPLOYEE OR MEMBER CAN ENROLL, CHANGE OR DISCONTINUE COVERAGE

1. The employee or member may apply for coverage during:
 - a. the initial enrollment period; or
 - b. a re-enrollment period.
2. The insured employee or member may increase coverage at the next re-enrollment period.
3. The insured employee or member may decrease coverage at the next re-enrollment period.
4. The insured employee or member may discontinue coverage at the next re-enrollment period.

ELIGIBILITY OF DEPENDENTS

Eligible dependents are the insured employee or member's:

1. legal spouse or domestic partner; and
2. children and domestic partner's children.

A child is a person under age 26 who is:

1. the insured employee or member's or his or her domestic partner's natural or adopted son or daughter, stepson or stepdaughter; or
2. a foster child who is placed with the insured employee or member or his or her domestic partner by an authorized placement agency or by judgment, decree or other order of any court of competent jurisdiction; or
3. the insured employee or member's or his or her domestic partner's grandchild in his or her custody.

A child born to the insured employee or member or his or her spouse or domestic partner, will be eligible for coverage. This coverage begins at the moment of birth of such child and benefits will be the same as provided for any other child insured under this policy. No additional premium will be required for newborns added if the insured employee or member already has children or family coverage in force at the time the newborn is added.

GENERAL PROVISIONS (Continued)

ELIGIBILITY OF DEPENDENTS (Continued)

If the employee or member does not already have children or family coverage in force, or does not have coverage in force that covers more than one child, newborn children are automatically covered from the moment of birth for a period of 31 days. If the insured employee or member desires uninterrupted coverage for a newborn child, he or she must notify the policyholder within 31 days of that child's birth. Upon notice to us, we will change the coverage to include the additional child and provide notification of the additional premium due. If the insured employee or member does not notify the policyholder within 31 days of the birth of the child, the temporary automatic coverage ends.

If the insured employee or member marries and desires coverage for his or her spouse, he or she must notify the policyholder of the marriage within 31 days of the marriage. Upon notice to us, we will change the coverage to include the insured employee or member's spouse and provide notification of the additional premium due.

If the insured employee or member enters into a domestic partnership and desires coverage for his or her domestic partner, he or she must notify the policyholder of the domestic partnership within 31 days of the date the domestic partnership was formed. Upon notice to us, we will change the coverage to include the insured employee or member's domestic partner and provide notification of the additional premium due.

An adopted child or child pending adoption will be covered as follows:

1. Coverage is retroactive from the moment of birth for a child with respect to whom a decree of adoption by the insured employee or member has been entered within 31 days after the date of birth.
2. If adoption proceedings have been instituted by the insured employee or member within 31 days after the date of birth and he or she has temporary custody, coverage is provided from the moment of birth.
3. Coverage shall begin from the moment of placement.

Coverage will be provided as long as the insured employee or member has custody of the child pursuant to decree of the court and required premiums are paid.

If the insured employee or member does not already have children or family coverage in force, or does not have coverage in force that covers more than one child, adopted children or children pending adoption are automatically covered as described above for a period of 31 days. If the insured employee or member desires uninterrupted coverage for an adopted child or child pending adoption, he or she must notify the policyholder within 31 days of the moment of placement. Upon notice to us, we will change the coverage to include the additional adopted child or child pending adoption and provide notification of the additional premium due.

No additional premium will be required for an adopted child or foster child added if the insured employee or member already has children or family coverage in force at the time the adopted child or foster child is added.

TERMINATION OF COVERAGE

The insured employee or member's coverage under this policy ends on the earliest of:

1. the date this policy is canceled; or
2. the last day of the period for which any required premium payments were made; or
3. the last day the insured employee or member is actively employed with the employer or a member in good standing in the labor union, association or other entity that is the policyholder, except as provided under the TEMPORARY LAYOFF, LEAVE OF ABSENCE OR FAMILY AND MEDICAL LEAVE OF ABSENCE provision; or
4. the date the insured employee or member is no longer in an eligible class; or
5. the date the insured employee or member's class is no longer eligible; or
6. our discovery of fraud or material misrepresentation in the presentation of a claim under this policy.

We will provide coverage for a payable claim that occurs while a covered person is covered under this policy.

If the insured employee or member's spouse is a covered person, the spouse's coverage ends upon valid decree of divorce or the insured employee or member's death.

If the insured employee or member's domestic partner is a covered person, the domestic partner's coverage ends upon termination of the domestic partnership or the insured employee or member's death.

Coverage for a child will end on the issue day of the month that follows when the insured employee or member dies or the child: (a) reaches age 26; or (b) otherwise does not meet the requirements of an eligible dependent.

GENERAL PROVISIONS (Continued)

TERMINATION OF COVERAGE (Continued)

Coverage does not end for an incapacitated dependent child who:

1. is incapable of self-sustaining employment by reason of mental or physical incapacity; and
2. became so incapacitated prior to the attainment of the limiting age of eligibility under this policy; and
3. is chiefly dependent upon the insured employee or member for support and maintenance.

Coverage for an incapacitated dependent child continues as long as this policy remains in force and the child remains in such condition. Proof of the incapacity and dependency of the child must be furnished, in writing, to us when the child reaches the limiting age of eligibility. Thereafter, such proof must be furnished as often as may be required, but no more often than annually after child's attainment of the limiting age for eligibility.

If we accept a premium for coverage extending beyond the date, age or event specified for termination as to a covered person, such premium will be refunded, coverage will terminate and claims will not be paid. There may be no refund due if the insured employee or member has coverage in force that covers more than one child and there are other eligible dependents still insured under this policy.

Coverage may be eligible for continuation as outlined in the PORTABILITY PRIVILEGE provision.

TEMPORARY LAYOFF, LEAVE OF ABSENCE OR FAMILY AND MEDICAL LEAVE OF ABSENCE

If the insured employee or member ceases active employment or membership in the union or association because of a temporary layoff or leave of absence while coverage is in force, we will continue the coverage in accordance with the personnel practices of the policyholder, if premium payments continue and the policyholder approved the leave in writing. Coverage will be continued for 3 months following the date the insured employee or member ceased active employment or membership in the union or association.

