ATTACHMENT D

UNUM 100% VOLUNTARY LONG TERM DISABILITY INSURANCE

Additional Long Term DI Details

Policy Inception Date: April 1, 2017

Rate History:

	2025	2024	2023	2022	2021
Base	$0.567	$0.567	$0.567	$0.567	$0.567
Buy Up	$0.999	$0.999	$0.999	$0.999	$0.999

Tech Subsidy/Implementation Credit: None

Commissions: Flat 12% paid to ben admin Amerilife

Plan Changes: None since inception

City of Baton Rouge Parish of East Baton Rouge

Your Group Long Term Disability Plan

Policy No. 471105 011

Underwritten by Unum Life Insurance Company of America

3/29/2017

CERTIFICATE OF COVERAGE

Unum Life Insurance Company of America (referred to as Unum) welcomes you as a client.

This is your certificate of coverage as long as you are eligible for coverage and you become insured. You will want to read it carefully and keep it in a safe place.

Unum has written your certificate of coverage in plain English. However, a few terms and provisions are written as required by insurance law. If you have any questions about any of the terms and provisions, please consult Unum's claims paying office. Unum will assist you in any way to help you understand your benefits.

If the terms and provisions of the certificate of coverage (issued to you) are different from the policy (issued to the policyholder), the policy will govern. If a provision conflicts with state law on the effective date of the policy, the provision will be administered according to the law. Your coverage may be cancelled or changed in whole or in part under the terms and provisions of the policy.

The 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 any amendments.

For purposes of effective dates and ending dates under the group policy, all days begin at 12:01 a.m. and end at 12:00 midnight at the Policyholder's address.

Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122

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BENEFITS AT A GLANCE

LONG TERM DISABILITY PLAN

This long term disability plan provides financial protection for you by paying a portion of your income while you are disabled. In some cases, you can receive disability payments even if you work while you are disabled.

EMPLOYER'S ORIGINAL PLAN EFFECTIVE DATE: April 1, 2017

POLICY NUMBER: 471105 011

ELIGIBLE GROUP(S):

All full-time employees in active employment in the United States with the Employer

MINIMUM HOURS REQUIREMENT:

Employees must be in active employment at least 30 hours per week.

WAITING PERIOD:

For employees in an eligible group on or before April 1, 2017: First of the month coincident with or next following the date you enter an eligible group

For employees entering an eligible group after April 1, 2017: First of the month coincident with or next following the date you enter an eligible group

Employees are not eligible for coverage until the waiting period has been completed. You must be in continuous active employment in an eligible group during the specified waiting period.

ENROLLMENT:

Employees who are eligible may apply for and change their coverage at any time within the first 31 days of being eligible.

After 31 days, employees who are eligible may apply for and change their coverage during any scheduled enrollment period or within 31 days of a change in status.

You may decrease or cancel any coverage for which you make contributions at any time.

EVIDENCE OF INSURABILITY:

Evidence of insurability is required:

- for any amount of coverage applied for more than 31 days after you are first eligible for coverage.
- if you reapply for coverage after it terminates.

However, once your coverage is effective, evidence of insurability is not required for an increase in coverage made during a scheduled enrollment period or within 31 days of a change in status.

WHO PAYS FOR THE COVERAGE:

You must make contributions for your coverage.

No premium contributions are required for your coverage while you are receiving benefit payments under this plan.

ELIMINATION PERIOD:

180 days

Benefits begin the day after the elimination period is completed.

MONTHLY BENEFIT:

Choice 1

50% of monthly earnings to a maximum benefit of $6,000 per month.

Your payment may be reduced by deductible sources of income and disability earnings. Some disabilities may not be covered or may have limited coverage under this plan.

Choice 2

60% of monthly earnings to a maximum benefit of $6,000 per month.

Your payment may be reduced by deductible sources of income and disability earnings. Some disabilities may not be covered or may have limited coverage under this plan.

MINIMUM MONTHLY BENEFIT:

The greater of:

- $100; or
- 10% of your gross disability payment.

MAXIMUM PERIOD OF PAYMENT:

Age at Disability	Maximum Period of Payment To Social Security Normal Retirement Age
Less than Age 62	
Age 62	60 months
Age 63	48 months
Age 64	42 months
Age 65	36 months
Age 66	30 months
Age 67	24 months
Age 68	18 months
Age 69 or older	12 months

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

OTHER FEATURES:

Dependent Care Expense Benefit

Pre-Existing: 3/12

Rehabilitation and Return to Work Assistance Benefit

Survivor Benefit

Work Life Assistance Program

The above items are only highlights of this plan. For a full description of your coverage, continue reading your certificate of coverage and if you make contributions to the plan, refer to your confirmation of coverage. The plan includes enrollment, risk management and other support services related to your Employer's benefit program.

CLAIM INFORMATION

LONG TERM DISABILITY

WHEN DO YOU NOTIFY UNUM OF A CLAIM?

We encourage you to notify us of your claim as soon as possible so that a claim decision can be made in a timely manner. Notice of claim should be sent within 30 days after the date your disability begins. In addition, you must send Unum proof of your claim no later than one year after the date your disability begins unless your failure to do so is due to your lack of legal capacity. In no event can proof of your claim be submitted after the expiration of the time limit for commencing a legal proceeding as stated in this policy, even if your failure to provide proof of claim is due to a lack of legal capacity or if state law provides an exception to the one year time period.

You must notify us immediately when you return to work in any capacity.

HOW DO YOU FILE PROOF OF CLAIM?

You and your Employer must fill out your own sections of the claim form and then give it to your attending physician. Your physician should fill out his or her section of the form and send it directly to Unum.

The form to use to submit your proof of claim is available from your Employer, or you can request the form from us. If you do not receive the form from Unum or your Employer within 15 days of your request, send Unum proof of claim without waiting for the form.

WHAT INFORMATION IS NEEDED AS PROOF OF YOUR CLAIM?

Proof of your claim, provided at your expense, must show:

- the date your disability began;
- the existence and cause of your sickness or injury;
- that your sickness or injury causes you to have limitations on your functioning and restrictions on your activities preventing you from performing the material and substantial duties of your regular occupation or of any other gainful occupation for which you are reasonably fitted by education, training, or experience;
- that you are under the **regular care** of a **physician**;
- the name and address of any **hospital or institution** where you received treatment, including all attending physicians; and
- the appropriate documentation of your monthly earnings, any disability earnings, and any deductible sources of income.

In some cases, you will be required to give Unum authorization to obtain additional medical information, to provide non-medical information and to be examined as often as is reasonably required as part of your proof of claim, or proof of continuing disability. We may also require that you send us appropriate financial records, which may include income tax returns, which we believe are necessary to substantiate your income. We may request that you send periodic proof of your claim. This proof, provided at your expense, must be received within 45 days of a request by us. Unum will deny your claim, or stop sending your payments, if the appropriate information is not submitted.

We may require you to be examined by a physician, other medical practitioner and/or vocational expert of our choice. Unum will pay for this examination. We can require an examination as often as it is reasonable to do so. We may also require you to meet with and be interviewed by an authorized Unum Representative. Unum will deny your claim, or stop sending your payments, if you fail to comply with our requests.

Time limits for giving notice of a claim, providing proof of loss or bringing any action on the policy will not be less than that allowed under the law.

TO WHOM WILL UNUM MAKE PAYMENTS?

Unum will make payments to you.

WHAT HAPPENS IF UNUM OVERPAYS YOUR CLAIM?

Unum has the right to recover any overpayments due to:

- fraud;
- any error Unum makes in processing a claim;
- disability earnings; or
- deductible sources of income.

You must reimburse us in full. We will determine the method by which the repayment is to be made which may include reducing or withholding future payments including the minimum monthly payment.

Unum will not recover more money than the amount we paid you.

Any unpaid premium due for your coverage under this policy may be recovered by us by offsetting against amounts otherwise payable to you under this policy, or by other legally permitted means.

GENERAL PROVISIONS

WHAT IS THE CERTIFICATE OF COVERAGE?

This certificate of coverage is a written statement prepared by Unum and may include attachments. It tells you:

- the coverage for which you may be entitled;
- to whom Unum will make a payment; and
- the limitations, exclusions and requirements that apply within a plan.

WHEN ARE YOU ELIGIBLE FOR COVERAGE?

If you are working for your Employer in an eligible group, the date you are eligible for coverage is the later of:

- the plan effective date; or
- the day after you complete your **waiting period**.

WHAT COVERAGE CHOICES DOES THE PLAN PROVIDE?

If the plan provides additional coverage choices for you to select from, you may apply for these other choices. Refer to the **BENEFITS AT A GLANCE** section and the **BENEFIT INFORMATION** section for the additional coverage choices, if any.

WHEN DOES YOUR COVERAGE BEGIN?