If the insured employee or member's coverage ends while on a Family and Medical Leave of Absence, the coverage will be reinstated when he or she returns to active status.

DISCRETIONARY AUTHORITY, IF GOVERNED BY ERISA

The following applies only when the administration of the policy is governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. 1001 et seq.:

We have the discretion and authority to construe disputed or seemingly inconsistent provisions of the policy and to make all decisions regarding eligibility and/or entitlement to coverage or benefits. Whenever we make reasonable determinations which are not arbitrary or capricious in the administration of the policy, such determinations shall be final and conclusive.

LEGAL ACTION

No legal action may be brought to obtain benefits under this policy:

1. for at least 60 days after proof of loss has been furnished; or
2. after the expiration of 3 years from the time written proof of loss is required to have been furnished.

INCONTESTABILITY

After 2 years from the effective date of the policy, no misstatement, made in writing, can be used to void coverage or deny a claim for a loss incurred.

CLERICAL ERROR

Clerical error on the part of the policyholder or us will not invalidate insurance otherwise in force nor continue insurance otherwise terminated. Upon discovery of any error, an adjustment will be made in the premiums and/or benefits available. Complete proof must be supplied by us or the policyholder documenting any clerical errors.

GENERAL PROVISIONS (Continued)

AGENCY

For purposes of this policy, the policyholder acts on its own behalf or as the insured employee or member's agent. Under no circumstances will the policyholder be deemed the agent of American Heritage Life Insurance Company.

ENTIRE CONTRACT

The contract consists of the following items:

1. the group policy; and
2. any amendments and endorsements; and
3. the applications and other written statements of the policyholder; and
4. any individual applications, enrollments or other statements made by a covered person.

Any statements made by the policyholder or by a covered person are representations and not warranties. Only written statements signed by the policyholder or a covered person will be used in defense of a claim. A copy of any written statement, if applicable, will be furnished to the policyholder or the covered person or his or her personal representative, if any, if such written statement will be used in defense of a claim.

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PORTABILITY PRIVILEGE

We will provide portability coverage, subject to these provisions.

Such coverage will not be available for an insured employee or member, unless:

1. coverage under the policy terminates under the TERMINATION OF COVERAGE provision; and
2. we receive a written request and payment of the first premium for the portability coverage no later than 30 days after such termination; and
3. the request is made for that purpose.

No portability coverage will be provided for any person, if his or her insurance under the policy terminated due to his or her failure to make required premium payments.

PORTABILITY COVERAGE

The benefits, terms and conditions of the portability coverage will be the same as those provided under the policy when the insurance terminated. Portability coverage may include any eligible dependents who were covered under the policy. Any change made to the policy after a person is insured under the portability privilege will not apply to that covered person unless it is required by law.

Portability coverage will be effective on the day after insurance under the policy terminates.

PORTABILITY PREMIUMS

Premiums for portability coverage are due and payable in advance to us at our home office. Premium due dates are the first day of each calendar month. The portability premium rate may differ from the premium rate in effect for insured employees or members and may change on any premium due date. Written notice will be given at least 45 days before a change is to take effect.

GRACE PERIOD

The grace period, as defined, will apply to each certificate holder of portability coverage as if such insured employee or member is the policyholder.

TERMINATION OF INSURANCE

Insurance under this portability privilege ends on the earliest of:

1. The date the person again becomes eligible for insurance under the policy.
2. The last day for which premiums have been paid, if the insured employee or member fails to pay premiums when due, subject to the grace period.
3. With respect to insurance for dependents:
 - a. the date the insured employee or member's insurance terminates; or
 - b. the date the dependent ceases to be an eligible dependent, as defined.
4. 36 months after the date portability coverage became effective.

A dependent child whose portability coverage terminates when he or she reaches the age limit may apply for portability coverage in his or her own name, if he or she is otherwise eligible.

Portability coverage will remain in effect for no longer than 36 months.

TERMINATION OF THE POLICY

If the policy terminates, the insured employee or member and his or her covered dependents will be eligible to exercise the portability privilege on the termination date of the policy. Portability coverage may continue beyond the termination date of the policy, subject to the timely payment of premiums. Benefits for portability coverage will be determined as if the policy had remained in full force and effect.

EXCLUSIONS

We will not pay benefits for any loss caused by or resulting from (directly or indirectly):

1. any act of war whether or not declared, participation in a riot, insurrection or rebellion; or
2. suicide, or any attempt at suicide, whether sane or insane; or
3. injury incurred while engaging in an illegal occupation or committing or attempting to commit an assault or felony; or
4. dental or plastic surgery for cosmetic purposes except when such surgery is required to: (a) treat an injury; or (b) correct a disorder of normal bodily function; or
5. intentionally self-inflicted injuries; or
6. confinement that begins before the covered person's effective date of coverage; or
7. the reversal of a tubal ligation or vasectomy; or
8. artificial insemination, in vitro fertilization, and test tube fertilization, including any related testing, medications or physician services, unless required by law; or
9. participation in any form of aeronautics (including parachuting and hang gliding) except as a fare-paying passenger in a licensed aircraft provided by a common carrier and operating between definitely established airports; or
10. a newborn child's routine nursing or routine well baby care during the initial confinement in a hospital; or
11. driving in any organized or scheduled race or speed test or while testing an automobile or any motorized vehicle on any racetrack or speedway.

GENERAL BENEFIT INFORMATION

We pay the following benefit(s) for service and treatment administered to or received by a covered person. Such service or treatment must be: (a) incurred by a covered person while coverage under this policy is in force on that person; and (b) provided for the care and treatment of sickness or injury of a covered person. Any loss not stated in the policy is not covered under this policy. Treatment must be received in the United States or its territories.

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BENEFIT INFORMATION

First Day Hospital Confinement: We pay the amount stated on page 3 for the first day a covered person is confined in a hospital. This benefit is payable only once per continuous confinement in a hospital per covered person, and is limited to once every 30 days.

This benefit is not payable for a newborn child's initial confinement in a hospital. A newborn child's initial confinement in a hospital includes any transfers to another hospital before such child is discharged to his or her home.

The covered person must provide proof that a hospital room and board charge is incurred.

BENEFIT INFORMATION

Daily Hospital Confinement: We pay the amount stated on page 3 per day when a covered person is confined in a hospital.

If the First Day Hospital Confinement benefit is payable, this benefit pays for each day after the first day of a continuous confinement in a hospital for a maximum of 9 days. If the First Day Hospital Confinement benefit is not payable, this benefit pays for each day of a continuous confinement in a hospital for a maximum of 10 days.

This benefit is not payable for:

1. any day for which the First Day Hospital Confinement benefit is payable; or
2. a newborn child's routine nursing or routine well baby care during the initial confinement in a hospital.

The covered person must provide proof for each day that a hospital room and board charge is incurred.

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BENEFIT INFORMATION

Hospital Intensive Care: We pay the amount stated on page 3 for each day a covered person is confined in a hospital intensive care unit. This benefit is paid in addition to the First Day Hospital Confinement benefit and Daily Hospital Confinement benefit.

The maximum number of days this benefit is payable is 10 days for each continuous confinement in a hospital intensive care unit.

The covered person must provide proof for each day that a hospital room and board charge is incurred.

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CLAIM INFORMATION

NOTICE OF CLAIM

We encourage the insured employee or member to notify us of a claim as soon as possible so that a claim decision can be made in a timely manner. Written notice of claim must be given to us within 20 days after the occurrence or commencement of any benefit covered by this policy, or as soon as reasonably possible. Notice given to us by, or on behalf of, the insured employee or member or the beneficiary at 4920 San Pablo Road S, Suite 200C, Jacksonville, Florida 32224-1844, or to any authorized agent of ours, with the insured employee or member's name and certificate number, is notice to us.

The claim form can be requested from us. If the form is not received within 15 days of the request, written proof of the claim may be sent to us without waiting for the form.

FILING A CLAIM

The insured employee or member must complete all applicable sections of the claim form and then give it to the attending physician. The physician should complete his or her section of the form and send it directly to us.

PROOF OF CLAIM

Written proof must be given to us within 90 days after each loss. If it is not possible to give us written proof in the time required, we will not reduce or deny any claim for this reason, as long as the proof is filed as soon as reasonably possible. In any event, the proof required must be given to us no later than 1 year from the time specified unless the insured employee or member is legally incapacitated.

PHYSICAL EXAMINATION AND AUTOPSY

We have the right, at our own expense, to have any covered person examined by a physician of our choosing, as often as may be reasonably required while a claim is pending. We may have an autopsy performed during the period of contestability, where it is not forbidden by law.

PAYMENT OF CLAIMS

After receiving written proof of loss, we pay all benefits then due under this policy within 30 days of receipt of written proof of claim. We will make payments to the insured employee or member unless such payments are assigned. Any amounts unpaid at the insured employee or member's death may, at our option, be paid either to the named beneficiary or to the insured employee or member's estate.

If benefits are payable to the insured employee or member's estate or a beneficiary who cannot execute a valid release, we can pay benefits up to \$1,000, to someone related to the insured employee or member or beneficiary by blood or marriage whom we consider to be entitled to the benefits. We will be discharged to the extent of any such payment made in good faith.

ASSIGNMENT

An assignment of the coverage under this policy is not binding on us, unless:

1. it is a written request; and
2. it is received and recorded by us at our home office.

We are not responsible for the validity of any assignment. An assignment is subject to any payment we make or other action we take before we record the assignment. An assignee may not change the owner or beneficiary.

CLAIM INFORMATION (Continued)

OVERPAID CLAIM

We have the right to recover any overpayments due to:

1. fraud; or
2. any error we make in processing a claim.

The insured employee or member must reimburse us in full. We will work with such insured employee or member to develop a reasonable method of repayment if he or she is financially unable to repay us in a lump sum.

We will not recover more money than the amount we overpaid.

UNPAID PREMIUM

Any unpaid premium that is due may be deducted from the payment of the covered person's claim.

CLAIM REVIEW

If a claim is denied, we will give written notice of:

1. the reason for denial; and
2. the policy provision that relates to the denial; and
3. the right to ask for a review of the claim; and
4. any additional information that might allow us to change our decision.

The insured employee or member may, upon written request, read any reports that are not confidential. For a small fee, we will make copies of those reports for his or her use.

APPEALS PROCEDURE

Prior to filing any lawsuit and within 60 days after denial of a claim, the insured employee or member or his or her beneficiary may appeal any denial of benefits under the policy by making a written request for review of the denial.

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GLOSSARY

(Glossary may contain terms that are not included in the coverage selected)

Accident means a sudden, unforeseen and unexpected event which occurs without the covered person's intent which results in an injury to the covered person independent of disease, infirmity or any other cause.

Active employment means the employee or member is working for the employer for earnings that are paid regularly and that he or she is performing the material and substantial duties of his or her regular occupation. For the purposes of this policy:

1. the employee or member must be working at least the minimum number of hours as described under the Eligible Class(es); and
2. the employee or member will be deemed to be in active employment on a day which is not the employer's scheduled work days only if he or she was actively employed on the preceding scheduled work day.

The employee's or member's work site must be:

1. the employer's usual place of business; or
2. an alternative work site at the direction of the employer; or
3. a location to which the job requires such employee or member to travel.

Normal vacation is considered active employment. However, if vacation days are used to cover sickness or injury, those days are not considered active employment. Temporary and seasonal workers are excluded from coverage.

Ambulatory surgical center means a licensed surgical center consisting of an operating room, facilities for the administration of general anesthesia and a post surgery recovery room in which the patient is admitted to, and discharged from, within a period of less than 24 hours.