Your coverage will begin at 12:01 a.m. on the first of the month coincident with or next following the latest of:

- the date you are eligible for coverage;
- the date you apply for coverage; or
- the date Unum approves your application, if **evidence of insurability** is required.

WHEN CAN YOU APPLY FOR COVERAGE IF YOU DID NOT APPLY OR DECLINED WHEN YOU WERE FIRST ELIGIBLE FOR COVERAGE OR YOU VOLUNTARILY CANCELLED YOUR COVERAGE?

You can apply for coverage only during a **scheduled enrollment period** or within 31 days of a **change in status**. Evidence of insurability is required. Unum and your Employer determine when the scheduled enrollment period begins and ends. Your coverage will begin at 12:01 a.m. on the first of the month coincident with or next following the date Unum approves your application.

An evidence of insurability form can be obtained from your Employer.

HOW CAN YOU CHANGE YOUR COVERAGE?

You can change your coverage choices, if any, at the time specified in the **BENEFITS AT A GLANCE** section. Changes in coverage may require evidence of insurability as stated in the **BENEFITS AT A GLANCE** section.

You may choose to:

- increase your coverage up to the maximum monthly benefit available under the plan;
- decrease your coverage provided it is not less than an amount available on the plan; or
- choose not to participate in the plan.

If you end employment and are rehired within the same plan year, you may be insured on your eligibility date for coverage that you had under the plan when you ended employment. You cannot change your coverage until the next scheduled enrollment period or change in status.

WHEN DO CHANGES IN YOUR COVERAGE TAKE EFFECT?

A change in coverage that is made during a scheduled enrollment period will begin at 12:01 a.m. on the later of:

- the first of the month coincident with or next following the scheduled enrollment period; or
- the first of the month coincident with or next following the date Unum approves your application, if evidence of insurability is required.

Once your coverage begins, any decrease in coverage you make at other than a scheduled enrollment will take effect on the first of the month coincident with or next following the date the change is reported to us by your Employer or, if later the first of the month coincident with or next following the date specified by your Employer.

Any decrease in coverage will not affect a payable claim that occurs prior to the decrease.

If you are not in active employment due to injury or sickness, or if you are on a covered leave of absence any increased or additional coverage will begin on the date you return to active employment.

A change in coverage due to a **change in status** will begin at 12:01 a.m. on the first of the month coincident with or next following the latest of:

- the date of the change in status, if you apply on or before that date;
- the date you apply, if you apply within 31 days after the date of the change in status; or
- the date Unum approves your application, if evidence of insurability is required.

Changes in coverage must be consistent with the change in status.

WHAT IF YOU ARE ABSENT FROM WORK ON THE DATE YOUR COVERAGE WOULD NORMALLY BEGIN?

If you are absent from work due to injury, sickness or leave of absence, your coverage will begin on the first of the month coincident with or next following the date you return to **active employment**.

ONCE YOUR COVERAGE BEGINS, WHAT HAPPENS IF YOU ARE TEMPORARILY NOT WORKING?

If you are on a **leave of absence**, other than a family and medical leave, and if premium is paid, you will be covered through the end of the month following 60 days from the date your leave of absence begins.

WHAT HAPPENS TO YOUR COVERAGE UNDER THIS POLICY WHILE YOU ARE ON A FAMILY AND MEDICAL LEAVE OF ABSENCE?

We will continue your coverage in accordance with your Employer's Human Resource policy on family and medical leaves of absence if premium payments continue and your Employer has approved your leave in writing.

Your coverage will be continued until the end of the later of:

1. the leave period required by the federal Family and Medical Leave Act of 1993 and any amendments; or
2. the leave period required by applicable state law.

If your Employer's Human Resource policy doesn't provide for continuation of your coverage during a family and medical leave of absence, your coverage will be reinstated when you return to active employment.

We will not:

- apply a new waiting period;
- apply a new pre-existing condition exclusion; or
- require evidence of insurability.

WHEN WILL CHANGES MADE BY YOUR EMPLOYER TAKE EFFECT?

Once your coverage begins, any change requested by your Employer will take effect on the first of the month coincident with or next following the date the change occurs if you are in active employment.

If you are not in active employment due to injury or sickness, or if you are on a covered leave of absence, any change requested by your Employer will begin on the first of the month coincident with or next following the date you return to active employment.

Any decrease in coverage will take effect immediately but will not affect a **payable claim** that occurs prior to the effective date of the change.

WHEN DOES YOUR COVERAGE END?

If you choose to cancel your coverage under the policy or a plan, your coverage ends on the first of the month following the date you provide notification to your Employer.

Otherwise, your coverage under the policy or a plan ends on the earliest of the following:

- the date the policy or a plan is cancelled;

- the date you no longer are in an eligible group;
- the date your eligible group is no longer covered;
- the last day of the period for which you made any required contributions; or
- the last day you are in active employment.

However, as long as premium is paid as required, coverage will continue:

- while benefits are being paid;
- while you are fulfilling the requirements of your elimination period; or
- in accordance with the leave of absence provision of this policy or plan.

Unum will provide coverage for a payable claim which occurs while you are covered under the policy or plan.

WHAT ARE THE TIME LIMITS FOR LEGAL PROCEEDINGS?

You can start legal action regarding your claim 60 days after proof of claim has been given and up to 3 years from the later of when original proof of your claim was first required to have been given; or your claim was denied; or your benefits were terminated, unless otherwise provided under federal law.

HOW CAN STATEMENTS MADE IN YOUR APPLICATION FOR THIS COVERAGE BE USED?

Unum considers any statements you make in a signed application for coverage or evidence of insurability form, or that your Employer makes in the application process, a representation and not a warranty. If any of the statements you or your Employer make are not complete and/or not true at the time they are made, we can:

- reduce or deny any claim; or
- cancel your coverage from the original effective date.

Except for misstatement of age, as a basis for doing this, we will use only statements made by the Employer in the application process or statements made by you in a signed application or evidence of insurability form. These statements cannot be used to reduce or deny coverage if your coverage has been in force for at least 3 years.

However, if the Employer gives us information about you that is incorrect, we will:

- use the facts to decide whether you have coverage under the plan and in what amounts; and
- make a fair adjustment of the premium.

HOW MAY UNUM COMMUNICATE WITH YOU OR YOUR EMPLOYER?

Unum may provide notices, information and other communications to you or your Employer in written, electronic or telephonic form.

HOW WILL UNUM HANDLE INSURANCE FRAUD?

Unum wants to ensure you and your Employer do not incur additional insurance costs as a result of the undermining effects of insurance fraud. Unum promises to

focus on all means necessary to support fraud detection, investigation, and prosecution.

It is a crime if you knowingly, and with intent to injure, defraud or deceive Unum, or provide any information, including filing a claim, that contains any false, incomplete or misleading information. These actions, as well as submission of materially false information, will result in denial of your claim, and are subject to prosecution and punishment to the full extent under state and/or federal law. Unum will pursue all appropriate legal remedies in the event of insurance fraud.

DOES THE POLICY REPLACE OR AFFECT ANY WORKERS' COMPENSATION OR STATE DISABILITY INSURANCE?

The policy does not replace or affect the requirements for coverage by any workers' compensation or state disability insurance.

DOES YOUR EMPLOYER ACT AS YOUR AGENT OR UNUM'S AGENT?

For purposes of the policy, your Employer acts on its own behalf or as your agent. Under no circumstances will your Employer be deemed the agent of Unum.

LONG TERM DISABILITY

BENEFIT INFORMATION

HOW DOES UNUM DEFINE DISABILITY?

You are disabled when Unum determines that:

- you are **limited** from performing the **material and substantial duties** of your **regular occupation** due to your **sickness** or **injury**; and
- you have a 20% or more loss in your **indexed monthly earnings** due to the same sickness or injury.

After 24 months of payments, you are disabled when Unum determines that due to the same sickness or injury, you are unable to perform the duties of any **gainful occupation** for which you are reasonably fitted by education, training or experience.

You must be under the regular care of a physician in order to be considered disabled.

The loss of a professional or occupational license or certification does not, in itself, constitute disability.

HOW LONG MUST YOU BE DISABLED BEFORE YOU ARE ELIGIBLE TO RECEIVE BENEFITS?

You must be continuously disabled through your **elimination period**. Unum will treat your disability as continuous if your disability stops for 30 days or less during the elimination period. The days that you are not disabled will not count toward your elimination period.

Your elimination period is 180 days.

You are not required to have a 20% or more loss in your indexed monthly earnings due to the same injury or sickness to be considered disabled during the elimination period.

CAN YOU SATISFY YOUR ELIMINATION PERIOD IF YOU ARE WORKING?

Yes. If you are working while you are disabled, the days you are disabled will count toward your elimination period.