Calendar year means a consecutive 12 month period beginning on January 1st of each year and ending on December 31st of the same year.

Complications of pregnancy mean any of the following:

1. a condition whose diagnosis is distinct from pregnancy but that is adversely affected by or caused by pregnancy, such as acute nephritis or nephrosis, cardiac decompensation, missed abortion, or similar medical and surgical conditions of comparable severity; and
2. a non-elective caesarean section; and
3. termination of ectopic pregnancy; and
4. spontaneous termination of pregnancy during a period of gestation in which a viable birth is not possible.

Complications of pregnancy do not include: false labor; or occasional spotting; or morning sickness; or body aches; or body pains; or prescribed rest; or hyperemesis gravidarum; or pre-eclampsia; or premature births; or multiple births (twins, triplets, etc.); or any condition caused by the pregnancy that places the covered person or the pregnancy at risk.

Confined or confinement means admitted to and confined as an inpatient in an institution for which a room and board charge is made by the institution. It does not include confinement for an observation room.

Continuous confinement means one continuous confinement or two or more confinements not separated by more than 24 hours. If there are more than 24 hours between confinements, they are considered separate confinements.

Cosmetic means surgery or other treatment to improve a person's appearance which is not required for treatment of a sickness or injury.

Coverage year means a consecutive 12 month period during which an insured employee or member's insurance is in force. The first coverage year begins on the effective date of the insured employee or member's insurance under the group policy and ends after 12 consecutive months of coverage. Dependents added later will have the same coverage year as the insured employee or member.

GLOSSARY (Continued)

Covered person means any of the following:

1. any eligible family member (including the employee or member) named on the enrollment form and acceptable for coverage by us; or
2. any eligible family member added by endorsement after the effective date; or
3. a newborn child or adopted child.

Day means a 24 hour period.

Domestic partner means the insured employee or member's same-sex or opposite-sex partner who is eligible for coverage provided that:

1. both the insured employee or member and his or her same-sex or opposite-sex partner must be considered as domestic partners according to the law of the insured employee or member's state of residence; or
2. if the insured employee or member's state of residence has no domestic partnership law, he or she must satisfy the definition of domestic partner as defined by the policyholder.

Eligibility waiting period means the continuous period of time that the employee or member must be in active employment in an eligible class before he or she is eligible for coverage.

Emergency treatment center means the emergency room of a hospital or ambulatory surgical center, or satellite emergency center of a hospital.

Employee means a person who is: (a) a citizen or resident of the United States or one of its territories; and (b) in active employment with the employer or is a member in good standing in the labor union, association or other entity named as the policyholder.

Employer means the individual, company or corporation where the employee or member is in active employment, and includes any division, subsidiary, or affiliated company named in this policy.

Family coverage means coverage that includes the insured employee or member, as defined, his or her eligible spouse or domestic partner and children.

Grace period means a period of 31 days following the premium due date during which premium payment may be made.

Hospital means a legally operated institution with established facilities (either on its premises or available to the hospital on a contractual, pre-arranged basis and under the supervision of a staff of one or more duly licensed physicians), for the care and treatment of sick and injured persons for diagnosis, surgery, and 24 hour nursing service. Hospital does not include:

1. any institution which is mainly a rest home, nursing home, convalescent home, or home for the aged; or
2. any institution which is mainly for the care and treatment of alcoholics or drug addicts, or mental or nervous disorders.

Hospital intensive care unit means a hospital area of special care, including cardiac and coronary care units, surgical intensive care units or cardiovascular intensive care units, which at the time of admission are separate and apart from the surgical recovery room, or other rooms, beds or wards normally used for patient confinement. In addition, such a unit must provide the following:

1. 24 hour continuous nursing care and attendance by nurses assigned to the unit on a full-time basis; and
2. direction and/or supervision by a full-time physician director or a standing "intensive care" committee of the medical staff; and
3. special medical apparatus used to treat the critically ill.

The following do not qualify as "Hospital intensive care units":

1. progressive care units;
2. sub-acute intensive care units;
3. intermediate care units;
4. private rooms with monitoring;
5. step-down units; or
6. any other lesser care treatment units.

GLOSSARY (Continued)

Individual and child(ren) coverage means coverage that includes only the insured employee or member, as defined, and eligible children.

Individual and spouse coverage means coverage that includes only the insured employee or member, as defined, and his or her eligible spouse or domestic partner.

Individual coverage means coverage that includes only the insured employee or member, as defined.

Initial enrollment period means one of the following periods during which the employee or member may first apply in writing for coverage under this policy:

1. if the employee or member is eligible for coverage on the policy effective date, a period before the policy effective date as set by us and the policyholder; or
2. if the employee or member becomes eligible for coverage after the policy effective date, the period ending 31 days after the date he or she is first eligible to apply for coverage.

Injury means accidental bodily injury to a covered person, as the result of an accident while coverage under this policy is in force, and the injury is the direct cause of the loss independent of disease, bodily infirmity or any other cause. All injuries sustained in any one accident and all complications and recurrences of complications are considered to be a single "injury".

Inpatient means a covered person who is a resident patient using the room and board facilities of an institution.

Insured employee or member means the employee or member accepted for coverage by us who has completed and signed the enrollment form and whose name appears on the certificate specification page.

Issue day means the same day of the month as the effective date of coverage.

Material and substantial duties mean duties that:

1. are normally required for the performance of the employee or member's regular occupation; and
2. cannot be reasonably omitted or modified, except that if the employee or member is required to work on average in excess of 40 hours per week. We will consider him or her able to perform that requirement if he/she is working or has the capacity to work 40 hours per week.

Member means a member in good standing in a labor union, association or other entity named as the policyholder and who is: (a) a citizen or resident of the United States; and (b) is (1) engaged in, or (2) able to engage in and currently seeking, active employment.

Mental or nervous disorder means a psychiatric or psychological condition regardless of cause, such as schizophrenia, depression, manic depressive or bipolar illness, anxiety, post traumatic stress disorder, personality disorders and/or adjustment disorders or other conditions. These conditions are usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs or other similar methods.