WHEN WILL YOU BEGIN TO RECEIVE PAYMENTS?

You will begin to receive payments when we approve your claim, providing the elimination period has been met and you are disabled. We will send you a payment monthly for any period for which Unum is liable.

HOW MUCH WILL UNUM PAY YOU IF YOU ARE DISABLED?

We will follow this process to figure your payment:

CHOICE 1

1. Multiply your monthly earnings by 50%.
2. The maximum **monthly benefit** is $6,000.
3. Compare the answer from Item 1 with the maximum monthly benefit. The lesser of these two amounts is your **gross disability payment.**
4. Subtract from your gross disability payment any **deductible sources of income.**

The amount figured in Item 4 is your **monthly payment.**

Your monthly payment may be reduced based on your disability earnings.

If, at any time after the elimination period, you are disabled for less than 1 month, we will send you 1/30 of your monthly payment for each day of disability and 1/30 of any additional benefits for each day of disability.

CHOICE 2

1. Multiply your monthly earnings by 60%.
2. The maximum **monthly benefit** is $6,000.
3. Compare the answer from Item 1 with the maximum monthly benefit. The lesser of these two amounts is your **gross disability payment.**
4. Subtract from your gross disability payment any **deductible sources of income.**

The amount figured in Item 4 is your **monthly payment.**

Your monthly payment may be reduced based on your disability earnings.

If, at any time after the elimination period, you are disabled for less than 1 month, we will send you 1/30 of your monthly payment for each day of disability and 1/30 of any additional benefits for each day of disability.

WILL UNUM EVER PAY MORE THAN 100% OF MONTHLY EARNINGS?

The total benefit payable to you on a monthly basis (including all benefits provided under this plan) will not exceed 100% of your monthly earnings. However, if you are participating in Unum's Rehabilitation and Return to Work Assistance program, the total benefit payable to you on a monthly basis (including all benefits provided under this plan) will not exceed 110% of your monthly earnings.

WHAT ARE YOUR MONTHLY EARNINGS?

"Monthly Earnings" means your average gross monthly income as figured:

a. from the income box on your W-2 form which reflects wages, tips and other compensation received from your Employer for the calendar year just prior to your date of disability; or

b. for the period of your employment with your Employer if you did not receive a W-2 form prior to your date of disability.

Average gross monthly income is your total income before taxes. It is prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It does not include income received

from car, housing or moving allowances, Employer contributions to a qualified deferred compensation plan, or income received from sources other than your Employer.

WHAT WILL WE USE FOR MONTHLY EARNINGS IF YOU BECOME DISABLED DURING A COVERED LEAVE OF ABSENCE?

If you become disabled while you are on a covered leave of absence, we will use your monthly earnings from your Employer in effect just prior to the date your absence begins.

HOW MUCH WILL UNUM PAY YOU IF YOU ARE DISABLED AND WORKING?

We will send you the monthly payment if you are disabled and your monthly **disability earnings**, if any, are less than 20% of your indexed monthly earnings, due to the same sickness or injury.

If you are disabled and your monthly disability earnings are from 20% through 80% of your indexed monthly earnings, due to the same sickness or injury, Unum will figure your payment as follows:

During the first 12 months of payments, while working, your monthly payment will not be reduced as long as disability earnings plus the gross disability payment does not exceed 100% of indexed monthly earnings.

1. Add your monthly disability earnings to your gross disability payment.
2. Compare the answer in Item 1 to your indexed monthly earnings.

If the answer from Item 1 is less than or equal to 100% of your indexed monthly earnings, Unum will not further reduce your monthly payment.

If the answer from Item 1 is more than 100% of your indexed monthly earnings, Unum will subtract the amount over 100% from your monthly payment.

After 12 months of payments, while working, you will receive payments based on the percentage of income you are losing due to your disability.

1. Subtract your disability earnings from your indexed monthly earnings.
2. Divide the answer in Item 1 by your indexed monthly earnings. This is your percentage of lost earnings.
3. Multiply your monthly payment by the answer in Item 2.

This is the amount Unum will pay you each month.

As part of your proof of disability earnings, we can require that you send us appropriate financial records, which may include income tax returns, which we believe are necessary to substantiate your income.

After the elimination period, if you are disabled for less than 1 month, we will send you 1/30 of your payment for each day of disability.

HOW DO WE PROTECT YOU IF YOUR DISABILITY EARNINGS FLUCTUATE?

If your disability earnings have fluctuated from month to month, Unum may determine your benefit eligibility based on the average of your disability earnings over the most recent 3 months.

WHAT ARE DEDUCTIBLE SOURCES OF INCOME?

Unum will subtract from your gross disability payment the following deductible sources of income:

1. The amount that you receive or are entitled to receive under:

   - a workers' compensation law.
   - an occupational disease law.
   - any other **act** or **law** with similar intent.

2. The amount that you receive or are entitled to receive as disability income or disability retirement payments under any:

   - state compulsory benefit **act** or **law**.
   - group plan sponsored by your Employer.
   - other group insurance plan.
   - **governmental retirement system**.

3. The amount that you, your spouse and your children receive or are entitled to receive as disability payments because of your disability under:

   - the United States Social Security Act.
   - the Canada Pension **Plan**.
   - the Quebec Pension Plan.
   - any similar plan or act.

4. The amount that you receive as retirement payments or the amount your spouse and children receive as retirement payments because you are receiving retirement payments under:

   - the United States Social Security Act.
   - the Canada Pension Plan.
   - the Quebec Pension Plan.
   - any similar plan or act.

5. The amount that you receive as retirement payments under any governmental retirement system. Retirement payments do not include payments made at the later of age 62 or normal retirement age under your Employer's retirement plan which are attributable to contributions you made on a post tax basis to the system.

   Regardless of how retirement payments are distributed, Unum will consider payments attributable to your post tax contributions to be distributed throughout your lifetime.

   Amounts received do not include amounts rolled over or transferred to any eligible retirement plan. Unum will use the definition of eligible retirement plan as

defined in Section 402 of the Internal Revenue Code including any future amendments which affect the definition.

6. The amount that you:

   - receive as disability payments under your Employer's **retirement plan.**
   - voluntarily elect to receive as retirement payments under your Employer's retirement plan.
   - receive as retirement payments when you reach the later of age 62 or normal retirement age, as defined in your Employer's retirement plan.

   Disability payments under a retirement plan will be those benefits which are paid due to disability and do not reduce the retirement benefit which would have been paid if the disability had not occurred.

   Retirement payments will be those benefits which are based on your **Employer's contribution** to the retirement plan. Disability benefits which reduce the retirement benefit under the plan will also be considered as a retirement benefit.

   Regardless of how the retirement funds from the retirement plan are distributed, Unum will consider your and your Employer's contributions to be distributed simultaneously throughout your lifetime.

   Amounts received do not include amounts rolled over or transferred to any eligible retirement plan. Unum will use the definition of eligible retirement plan as defined in Section 402 of the Internal Revenue Code including any future amendments which affect the definition.

7. The amount that you receive under Title 46, United States Code Section 688 (The Jones Act).

With the exception of retirement payments, Unum will only subtract deductible sources of income which are payable for the same period of disability for which we are paying benefits.

We will not reduce your payment by your Social Security retirement income if your disability begins after age 65 and you were already receiving Social Security retirement payments.

WHAT ARE NOT DEDUCTIBLE SOURCES OF INCOME?

Unum will not subtract from your gross disability payment income you receive from, but not limited to, the following:

- 401(k) plans
- profit sharing plans
- thrift plans
- tax sheltered annuities
- stock ownership plans
- non-qualified plans of deferred compensation
- pension plans for partners
- military pension and disability income plans
- credit disability insurance
- franchise disability income plans

- a retirement plan from another Employer
- individual retirement accounts (IRA)
- individual disability income plans
- no fault motor vehicle plans
- **salary continuation** or **accumulated sick leave** plans, except disability income payments you receive under a group plan sponsored by your Employer

WHAT IF SUBTRACTING DEDUCTIBLE SOURCES OF INCOME RESULTS IN A ZERO BENEFIT? (Minimum Benefit)

The minimum monthly payment is the greater of:

- $100; or
- 10% of your gross disability payment.

Unum may apply this amount toward an outstanding overpayment.

WHAT HAPPENS WHEN YOU RECEIVE A COST OF LIVING INCREASE FROM DEDUCTIBLE SOURCES OF INCOME?

Once Unum has subtracted any deductible source of income from your gross disability payment, Unum will not further reduce your payment due to a cost of living increase from that source.

WHAT IF UNUM DETERMINES YOU MAY QUALIFY FOR DEDUCTIBLE INCOME BENEFITS?