Nurse means any one of the following who is not a member of the covered person's immediate family:

1. licensed practical nurse (L.P.N.); or
2. licensed vocational nurse (L.V.N.); or
3. graduate registered nurse (R.N.).

Payable claim means a claim for which we are liable under the terms of this policy.

GLOSSARY (Continued)

Physician means:

1. a person performing tasks that are within the limits of his or her medical license; and
2. a person who is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
3. a person who is a legally qualified medical practitioner according to the laws and regulations of the state he or she practices in.

We will not recognize the insured employee or member, his or her spouse or domestic partner, children, parents, or siblings as a physician for a claim.

Policyholder means the legal entity to whom this policy is issued.

Re-enrollment period means a period of time as set by the policyholder and us during which the insured employee or member may apply, in writing, for coverage under the policy, or change coverage under the policy if currently enrolled.

Residential treatment facility means an institution which provides coordinated inpatient treatment of mental or nervous disorders or chemical dependency by trained medical personnel and counselors pursuant to a written treatment plan approved and monitored by a physician. The institution must also be affiliated with a hospital under a contractual agreement with an established system for patient referral, be accredited as a treatment facility by the Joint Commission on Accreditation of Hospitals, and licensed, certified or approved as a mental health or chemical dependency treatment program or center by any federal, state or municipal agency having legal authority to so license, certify or approve.

Sickness means an illness or disease that must begin while the covered person is insured under this policy.

Skilled nursing facility means an institution that meets all of the following standards:

1. it is licensed by the state in which it is located; and
2. it is a separate facility or a distinct part of another facility physically separated from the rest of such facility; and
3. it provides confined nursing care to individuals who are not able to care for themselves and who require nursing care; and
4. its primary function is to provide nursing care, and room and board; and the facility charges for these services. The care must be performed under the direction of a licensed physician or licensed nurse; and
5. it is not a hospital, a home for the aged, a retirement home, a rest home, a community living center, or a place mainly for the treatment of alcoholism, mental illness or drug abuse.

Surgery means manual procedures involving cutting of body tissue, debridement or permanent joining of body tissue for repair of wounds, treatment of fractured bones or dislocated joints, endoscopic procedures, and other manual procedures, when used in lieu of cutting for purposes of removal, destruction or repair of body tissue.

Temporary layoff or **leave of absence** or **family and medical leave of absence** means the insured employee or member is absent from active employment for a period of time that has been agreed to in advance in writing by the current employer.

Normal vacation time or any period of disability is not considered a temporary layoff or leave of absence.

We, us and **our** means American Heritage Life Insurance Company.

AMERICAN HERITAGE LIFE INSURANCE COMPANY

HOME OFFICE:

4920 SAN PABLO ROAD S, SUITE 200C

JACKSONVILLE, FLORIDA 32224-1844

(800) 521-3535

A Stock Company

**THIS IS A GROUP HOSPITAL INDEMNITY ONLY POLICY WHICH PROVIDES
LIMITED BENEFITS AS STATED OR OTHER BENEFITS SPECIFICALLY
DESCRIBED WITHIN THIS POLICY**

Important Privacy Policy Notice

At American Heritage Life Insurance Company (“AHL”), we value you as a customer. We also share your concerns about privacy. We are sending this notice to explain how we treat personal information (“customer information”) that is not public. This is information that we obtain from you or other sources when we provide you with products and services.

We want you to know that we respect your privacy and we protect your information.

- We do not sell customer information.
- We do not share your information with persons, companies, or organizations outside of AHL that would use that information to contact you about their products and services.
- We expect persons or organizations that provide services on our behalf to keep your information confidential. We also expect them to use your information only to provide the services we’ve asked them to perform.
- We communicate to our employees about the need to protect your information. We have established safeguards (these are physical, electronic and procedural) to protect this information.

Below are answers to questions that you might have about privacy. You may be wondering...

What do we do with your information?

AHL does not sell your customer or medical information to anyone. We do not share it with companies or organizations outside of AHL that would use that information to contact you about their own products and services. If this were to change, we would offer you the option to opt out of this type of information sharing. Also, we would obtain your consent before we share medical information for marketing purposes.

We may utilize Artificial Intelligence (AI) technologies to streamline administrative and operational processes. These technologies may collect and analyze your data to optimize our delivery of services to you. We are committed to protecting your privacy and ensuring that all AI applications comply with state and federal regulations. Your data is securely processed, and we would obtain your explicit consent for any use beyond performing services on your behalf.

Your agent or broker may use your information to help you with your insurance needs. We may also communicate with you about products, features, and options in which you have expressed an interest. Without your consent, we may provide your information to persons or organizations in and out of AHL. This would be done as permitted or required by law. We may do this to:

- Fulfill a transaction you have requested.
- Service your policy.
- Market our products to you.
- Investigate or handle claims.
- Detect or prevent fraud.
- Participate in insurance support organizations (Information from a report by an insurance support organization may be retained by that organization and distributed to other persons.).
- Comply with lawful requests from regulatory and law enforcement authorities.

These persons or organizations may include:

- Our affiliated companies.
- Companies that perform services, including marketing, on our behalf.
- Other financial institutions with which we have an agreement for the sale of financial products.
- Other insurance companies to perform their role in an insurance transaction involving you.
- Businesses that conduct actuarial or research studies.
- Persons requesting information pursuant to a subpoena or court order.
- Your agent or broker.
- An employer, if your premiums are payroll deducted.
- The creditor who sold you insurance, if your policy is credit insurance.

What kind of customer information do we have, and where did we get it?

Much of the information that we have about you comes from you. When you perform certain transactions, you may give us information such as your name, address, and Social Security Number. These transactions include when you submit: an application for insurance; a request for insurance; a request for products and services we offer; or a request for an insurance quote. We may have contacted you by telephone or mail for additional information. We keep information about the types of services you purchase from us and our affiliates. Examples of this include premiums, fund values, and payment history. We may collect information from outside sources such as consumer reporting agencies and health care providers. The information we collect may include the following:

- Motor vehicle reports.
- Credit reports.
- Medical information.