When we determine that you may qualify for benefits under Item(s) 1, 2 and 3 in the deductible sources of income section, we will estimate your entitlement to these benefits and your Long Term Disability payment will be reduced by these estimated amounts if such benefits:

- have not been awarded; and
- have not been denied; or
- have been denied and the denial is being appealed.

Your Long Term Disability payment will NOT be reduced by the estimated amount if you:

- apply for the disability payments under Item(s) 1, 2 and 3 in the deductible sources of income section, and if denied, appeal to all administrative levels Unum feels are necessary;
- provide documentation of your application and/or appeal; and
- sign Unum's payment option form. This form states that you promise to pay us any overpayment caused by an award.

If your payment has been reduced by an estimated amount, your payment will be adjusted when we receive proof:

- of the amount awarded; or
- that benefits have been denied and all appeals Unum feels are necessary have been completed. In this case, a lump sum refund of the estimated amount will be made to you.

If you receive a lump sum payment from any deductible sources of income, the lump sum will be pro-rated on a monthly basis over the time period for which the sum was given. If no time period is stated, we will use a reasonable one.

HOW LONG WILL UNUM CONTINUE TO SEND YOU PAYMENTS?

Unum will send you a payment each month up to the **maximum period of payment**. Your maximum period of payment is based on your age at disability as follows:

Age at Disability	Maximum Period of Payment
Less than Age 62	To Social Security Normal Retirement Age
Age 62	60 months
Age 63	48 months
Age 64	42 months
Age 65	36 months
Age 66	30 months
Age 67	24 months
Age 68	18 months
Age 69 or older	12 months

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

WHEN WILL PAYMENTS STOP?

We will stop sending you payments and your claim will end on the earliest of the following:

- during the first 24 months of payments, when you are able to work in your regular occupation on a **part-time basis** and you do not;
- after 24 months of payments, when you are able to work in any gainful occupation on a part-time basis and you do not;
- if you are working and your monthly disability earnings exceed 80% of your indexed monthly earnings, the date your earnings exceed 80%;
- the end of the maximum period of payment;
- the date you are no longer disabled under the terms of the plan, unless you are eligible to receive benefits under Unum's Rehabilitation and Return to Work Assistance program;
- the date you fail to submit proof of continuing disability;

- after 12 months of payments if you are considered to reside outside the United States or Canada. You will be considered to reside outside these countries when you have been outside the United States or Canada for a total period of 6 months or more during any 12 consecutive months of benefits;
- the date you die.

WHAT DISABILITIES HAVE A LIMITED PAY PERIOD UNDER YOUR PLAN?

The lifetime cumulative maximum benefit period for all disabilities due to **mental illness** and disabilities based primarily on **self-reported symptoms** is 24 months. Only 24 months of benefits will be paid for any combination of such disabilities even if the disabilities:

- are not continuous; and/or
- are not related.

However, Unum will send you payments beyond the 24 month period if you meet one of these conditions:

1. If you are confined to a **hospital or institution** at the end of the 24 month period, Unum will continue to send you payments during your confinement.

   If you are still disabled when you are discharged, Unum will send you payments for a recovery period of up to 90 days.

   If you become reconfined at any time during the recovery period and remain confined for at least 14 days in a row, Unum will send payments during that additional confinement and for one additional recovery period up to 90 more days.

2. If you are not confined to a hospital or institution but become confined for a period of at least 14 days within 90 days after the 24 month period for which you have received payments, Unum will send payments during the length of the confinement.

Under no circumstances will Unum pay beyond the maximum period of payment as indicated in the **BENEFITS AT A GLANCE** section of your policy.

Unum will not apply the mental illness limitation to dementia if it is a result of:

- stroke;
- trauma;
- viral infection;
- Alzheimer's disease; or
- other conditions not listed which are not usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs, or other similar methods of treatment.

WHAT DISABILITIES ARE NOT COVERED UNDER YOUR PLAN?

Your plan does not cover any disabilities caused by, contributed to by, or resulting from your:

- intentionally self-inflicted injuries.

- active participation in a riot.
- loss of a professional license, occupational license or certification.
- commission of a crime for which you have been convicted.
- pre-existing condition.

Your plan will not cover a disability due to war, declared or undeclared, or any act of war.

Unum will not pay a benefit for any period of disability during which you are incarcerated.

WHAT IS A PRE-EXISTING CONDITION?

You have a pre-existing condition if:

- you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines in the 3 months just prior to your effective date of coverage; and
- the disability begins in the first 12 months after your effective date of coverage.

In addition, this plan will not cover an increase in coverage if you have a pre-existing condition. An increase in coverage includes, if applicable to the plan, applying for additional benefit amounts. You have a pre-existing condition if:

- you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines in the 3 months just prior to the date your coverage increased; and
- the disability begins in the first 12 months after your coverage increased.

WHAT HAPPENS IF YOU RETURN TO WORK FULL TIME WITH THE POLICYHOLDER AND YOUR DISABILITY OCCURS AGAIN?

If you have a **recurrent disability**, Unum will treat your disability as part of your prior claim and you will not have to complete another elimination period if:

- you were continuously insured under the plan for the period between the end of your prior claim and your recurrent disability; and
- your recurrent disability occurs within 6 months from the end of your prior claim.

Your recurrent disability will be subject to the same terms of the plan as your prior claim and will be treated as a continuation of that disability.

Any disability which occurs after 6 months from the date your prior claim ended will be treated as a new claim. The new claim will be subject to all of the policy provisions, including the elimination period.

If you become entitled to payments under any other group long term disability plan, you will not be eligible for payments under the Unum plan.

LONG TERM DISABILITY

OTHER BENEFIT FEATURES

WHAT BENEFITS WILL BE PROVIDED TO YOU OR YOUR FAMILY IF YOU DIE OR ARE TERMINALLY ILL? (Survivor Benefit)

When Unum receives proof that you have died, we will pay your **eligible survivor** a lump sum benefit equal to 3 months of your gross disability payment if, on the date of your death:

- your disability had continued for 180 or more consecutive days; and
- you were receiving or were entitled to receive payments under the plan.

If you have no eligible survivors, payment will be made to your estate, unless there is none. In this case, no payment will be made.

However, we will first apply the survivor benefit to any overpayment which may exist on your claim.

You may receive your 3 month survivor benefit prior to your death if you have been diagnosed as terminally ill.

We will pay you a lump sum amount equal to 3 months of your gross disability payment if:

- you have been diagnosed with a terminal illness or condition;
- your life expectancy has been reduced to less than 12 months; and
- you are receiving monthly payments.

Your right to exercise this option and receive payment is subject to the following:

- you must make this election in writing to Unum; and
- your physician must certify in writing that you have a terminal illness or condition and your life expectancy has been reduced to less than 12 months.

This benefit is available to you on a voluntary basis and will only be payable once.

If you elect to receive this benefit prior to your death, no 3 month survivor benefit will be payable upon your death.

HOW CAN UNUM'S REHABILITATION AND RETURN TO WORK ASSISTANCE PROGRAM HELP YOU RETURN TO WORK?

Unum has a vocational Rehabilitation and Return to Work Assistance program available to assist you in returning to work. We will determine whether you are eligible for this program. In order to be eligible for rehabilitation services and benefits, you must be medically able to engage in a return to work program.

Your claim file will be reviewed by one of Unum's rehabilitation professionals to determine if a rehabilitation program might help you return to gainful employment. As your file is reviewed, medical and vocational information will be analyzed to determine an appropriate return to work program.

We will make the final determination of your eligibility for participation in the program.

We will provide you with a written Rehabilitation and Return to Work Assistance plan developed specifically for you.

The rehabilitation program may include, but is not limited to, the following services and benefits:

- coordination with your Employer to assist you to return to work;
- adaptive equipment or job accommodations to allow you to work;
- vocational evaluation to determine how your disability may impact your employment options;
- job placement services;
- resume preparation;
- job seeking skills training; or
- education and retraining expenses for a new occupation.

WHAT ADDITIONAL BENEFITS WILL UNUM PAY WHILE YOU PARTICIPATE IN A REHABILITATION AND RETURN TO WORK ASSISTANCE PROGRAM?

We will pay an additional disability benefit of 10% of your gross disability payment to a maximum benefit of $1,000 per month.

This benefit is not subject to policy provisions which would otherwise increase or reduce the benefit amount such as Deductible Sources of Income. However, the **Total Benefit Cap** will apply.

In addition, we will make monthly payments to you for 3 months following the date your disability ends if we determine you are no longer disabled while:

- you are participating in the Rehabilitation and Return to Work Assistance program; and
- you are not able to find employment.

This benefit payment may be paid in a lump sum.

WHEN WILL REHABILITATION AND RETURN TO WORK ASSISTANCE BENEFITS END?

Benefits for the Rehabilitation and Return to Work Assistance program will end on the earliest of the following dates:

- the date Unum determines that you are no longer eligible to participate in Unum's Rehabilitation and Return to Work Assistance program; or
- any other date on which monthly payments would stop in accordance with this plan.

WHAT ADDITIONAL BENEFIT IS AVAILABLE FOR DEPENDENT CARE EXPENSES TO ENABLE YOU TO PARTICIPATE IN UNUM'S REHABILITATION AND RETURN TO WORK ASSISTANCE PROGRAM?

While you are participating in Unum's Rehabilitation and Return to Work Assistance program, we will pay a Dependent Care Expense Benefit when you are disabled and you:

1. are incurring expenses to provide care for a child under the age of 15; and/or
2. start incurring expenses to provide care for a child age 15 or older or a family member who needs personal care assistance.

The payment of the Dependent Care Expense Benefit will begin immediately after you start Unum's Rehabilitation and Return to Work Assistance program.

Our payment of the Dependent Care Expense Benefit will:

1. be $350 per month, per **dependent**; and
2. not exceed $1,000 per month for all dependent care expenses combined.

To receive this benefit, you must provide satisfactory proof that you are incurring expenses that entitle you to the Dependent Care Expense Benefit.

Dependent Care Expense Benefits will end on the earlier of the following:

1. the date you are no longer incurring expenses for your dependent;
2. the date you no longer participate in Unum's Rehabilitation and Return to Work Assistance program; or
3. any other date payments would stop in accordance with this plan.

OTHER SERVICES

These services are also available from us as part of your Unum Long Term Disability plan.

IS THERE A WORK LIFE ASSISTANCE PROGRAM AVAILABLE WITH THE PLAN?

We do provide you and your dependents access to a work life assistance program designed to assist you with problems of daily living.

You can call and request assistance for virtually any personal or professional issue, from helping find a day care or transportation for an elderly parent, to researching possible colleges for a child, to helping to deal with the stress of the workplace. This work life program is available for everyday issues as well as crisis support.

This service is also available to your Employer.

This program can be accessed by a 1-800 telephone number available 24 hours a day, 7 days a week or online through a website.

Information about this program can be obtained through your plan administrator.

HOW CAN UNUM HELP YOUR EMPLOYER IDENTIFY AND PROVIDE WORKSITE MODIFICATION?

A worksite modification might be what is needed to allow you to perform the material and substantial duties of your regular occupation with your Employer. One of our designated professionals will assist you and your Employer to identify a modification we agree is likely to help you remain at work or return to work. This agreement will be in writing and must be signed by you, your Employer and Unum.

When this occurs, Unum will reimburse your Employer or the vendor providing the worksite modification services, for the cost of the modification, up to the greater of:

- $1,000; or
- the equivalent of 2 months of your monthly benefit.

This benefit is available to you on a one time only basis.

HOW CAN UNUM'S SOCIAL SECURITY CLAIMANT ADVOCACY PROGRAM ASSIST YOU WITH OBTAINING SOCIAL SECURITY DISABILITY BENEFITS?

In order to be eligible for assistance from Unum's Social Security claimant advocacy program, you must be receiving monthly payments from us. Unum can provide expert advice regarding your claim and assist you with your application or appeal.

Receiving Social Security benefits may enable:

- you to receive Medicare after 24 months of disability payments;
- you to protect your retirement benefits; and
- your family to be eligible for Social Security benefits.

We can assist you in obtaining Social Security disability benefits by:

- helping you find appropriate legal representation;
- obtaining medical and vocational evidence; and
- reimbursing pre-approved case management expenses.

GLOSSARY

ACTIVE EMPLOYMENT means you are working for your Employer for earnings that are paid regularly and that you are performing the material and substantial duties of your regular occupation. You must be regularly scheduled to work on average at least the minimum number of hours as described under the minimum hours requirement in each plan.

Your work site must be:

- your Employer's usual place of business;
- an alternative work site at the direction of your Employer, including your home; or
- a location to which your job requires you to travel.

Normal vacation is considered active employment.
Temporary and seasonal workers are excluded from coverage.

CHANGE IN STATUS means a change in status as defined in the regulations under Internal Revenue Code section 125, unless your Employer's cafeteria plan document or human resource policy contains more restrictive provisions. In that event, your Employer may restrict the situations where you can change your coverage.

DEDUCTIBLE SOURCES OF INCOME means income from deductible sources listed in the plan which you receive or are entitled to receive while you are disabled. This income will be subtracted from your gross disability payment.

DEPENDENT means:

- your child(ren) under the age of 15; and
- your child(ren) age 15 or over or a family member who requires personal care assistance.

DISABILITY EARNINGS means the earnings which you receive while you are disabled and working, plus the earnings you could receive if you were working to your **maximum capacity**.

ELIMINATION PERIOD means a period of continuous disability which must be satisfied before you are eligible to receive benefits from Unum.

EMPLOYEE means a person who is in active employment in the United States with the Employer.

EMPLOYER means the Policyholder, and includes any division, subsidiary or affiliated company named in the policy.

EMPLOYER'S CONTRIBUTION in the context of a retirement plan that is part of any federal, state, county, municipal or association retirement system means any contribution made by your Employer and any contribution made on your behalf which has been picked up by your Employer under Internal Revenue Code Section 414(h)(2) so that it does not constitute taxable income to you.

EVIDENCE OF INSURABILITY means a statement of your medical history which Unum will use to determine if you are approved for coverage. Evidence of insurability will be at Unum's expense.

GAINFUL OCCUPATION means an occupation that is or can be expected to provide you with an income at least equal to 80% of your indexed monthly earnings within 12 months of your return to work.

GOVERNMENTAL RETIREMENT SYSTEM means a plan which is part of any federal, state, county, municipal or association retirement system, including but not limited to, a state teachers retirement system, public employees retirement system or other similar retirement system for state or local government employees providing for the payment of retirement and/or disability benefits to individuals.

GRACE PERIOD means the period of time following the premium due date during which premium payment may be made.

GROSS DISABILITY PAYMENT means the benefit amount before Unum subtracts deductible sources of income and disability earnings.

HOSPITAL OR INSTITUTION means an accredited facility licensed to provide care and treatment for the condition causing your disability.

INDEXED MONTHLY EARNINGS means your monthly earnings adjusted on each anniversary of benefit payments by the lesser of 10% or the current annual percentage increase in the Consumer Price Index. Your indexed monthly earnings may increase or remain the same, but will never decrease.

The Consumer Price Index (CPI-U) is published by the U.S. Department of Labor. Unum reserves the right to use some other similar measurement if the Department of Labor changes or stops publishing the CPI-U.

Indexing is only used as a factor in the determination of the percentage of lost earnings while you are disabled and working and in the determination of gainful occupation.

INJURY means a bodily injury that is the direct result of an accident and not related to any other cause. Disability must begin while you are covered under the plan.

INSURED means any person covered under a plan.

LAW, PLAN OR ACT means the original enactments of the law, plan or act and all amendments.

LEAVE OF ABSENCE means you are temporarily absent from active employment for a period of time that has been agreed to in advance in writing by your Employer.

Your normal vacation time or any period of disability is not considered a leave of absence.

LIMITED means what you cannot or are unable to do.

MATERIAL AND SUBSTANTIAL DUTIES means duties that:

- are normally required for the performance of your regular occupation; and
- cannot be reasonably omitted or modified.

MAXIMUM CAPACITY means, based on your restrictions and limitations:

- during the first 24 months of disability, the greatest extent of work you are able to do in your regular occupation, that is reasonably available.
- beyond 24 months of disability, the greatest extent of work you are able to do in any occupation, that is reasonably available, for which you are reasonably fitted by education, training or experience.

MAXIMUM PERIOD OF PAYMENT means the longest period of time Unum will make payments to you for any one period of disability.

MENTAL ILLNESS means a psychiatric or psychological condition classified in the Diagnostic and Statistical Manual of Mental Health Disorders (DSM), published by the American Psychiatric Association, most current as of the start of a disability. Such disorders include, but are not limited to, psychotic, emotional or behavioral disorders, or disorders relatable to stress. If the DSM is discontinued or replaced, these disorders will be those classified in the diagnostic manual then used by the American Psychiatric Association as of the start of a disability.

MONTHLY BENEFIT means the total benefit amount for which an employee is insured under this plan subject to the maximum benefit.

MONTHLY EARNINGS means your gross monthly income from your Employer as defined in the plan.

MONTHLY PAYMENT means your payment after any deductible sources of income have been subtracted from your gross disability payment.

PART-TIME BASIS means the ability to work and earn between 20% and 80% of your indexed monthly earnings.

PAYABLE CLAIM means a claim for which Unum is liable under the terms of the policy.