How do we protect your customer information?

We expect any company with whom we share your information to use it only to provide the service we have asked them to perform. Information about you is also available within AHL to those individuals who may need to use it to fulfill and service the needs of our customers. We communicate the need to protect your information to all employees and agents. We especially communicate this need to individuals who have access to it. Plus, we have established physical, electronic, and procedural safeguards to protect your information. Note that if your relationship with us ends, your information will remain protected. This protection will be provided according to our privacy practices outlined in this Important Notice.

How can you find out what information we have about you?

You may request to see, or obtain by mail, the information about you in our records. If you believe that our information is incomplete or inaccurate, you may request that we correct, add to, or delete from the disputed information. In order to fulfill your request, we may make arrangements to copy and disclose your information to you on our behalf. This may be done with an insurance support organization or a consumer reporting agency. You may also request a more complete description of the entities to which we disclose your information, or the conditions that might warrant such disclosures. Please send any of the requests listed above in writing to:

American Heritage Life Insurance Company
Attn: Privacy
4920 San Pablo Road South, Suite 200C
Jacksonville, FL 32224

If you are an Internet user ...

Our website, www.standard.com/ahl, provides information about AHL, our products, and the agencies and brokers that represent us. You may also perform certain transactions on the website. When accessing our website, please be sure to read the Privacy Statement that appears there as it provides information relating to your use of the website. This includes, for example:

- 1) our use of online collecting devices known as "cookies";
- 2) how we collect information such as IP address (the number assigned to your computer when you use the Internet), browser and platform types, domain names, access times, referral data, and your activity while using our site;
- 3) who should use our website;
- 4) the security of information over the Internet;
- 5) links and co-branded sites.

We hope you have found this notice helpful. If you have any questions or would like more information, please don't hesitate to contact your agent or write to us at:

American Heritage Life Insurance Company
Attn: Privacy
4920 San Pablo Road South, Suite 200C
Jacksonville, FL 32224

This notice is being provided on behalf of the following companies: American Heritage Life Insurance Company, Holiday Life Insurance Company, Kentucky Home Mutual, Acme United Insurance Company, Keystone State Life, SMA Life Assurance Company, National Guardian Life

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

EFFECTIVE APRIL 14, 2003

We are required by the privacy regulations issued under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") to maintain the privacy of our Plan's customers' Protected Health Information, to provide those customers with notice of our legal duties and privacy practices with respect to Protected Health Information, and to send notification to affected customers if there is a breach of unsecured Protected Health Information. If your state provides privacy protections that are more stringent than those provided by HIPAA, we will maintain your Protected Health Information in accordance with the more stringent state standard.

This Notice applies to "Protected Health Information" associated with "Health Plans" issued by American Heritage Life Insurance Company.

This Notice describes how we may use and disclose Protected Health Information to perform claims handling, payment, general insurance operations, and for other purposes that are permitted or required by law. Use or disclosure of your Protected Health Information for the purposes described in this Notice may be made in writing, orally, or by electronic means.

We are required to abide by the terms of this Notice. However, we may change the terms of this Notice at any time. If we change this Notice, we may make the new notice terms effective for all of your Protected Health Information that we maintain, including any information we created or received prior to issuing the new notice. If we make a material revision to our Privacy Notice, copies will be sent to you if you are then currently insured under our Plan.

Protected Health Information means any identifiable information that we obtain from you or others that relates to your past, present, or future health care and treatment or the payment for your health care and treatment.

Uses and Disclosures of Protected Health Information With Your Written Authorization

Except as described in the next section of this Notice, we will not use or disclose your Protected Health Information for any purpose unless you have signed a form authorizing the use or disclosure. For example, most uses and disclosures of psychotherapy notes, uses and disclosures of Protected Health Information for marketing purposes, and disclosures that constitute a sale of Protected Health Information will be made only with your authorization. You have the right to revoke that authorization in writing at any time, except to the extent that we have already taken action in reliance on the authorization; or the authorization was obtained as a condition of obtaining coverage, to the extent that other law allows the insurer to contest a claim under the policy or the policy itself.

Uses and Disclosures of Protected Health Information Without Your Written Authorization

For Payment. We may make use of and disclose your Protected Health Information without your written authorization as may be necessary for payment purposes. For example, we may use information regarding your medical procedures and treatment to process and pay claims or certify these services are covered under your Plan.

For Plan Administrative Operations. We may make use of and disclose your Protected Health Information without your written authorization as necessary for our Plan administrative operations. Plan administrative operations include our usual business activities, examples of which are management, licensing, peer review, quality improvement and assurance, enrollment, underwriting, reinsurance, compliance, auditing, rating, claims handling, complaint handling and other functions related to your Plan. We are prohibited from using or disclosing genetic information for underwriting purposes.

We may utilize Artificial Intelligence (AI) technologies to streamline administrative and operational processes. These technologies may collect and analyze your data to optimize our delivery of services to you. We are committed to protecting your privacy and ensuring that all AI applications comply with HIPAA regulations. Your data is securely processed, and we would obtain your explicit consent for any use beyond performing services on your behalf.

To Individuals Involved In Your Care. We may, without your written authorization, for the purposes of treatment, payment or Plan administrative operations, disclose the fact that you are covered under a Plan or that payment has been processed to a family member, other relative, your close personal friend or any other person you may identify. In these circumstances, we would not disclose any Protected Health Information which is not directly relevant to that person's involvement with your care or with payment for your care.

If you have designated a person to receive information regarding payment of premium, we may inform that person if we have not received your premium payment.

We may also disclose limited Protected Health Information to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you.

To Our Business Associates. Certain aspects and components of our services are performed through contracts with outside persons or organizations. Examples of these may include, but are not limited to, our duly appointed insurance agents, financial auditors, reinsurers, legal services, enrollment and billing services, claim payment and medical management services. We may provide access to your Protected Health Information without your written authorization to one or more of these outside persons or organizations who assist us with payment or Plan administrative operations. We require these business associates to appropriately safeguard the privacy of your information.

To Plan Sponsors. If you are enrolled in a group health plan, we may share summary health information with your employer, union, or other employee organization that sponsors and maintains the group health plan, for purposes of obtaining premium bids; or modifying, amending, or terminating the group health plan; or enrollment and disenrollment information. Summary health information excludes genetic information.

For Other Products and Services. We may contact you without your written authorization to provide information regarding Plan upgrades or additional benefits that may be of interest to you. For example, we may use the fact that you currently are insured under a Plan for the purpose of communicating to you about changes to our Plan or products that could enhance or add value to existing coverage.

For Disclosure With Authorization. Unless otherwise excluded in this notice, we will not disclose any other Protected Health Information to any person or entity not specifically mentioned elsewhere in this Notice without your express written authorization.

For Other Uses and Disclosures. We are permitted or required by law to make some other uses and disclosures of your Protected Health Information without your authorization. We may release your Protected Health Information:

- if required by law to a government authorized health oversight agency or company conducting audits, investigations, or civil or criminal proceedings.
- if required to do so by a court or administrative ordered subpoena or discovery request. In most cases you will have notice of such a release.
- for public health activities, such as required reporting of disease, injury, birth and death and for required public health investigations.
- as required by law if we suspect child abuse or neglect or if we believe you to be a victim of abuse, neglect or domestic violence.
- to the Food and Drug Administration if necessary to report adverse events, product defects or to participate in product recalls.
- to law enforcement officials as required by law to report wounds, injuries or crimes.
- to coroners, medical examiners and/or funeral directors consistent with law.

- for a national security or intelligence activity or, if you are a member of the military, as required by the armed forces.
- to workers' compensation agencies or similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

Your Rights

Right to Inspect and Copy Your Protected Health Information. You may have access to our records that contain your Protected Health Information in order to inspect and obtain copies of the records. Under limited circumstances, we may deny you access to a portion of your records. If you desire access to your records, please call us or send your request in writing using the telephone number and address listed in the "Contact Information" section at the end of this Notice. If you request copies, we may charge you copying and mailing costs. If you request a copy of your Protected Health Information in electronic form, we will provide it to you electronically only if the record is readily producible in electronic form.

Right to Amend Your Protected Health Information. You have the right to request that we amend your Protected Health Information maintained in our enrollment, payment, claims adjudication and case or medical management records, or other records we use to make decisions about you. If you desire to amend these records, please send your request in writing to the address listed in the "Contact Information" section at the end of this Notice. We will comply with your request unless special circumstances apply. If your physician or other health care provider created the information that you desire to amend, you should contact the provider to amend the information.

Right to an Accounting of the Disclosures of Your Protected Health Information. Upon request, you may obtain an accounting of certain disclosures of your Protected Health Information made by us on or after April 14, 2003, excluding disclosures made earlier than six years before the date of your request. If you request an accounting more than once during any 12-month period, we will charge you a reasonable fee for the subsequent accounting statements.

Right to Request Confidential Communications. We will accommodate your reasonable request to receive communications of your Protected Health Information from us by alternative means of communication or at alternative locations if the request clearly states that disclosure of that information could endanger you.

Right to Request Restrictions on Use and Disclosure of Your Protected Health Information. You have the right to request restrictions on some of our uses and disclosures of your Protected Health Information to family members and others involved in your care or payment for care; or some of our uses and disclosures used to carry out treatment, payment, or Plan administrative operations, by notifying us of your request for a restriction in writing mailed to the contact identified at the end of this Notice. Your request must describe in detail the restriction you are requesting. We are not required to agree to your restriction request but will attempt to accommodate your requests. We retain the right to terminate an agreed-to restriction. In the event of a termination of an agreed-to restriction by us, we will notify you of such termination, but the termination will only be effective for Protected Health Information we receive after we have notified you of the termination. You also have the right to terminate any agreed-to restriction by contacting us using the "Contact Information" provided at the end of this Notice.

Personal Representatives. You may exercise your rights through a personal representative who will be required to produce evidence of his or her authority to act on your behalf. Proof of authority may be made by a notarized power of attorney, a court order of appointment of the person as your legal guardian or conservator, or if you are the parent of a minor child. We reserve the right to deny access to your personal representative.

Right to Receive Paper Copy of this Notice. You may obtain a copy of this Notice. You may obtain a paper copy of this Notice even if you agreed to receive such notice electronically. Please contact us and we will mail it to you.

Complaints

If you believe your privacy rights have been violated, you can file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with the Plan, send it in writing to the address listed in the "Contact Information" section at the end of this Notice. There will be no retaliation for filing a complaint.

You may obtain a copy of this Notice by writing to us at the contact address below.

Contact Information

If you have questions or need further assistance regarding this Notice, you may contact:

American Heritage Life Insurance Company
Attn: HIPAA Privacy Officer
4920 San Pablo Road South, Suite 200C
Jacksonville, Florida 32224

Or, you may telephone the Customer Care Center at 1-800-521-3535.

**SUMMARY OF THE LOUISIANA LIFE AND HEALTH
INSURANCE GUARANTY ASSOCIATION LAW AND
NOTICE CONCERNING COVERAGE
LIMITATIONS AND EXCLUSIONS**

Residents of Louisiana who purchase life insurance, annuities, or health insurance should know that the insurance companies licensed in this state to write these types of insurance are required by law to be members of the Louisiana Life and Health Insurance Guaranty Association (LLHIGA). The purpose of LLHIGA 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 happens, LLHIGA 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. However, the valuable extra protection provided by these insurers through LLHIGA is limited. As noted in the disclaimer below, this protection is not a substitute for consumers' care in selecting companies that are well managed and financially stable.