PHYSICIAN means:

- a person performing tasks that are within the limits of his or her medical license; and
- a person who is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
- a person with a doctoral degree in Psychology (Ph.D. or Psy.D.) whose primary practice is treating patients; or
- a person who is a legally qualified medical practitioner according to the laws and regulations of the governing jurisdiction.

Unum will not recognize you, or your spouse, children, parents or siblings, a business or professional partner, or any person who has a financial affiliation or business interest with you, as a physician for a claim that you send to us.

PLAN means a line of coverage under the policy.

PRE-EXISTING CONDITION means a condition for which you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines for your condition during the given period of time as stated in the plan.

RECURRENT DISABILITY means a disability which is:

- caused by a worsening in your condition; and
- due to the same cause(s) as your prior disability which met the elimination period and for which Unum made a disability payment.

REGULAR CARE means:

- you personally visit a physician as frequently as is medically required, according to generally accepted medical standards, to effectively manage and treat your disabling condition(s); and
- you are receiving the most appropriate treatment and care which conforms with generally accepted medical standards, for your disabling condition(s) by a physician whose specialty or experience is the most appropriate for your disabling condition(s), according to generally accepted medical standards.

REGULAR OCCUPATION means the occupation you are routinely performing when your disability begins. Unum will look at your occupation as it is normally performed in the national economy, instead of how the work tasks are performed for a specific employer or at a specific location.

RETIREMENT PLAN means a defined contribution plan or defined benefit plan. These are plans which provide retirement benefits to employees and are not funded entirely by employee contributions. Retirement Plan does not include any plan which is part of any governmental retirement system.

SALARY CONTINUATION OR ACCUMULATED SICK LEAVE means continued payments to you by your Employer of all or part of your monthly earnings, after you become disabled as defined by the Policy. This continued payment must be part of an established plan maintained by your Employer for the benefit of all employees covered under the Policy. Salary continuation or accumulated sick leave does not include compensation paid to you by your Employer for work you actually perform after your disability begins. Such compensation is considered disability earnings, and would be taken into account in calculating your monthly payment.

SCHEDULED ENROLLMENT PERIOD means a period of time determined by Unum and your Employer.

SELF-REPORTED SYMPTOMS means the manifestations of your condition which you tell your physician, that are not verifiable using tests, procedures or clinical examinations standardly accepted in the practice of medicine. Examples of self-reported symptoms include, but are not limited to headaches, pain, fatigue, stiffness, soreness, ringing in ears, dizziness, numbness and loss of energy.

SICKNESS means an illness or disease. Disability must begin while you are covered under the plan.

SURVIVOR, ELIGIBLE means your spouse, if living; otherwise your children under age 25 equally.

TOTAL BENEFIT CAP means the total benefit payable to you on a monthly basis (including all benefits provided under this plan) will not exceed 100% of your monthly earnings. However, if you are participating in Unum's Rehabilitation and Return to Work Assistance program, the total benefit payable to you on a monthly basis (including all benefits provided under this plan) will not exceed 110% of your monthly earnings.

WAITING PERIOD means the continuous period of time (shown in each plan) that you must be in active employment in an eligible group before you are eligible for coverage under a plan.

WE, **US** and **OUR** means Unum Life Insurance Company of America.

YOU means an employee who is eligible for Unum coverage.

LONG TERM DISABILITY/SHORT TERM DISABILITY

THE FOLLOWING NOTICES AND CHANGES TO YOUR COVERAGE ARE REQUIRED BY CERTAIN STATES. PLEASE READ CAREFULLY.

State variations apply and are subject to change. Consult your employer or plan administrator for the most current state provisions that may apply to you.

If you have a complaint about your insurance you may contact Unum at 1-800-321-3889, or the department of insurance in your state of residence. Links to the websites of each state department of insurance can be found at www.naic.org.

Si usted tiene alguna queja acerca de su seguro puede comunicarse con Unum al 1-800-321-3889, o al departamento de seguros de su estado de residencia. Puede encontrar enlaces a los sitios web de los departamentos de seguros de cada estado en www.naic.org.

The states of **Florida and Maryland** require us to advise residents of those states that if your Certificate was issued in a jurisdiction other than the state in which you reside, it may not provide all of the benefits required by the laws of your residence state.

Full effect will be given to your state's civil union, domestic partner and same sex marriage laws to the extent they apply to you under a group insurance policy issued in another state.

If you are a resident of one of the states noted below, and the provisions referenced below appear in your Certificate in a form less favorable to you as an insured, they are amended as follows:

For residents of Colorado:

The **Pre-existing Condition** exclusion in the **OTHER FEATURES** provision of the **BENEFITS AT A GLANCE** section of the policy is amended so that if the last number is greater than 12 months, it is reduced to 12 months and any **Pre-existing Condition** exclusion in the **BENEFIT INFORMATION** section of the policy is amended so that it will be applied only if the disability begins in the first 12 months after the insured's effective date of coverage for the applicable benefit, or such shorter time as provided in the policy.

The **WHAT *DISABILITIES ARE NOT COVERED UNDER YOUR PLAN?*** provision in the **BENEFIT INFORMATION** section of the policy and in the **SPOUSE DISABILITY BENEFIT** provision in the **OTHER BENEFIT FEATURES** section of the policy is amended to provide that any exclusion for disabilities caused by, contributed to by, or resulting from your intentionally self-inflicted injuries will be applied only if you were sane when the injury was inflicted.

For residents of Louisiana:

The ***HOW CAN STATEMENTS IN YOUR APPLICATION FOR THIS COVERAGE BE USED?*** provision in the **GENERAL PROVISIONS** section of the policy is amended to provide that, except for fraud, misstatements made in your application cannot be used to reduce or deny coverage if your coverage has been in force for at least 3 years.

For residents of Minnesota:

The ***HOW CAN STATEMENTS IN YOUR APPLICATION FOR THIS COVERAGE BE USED?*** provision in the **GENERAL PROVISIONS** section of the policy is amended to provide that, except for fraud, misstatements made in your application cannot be used to reduce or deny coverage if your coverage has been in force for at least 2 years.

The ***WHAT ARE DEDUCTIBLE SOURCES OF INCOME?*** provision in the **BENEFIT INFORMATION** section of the policy is amended so that deductible sources of income will not include any amounts you receive as mandatory portions of any "no fault" motor vehicle plan or any amounts received from a third party (after subtracting attorney's fees) by judgment, settlement or otherwise, until after you have been fully compensated from this other source.

The **Pre-existing Condition** exclusion in the **BENEFIT INFORMATION** section of the policy will be applied by deleting the phrase "or you had symptoms for which an ordinarily prudent person would have consulted a health care provider."

If your coverage includes the **Spouse Disability Rider** benefit the exclusions for mental illness and alcoholism applicable to the rider are removed.

For residents of Montana:

The **Pre-existing Condition** exclusion in the **OTHER FEATURES** provision of the **BENEFITS AT A GLANCE** section of the policy is amended so that if the last number is greater than 12 months, it is reduced to 12 months and any **Pre-existing Condition** exclusion in the **BENEFIT INFORMATION** section of the policy is amended so that it will be applied only if the disability begins in the first 12 months after the insured's effective date of coverage for the applicable benefit, or such shorter time as provided in the policy.

The definition of pre-existing condition found in the provisions ***WHAT DISABILITIES ARE NOT COVERED UNDER YOUR PLAN?*** and ***WHAT DISABILITIES ARE NOT COVERED FOR A COST OF LIVING INCREASE?*** in the **BENEFIT INFORMATION** section of the policy, is amended to limit a pre-existing condition to "a sickness or injury for which you received medical advice or treatment from a provider of health care services or medical advice or treatment was recommended by a provider of health care services" during the time period specified in the policy.

For residents of New Hampshire:

The **Pre-existing Condition** exclusion in the **OTHER FEATURES** provision of the **BENEFITS AT A GLANCE** section of the policy is amended so that if the last number is greater than 12 months, it is reduced to 12 months and any **Pre-existing Condition** exclusion in the **BENEFIT INFORMATION** section of the policy is amended so that it will be applied only if the disability begins in the first 12 months after the insured's effective date of coverage for the applicable benefit, or such shorter time as provided in the policy.

The ***HOW CAN STATEMENTS IN YOUR APPLICATION FOR THIS COVERAGE BE USED?*** provision in the **GENERAL PROVISIONS** section of the policy is amended to provide that, except for fraud, misstatements made in your application cannot be used to reduce or deny coverage if your coverage has been in force for at least 2 years.

For residents of North Carolina:

The definition of pre-existing condition found in the provisions ***WHAT DISABILITIES ARE NOT COVERED UNDER YOUR PLAN?*** and ***WHAT DISABILITIES ARE NOT COVERED FOR A COST OF LIVING INCREASE?*** in the **BENEFIT INFORMATION** section of the policy, is amended by removing any reference to "symptoms arising from the sickness or injury, whether diagnosed or not."

For residents of South Carolina:

The **Pre-existing Condition** exclusion in the **OTHER FEATURES** provision of the **BENEFITS AT A GLANCE** section of the policy is amended so that if the last number is greater than 12 months, it is reduced to 12 months and any **Pre-existing Condition** exclusion in the **BENEFIT INFORMATION** section of the policy is amended so that it will be applied only if the disability begins in the first 12 months after the insured's effective date of coverage for the applicable benefit, or such shorter time as provided in the policy.

The ***WHAT IF YOU HAVE A DISABILITY DUE TO A PRE-EXISTING CONDITION WHEN YOUR EMPLOYER CHANGES INSURANCE CARRIERS TO UNUM?*** provision in the **BENEFIT INFORMATION** section of the policy, is amended to provide that Unum will credit the pre-existing condition period you satisfied under another similar group disability policy if you were covered under the prior policy within 30 days of being effective under this policy and you applied for this coverage when you first became eligible.

For residents of South Dakota:

The **Pre-existing Condition** limitation in the **OTHER FEATURES** provision of the **BENEFITS AT A GLANCE** section of the policy is amended so that if the last number is greater than 12 months, it is reduced to 12 months and any **Pre-existing Condition** limitation in the **BENEFIT INFORMATION** section of the policy is amended so that it will be applied only if the disability begins in the first 12 months after the insured's effective date of coverage for the applicable benefit, or such shorter time as provided in the policy.

For residents of Texas:

The ***HOW CAN STATEMENTS IN YOUR APPLICATION FOR THIS COVERAGE BE USED?*** provision in the **GENERAL PROVISIONS** section of the policy is amended to provide that, except for fraud, misstatements made in your application cannot be used to reduce or deny coverage if your coverage has been in force for at least 2 years.

The **Pre-existing Condition** exclusion in the **BENEFIT INFORMATION** section of the policy will be applied by deleting the phrase "or you had symptoms for which an ordinarily prudent person would have consulted a health care provider."

For residents of Utah:

The **Pre-existing Condition** exclusion in the **OTHER FEATURES** provision of the **BENEFITS AT A GLANCE** section of the policy is amended so that if the last number is greater than 12 months, it is reduced to 12 months and any **Pre-existing Condition** exclusion in the **BENEFIT INFORMATION** section of the policy is amended so that it

will be applied only if the disability begins in the first 12 months after the insured's effective date of coverage for the applicable benefit, or such shorter time as provided in the policy.

The ***HOW CAN STATEMENTS IN YOUR APPLICATION FOR THIS COVERAGE BE USED?*** provision in the **GENERAL PROVISIONS** section of the policy is amended to provide that, except for fraud, misstatements made in your application cannot be used to reduce or deny coverage if your coverage has been in force for at least 2 years.

For residents of Vermont:

If the policy is marketed in Vermont, the policyholder has a principal office or is organized in Vermont, or there are more than 25 Vermont residents insured under the policy:

The limitation specifying the number of months payments will be made for a disability caused by a mental and nervous condition is removed.

The **MINIMUM HOURS REQUIREMENT** stated in the **BENEFITS AT A GLANCE** section of the policy is reduced to 17.5 hours per week.

The **Pre-existing Condition** exclusion in the **OTHER FEATURES** provision of the **BENEFITS AT A GLANCE** section of the policy is amended so that if the last number is greater than 12 months, it is reduced to 12 months and any **Pre-existing Condition** exclusion in the **BENEFIT INFORMATION** section of the policy is amended so that it will be applied only if the disability begins in the first 12 months after the insured's effective date of coverage for the applicable benefit, or such shorter time as provided in the policy.

For residents of West Virginia:

The **Pre-existing Condition** exclusion in the **OTHER FEATURES** provision of the **BENEFITS AT A GLANCE** section of the policy is amended so that if the last number is greater than 12 months, it is reduced to 12 months and any **Pre-existing Condition** exclusion in the **BENEFIT INFORMATION** section of the policy is amended so that it will be applied only if the disability begins in the first 12 months after the insured's effective date of coverage for the applicable benefit, or such shorter time as provided in the policy.

For residents of Wisconsin:

The **Pre-existing Condition** exclusion in the **OTHER FEATURES** provision of the **BENEFITS AT A GLANCE** section of the policy is amended so that if the last number is greater than 12 months, it is reduced to 12 months and any **Pre-existing Condition** exclusion in the **BENEFIT INFORMATION** section of the policy is amended so that it will be applied only if the disability begins in the first 12 months after the insured's effective date of coverage for the applicable benefit, or such shorter time as provided in the policy.

Additional Claim and Appeal Information
Relative to policy issued by Unum Life Insurance Company of America ("Unum")

APPLICABILITY OF ERISA

If the policy provides benefits under a Plan which is subject to the Employee Retirement Income Security Act of 1974 (ERISA), the following provisions apply. Whether a Plan is governed by ERISA is determined by a court, however, your Employer may have information related to ERISA applicability. If ERISA applies, the following items constitute the Plan: the additional information contained in this document, the policy, including your certificate of coverage, and any additional summary plan description information provided by the Plan Administrator. Benefit determinations are controlled exclusively by the policy, your certificate of coverage, and the information in this document.

HOW TO FILE A CLAIM

If you wish to file a claim for benefits, you should follow the claim procedures described in your insurance certificate. To complete your claim filing, Unum must receive the claim information it requests from you (or your authorized representative), your attending physician and your Employer. If you or your authorized representative has any questions about what to do, you or your authorized representative should contact Unum directly.

CLAIMS PROCEDURES

Unum will give you notice of the decision no later than 45 days after the claim is filed. This time period may be extended twice by 30 days if Unum both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you of the circumstances requiring the extension of time and the date by which Unum expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days within which to provide the specified information. If you deliver the requested information within the time specified, any 30 day extension period will begin after you have provided that information. If you fail to deliver the requested information within the time specified, Unum may decide your claim without that information.

If your claim for benefits is wholly or partially denied, the notice of adverse benefit determination under the Plan will:

- state the specific reason(s) for the determination;
- reference specific Plan provision(s) on which the determination is based;
- describe additional material or information necessary to complete the claim and why such information is necessary;
- describe Plan procedures and time limits for appealing the determination, and your right to obtain information about those procedures and the right to bring a lawsuit under Section 502(a) of ERISA following an adverse determination from Unum on appeal; and

- disclose any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or state that such information will be provided free of charge upon request).

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

APPEAL PROCEDURES

You have 180 days from the receipt of notice of an adverse benefit determination to file an appeal. Requests for appeals should be sent to the address specified in the claim denial. A decision on review will be made not later than 45 days following receipt of the written request for review. If Unum determines that special circumstances require an extension of time for a decision on review, the review period may be extended by an additional 45 days (90 days in total). Unum will notify you in writing if an additional 45 day extension is needed.

If an extension is necessary due to your failure to submit the information necessary to decide the appeal, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days to provide the specified information. If you deliver the requested information within the time specified, the 45 day extension of the appeal period will begin after you have provided that information. If you fail to deliver the requested information within the time specified, Unum may decide your appeal without that information.

You will have the opportunity to submit written comments, documents, or other information in support of your appeal. You will have access to all relevant documents as defined by applicable U.S. Department of Labor regulations. The review of the adverse benefit determination will take into account all new information, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination.

The review will be conducted by Unum and will be made by a person different from the person who made the initial determination and such person will not be the original decision maker's subordinate. In the case of a claim denied on the grounds of a medical judgment, Unum will consult with a health professional with appropriate training and experience. The health care professional who is consulted on appeal will not be the individual who was consulted during the initial determination or a subordinate. If the advice of a medical or vocational expert was obtained by the Plan in connection with the denial of your claim, Unum will provide you with the names of each such expert, regardless of whether the advice was relied upon.

A notice that your request on appeal is denied will contain the following information:

- the specific reason(s) for the determination;

- a reference to the specific Plan provision(s) on which the determination is based;

- a statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or a statement that such information will be provided free of charge upon request);

- a statement describing your right to bring a lawsuit under Section 502(a) of ERISA if you disagree with the decision;

- the statement that you are entitled to receive upon request, and without charge, reasonable access to or copies of all documents, records or other information relevant to the determination; and

- the statement that "You or your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency".

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

Unless there are special circumstances, this administrative appeal process must be completed before you begin any legal action regarding your claim.

OTHER RIGHTS

Unum, for itself and as claims fiduciary for the Plan, is entitled to legal and equitable relief to enforce its right to recover any benefit overpayments caused by your receipt of disability earnings or deductible sources of income from a third party. This right of recovery is enforceable even if the amount you receive from the third party is less than the actual loss suffered by you but will not exceed the benefits paid you under the policy. Unum and the Plan have an equitable lien over such sources of income until any benefit overpayments have been recovered in full.