DISCLAIMER

The Louisiana Life and Health Insurance Guaranty Association provides coverage of claims under some types of policies if the insurer becomes impaired or insolvent. COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY. Even if coverage is provided, there are significant limits and exclusions. Coverage is generally conditioned upon residence in this state. Other conditions may also preclude coverage.

Insurance companies and insurance agents are prohibited by law from using the existence of the association or its coverage to sell you an insurance policy.

You should not rely on the availability of coverage under the Louisiana Life and Health Insurance Guaranty Association when selecting an insurer.

The Louisiana Life and Health Insurance Guaranty Association or the Department of Insurance will respond to any questions you may have which are not answered by this document.

**LLHIGA
P.O. Box 3337
Baton Rouge, LA 70821**

**Department of Insurance
P.O. Box 94214
Baton Rouge, LA 70804-9214**

The state law that provides for this safety-net coverage is called the Louisiana Life and Health Insurance Guaranty Association Law (the Law), and is set forth at R.S. 22:2081 et seq. The following 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 any person's rights or obligations under the Law or the rights or obligations of LLHIGA.

COVERAGE

Generally, individuals will be protected by the Life and Health Insurance Guaranty Association if they live in this state and hold a covered life, health, or annuity policy, plan or contract, issued by an insurer (including a health maintenance organization) authorized to conduct business in Louisiana. The beneficiaries, payees or assignees of insured persons may also be protected as well, even if they live in another state unless they are afforded coverage by the guaranty association of another state, or other circumstances described under the Law are applicable.

LAGA
EXCLUSIONS FROM COVERAGE

(over)

(3/19)

A person who holds a covered life, health, or annuity policy, plan or contract is not protected by LLHIGA if:

- (1) He is 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);
- (2) The insurer was not authorized to do business in this state;
- (3) His policy was issued by a profit or nonprofit hospital or medical service organization, 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, an insurance exchange, an organization that issues charitable gift annuities as is defined in R.S. 22:952(A)(3), or any entity similar to any of these.

LLHIGA also does not provide coverage for:

- (1) 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;
- (2) Any policy of reinsurance (unless an assumption certificate was issued);
- (3) Interest rate or crediting rate yields, or similar factors employed in calculating changes in value, that exceed an average rate;
- (4) Dividends, premium refunds, or similar fees or allowances described under the Law;
- (5) Credits given in connection with the administration of a policy by a group contract holder;
- (6) Employers', associations' or similar entities' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them) or uninsured;
- (7) Unallocated annuity contracts (which give rights to group contract holders, not individuals), except unallocated annuity contracts and defined contribution government plans qualified under section 403(b) of the United States *Internal Revenue Code* (26 U.S.C. §403(b));
- (8) An obligation that does not arise under the express written terms of the policy or contract issued by the insurer to the policy owner or contract owner, including but not limited to, claims described under the Law;
- (9) A policy or contract providing any hospital, medical, prescription drug or other health care benefits pursuant to "Medicare Part A coverage", "Medicare Part B coverage", "Medicare Part C coverage", "Medicare Part D coverage" or "Medicaid" and any regulation issued pursuant to those parts;
- (10) Interest or other changes in value to be determined by the use of an index or other external references but which have not been credited to the policy or contract or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired or insolvent insurer, whichever is earlier.

LIMITS ON AMOUNT OF COVERAGE

The Louisiana Life and Health Insurance Guaranty Association Law also limits the amount that LLHIGA is obligated to pay out. The benefits for which LLHIGA may become liable shall in no event exceed the lesser of the following:

- (1) LLHIGA cannot pay more than what the insurance company would owe under a policy or contract if it were not an impaired to an insolvent insurer.
- (2) For any one insured life, regardless of the number of policies or contracts there are with the same company, LLHIGA will pay a maximum of \$300,000 in life insurance death benefits, but not more than \$100,000 in net cash surrender and net cash withdrawal values for life insurance.
- (3) For any one insured life, regardless of the number of policies or contracts there are with the same company, LLHIGA will pay a maximum of \$500,000 in health insurance benefits, and LLHIGA will pay a maximum of \$250,000 in present value of annuities, including net cash surrender and net cash withdrawal values.

In no event, regardless of the number of policies and contracts there were with the same company, and no matter how many different types of coverage, LLHIGA shall not be liable to expend more than \$500,000 in the aggregate with respect to any one individual.

AMERICAN HERITAGE LIFE INSURANCE COMPANY

4920 San Pablo Road S, Suite 200C, Jacksonville, FL 32224-1844

NOTICE OF NON-INSURANCE VALUE-ADDED PRODUCTS OR SERVICES

American Heritage Life Insurance Company (“we,” “us,” “our”) may arrange for third party vendors to offer or provide value-added products or services to eligible covered persons insured with us at no or reduced cost.

The value-added products or services offered or provided are:

- Not specified in the policy or certificate;
- Related to the insurance coverage; and
- Primarily designed to satisfy one or more of the following:
 - Provide loss mitigation or loss control;
 - Reduce claim costs or claim settlement costs;
 - Provide education about liability risks or risk of loss to persons or property;
 - Monitor or assess risk, identify sources of risk, or develop strategies for eliminating or reducing risk;
 - Enhance health;
 - Enhance financial wellness through items such as education or financial planning services;
 - Provide post-loss services;
 - Incent behavioral changes to improve the health or reduce the risk of death or disability of a policyholder, potential policyholder, certificate holder, potential certificate holder, insured, potential insured, or applicant; or
 - Assist in the administration of the employee or retiree benefit insurance coverage.

The cost for the value-added products or services may be either billed directly to you or remitted to us by the policyholder, as agreed to by the policyholder.

Third party vendors are solely liable for providing the value-added products or services. We will not be responsible for third party vendors providing or failing to provide the value-added products or services to eligible covered persons. We will not be liable to eligible covered persons for the negligent provision of the value-added products or services by third party vendors.

The value-added products or services may automatically terminate with the policy or certificate. We reserve the right to terminate, modify, or replace any value-added products or services at any time with 31 days' advance written notice to the policyholder.