SUMMARY OF THE LOUISIANA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT 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 members of the Louisiana Life and Health Insurance Guaranty Association. The purpose of this Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Association will assess its other member insurance companies for the money to pay the covered 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 the Association is limited. As noted 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 certain 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 always 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. Drawer 44126
Baton Rouge, Louisiana 70804

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

The state law that provides for this safety-net coverage is called the Louisiana Life and Health Insurance Guaranty Association Law. 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 Act or the rights or obligations of the Association.

COVERAGE

Generally, individuals will be protected by the Louisiana Life and Health Insurance Guaranty 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 an

insurer authorized to conduct business in Louisiana. 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 Association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;
- their policy was issued by a non-profit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The Association also does not provide coverage for:

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

Other exceptions and exclusions may also be applicable depending upon the issuing insurer, the policy itself, the policyholder or policy owner, or other factors. For more information, see the Louisiana Life and Health Insurance Guaranty Association Law, Louisiana Revised Statutes R.S. 22:2081 et seq.

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the Association is obligated to pay out. The Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Association will pay a maximum of $500,000 no matter how many policies and contracts there were with the same company, even if they provided different types of coverage. Within this overall $500,000 limit, the Association will not pay more than: $500,000 in health insurance benefits; $250,000 in present value of annuities (including cash surrender and cash withdrawal values); or $300,000 in life insurance death benefits (but not more than $100,000 in cash surrender and cash withdrawal values) - again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverage. Other conditions, requirements or exclusions may apply.

City of Baton Rouge

Long Term Disability Insurance

How does it work?

This coverage provides a monthly benefit if you have a covered illness or injury and you can't work for a few months — or even longer.

You're generally considered disabled if you're unable to do important parts of your job — and your income suffers as a result.

Why is this coverage so valuable?

You can use the money however you choose. It can help you pay for your rent or mortgage, groceries, out-of-pocket medical expenses and more.

Consider your expenses

Utilities	$
Housing	$
Groceries	$
Transportation	$
Child care/Elder care	$
Medical/Personal care	$
Education	$
Insurance	$

Policy 471105

What else is included?

Survivor Benefit

If you die while you've been disabled and receiving benefits for at least 180 days, your family could get a benefit equal to 3 months of your gross disability payment.

Waiver of premium

If you're disabled and receiving benefit payments, Unum waives your cost until you return to work.

Work-life balance Employee Assistance Program

Get access to professional help for a range of personal and work-related issues, including counselor referrals, financial planning and legal support.

Worldwide emergency travel assistance

One phone call gets you and your family immediate help anywhere in the world, as long as you're traveling 100 or more miles from home. However, a spouse traveling on business for his or her employer is not covered.

How much coverage can I get?

	You are eligible for coverage if you are an active employee in the United States working a minimum of 30 hours per week.
You*	Choose to cover 50% or 60% of your monthly income, up to a maximum payment of $6,000. The monthly benefit may be reduced or offset by other sources of income.

*See the Legal Disclosures for more information.

This plan does not cover pre-existing conditions. See the disclosure section to learn more.

If you didn't get coverage when you were first eligible, you'll have to answer health questions now. If you're newly eligible, you may not have to answer health questions. If you already have coverage, you can increase it up to the maximum available with no health questions. New coverage is subject to pre-existing condition limitations. However, once your coverage is effective, evidence of insurability is not required for an increase in coverage made during a scheduled enrollment period or within 31 days of a change in status.

Elimination period (EP)

Your elimination period is 180 days. This is the number of days that must pass after a covered accident or illness before you can begin to receive benefits.

Benefit duration (BD)

This is the maximum length of time you can receive benefits while you're disabled. You can receive benefits up to the Social Security (SS) normal retirement age.

Calculate your cost

- Follow the instructions on the worksheet at right to determine your cost per paycheck.
- For step 2, enter the amount that is less: 1) your annual earnings or 2) the maximum covered annual earnings listed on the rate chart, based on your age and coverage percentage amount you want.

(Choose the age you will be when your coverage becomes effective on 01/01/2025.)

Disability worksheet

1 Enter your annual earnings and calculate your maximum monthly benefit available.

$_____	÷ 12 =	$_____	x	____% =	$_____	
Your annual earnings		Your monthly earnings		(The % plan that you want)	Max monthly benefit available (If the amount exceeds the plan max of $6,000, enter $6,000)	

2 Calculate your cost per paycheck

$_____	÷ 100 =	$_____	x	$_____	=	$_____	÷	_____	=	$_____
Your annual earnings				Rate for the option you choose				Number of paychecks per year		Total cost per paycheck

Rates

Percent of monthly income ›	Option 1 50% EP: 180 days BD: SS retirement age	Option 2 60% EP: 180 days BD: SS retirement age
Maximum covered annual earnings ›	$144,000	$120,000
Age: 15-24	$0.063	$0.090
25-29	$0.099	$0.153
30-34	$0.180	$0.270
35-39	$0.333	$0.432
40-44	$0.513	$0.648
45-49	$0.567	$0.999
50-54	$0.720	$0.954
55-59	$1.044	$1.197
60-64	$0.837	$1.359
65-69	$0.504	$0.729
70+	$0.387	$0.567

Billed amount may vary slightly. Your rate is based on your age and will increase as you move to the next age band.

Exclusions and limitations

Active employee

You are considered in active employment, if on the day you apply for coverage, you are being paid regularly by your employer for the required minimum hours each week and you are performing the material and substantial duties of your regular occupation.

Delayed effective date of coverage

Insurance coverage will be delayed if you are not an active employee because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective.

Benefit duration (BD)

The duration of your benefit payments is based on your age when your disability occurs. Your Long Term Disability benefits are payable while you continue to meet the definition of disability. Please refer to your plan document for the duration of benefits under this policy.

Definition of disability

You are considered disabled when Unum determines that:

- You are limited from performing the material and substantial duties of your regular occupation due to sickness or injury; and
- You have a 20% or more loss of indexed monthly earnings due to the same sickness or injury

After 24 months, you are considered disabled when Unum determines that due to the same sickness or injury, you are unable to perform the duties of any gainful occupation for which you are reasonably fitted by education, training or experience.
You must be under the regular care of a physician in order to be considered disabled.
The loss of a professional or occupational license or certification does not, in itself, constitute disability.
"Substantial and material acts" means the important tasks, functions and operations that are generally required by employers from those engaged in your usual occupation and that cannot be reasonably omitted or modified.
Unless the policy specifies otherwise, as part of the disability claims evaluation process, Unum will evaluate your occupation based on how it is normally performed in the national economy, not how work is performed for a specific employer, at a specific location or in a specific region.

Pre-existing conditions

You have a pre-existing condition if:

- You received medical treatment, consultation, care or services including diagnostic measures for the condition, or took prescribed drugs or medicines for it in the 3 months just prior to your effective date of coverage; and
- The disability begins in the first 12 months after your effective date of coverage.

Deductible sources of income

Your disability benefit may be reduced by deductible sources of income and any earnings you have while you are disabled, including such items as group disability benefits or other amounts you receive or are entitled to receive:

- Workers' compensation or similar occupational benefit laws, including a temporary disability benefit under a workers' compensation law
- State compulsory benefit laws
- Automobile liability insurance policy
- No fault motor vehicle plan
- Third-party settlements
- Other group insurance plans
- A group plan sponsored by your employer
- Governmental retirement system
- Salary continuation or sick leave plans, if applicable
- Retirement payments
- Social Security or similar governmental programs

Exclusions and limitations

Benefits will not be paid for disabilities caused by, contributed to by, or resulting from:

- Intentionally self-inflicted injuries;
- Active participation in a riot;
- War, declared or undeclared or any act of war;
- Commission of a crime for which you have been convicted;
- Loss of professional license, occupational license or certification; or
- Pre-existing conditions (See the disclosure section to learn more).

The loss of a professional or occupational license does not, in itself, constitute disability.
Unum will not pay a benefit for any period of disability during which you are incarcerated.
The lifetime cumulative maximum benefit for all disabilities due to mental illness is 24 months. Disabilities based primarily on self-reported symptoms are limited to 24 months. Only 24 months of benefits will be paid for any combination of such disabilities even if the disabilities are not continuous and/or are not related.
Payments can continue beyond 24 months only if you are confined to a hospital or institution as a result of the disability.

Termination of coverage

Your coverage under the policy ends on the earliest of the following:

- The date the policy or plan is cancelled
- The date you no longer are in an eligible group
- The date your eligible group is no longer covered
- The last day of the period for which you made any required contributions
- The last day you are in active employment except as provided under the covered layoff or leave of absence provision.

Unum will provide coverage for a payable claim that occurs while you are covered under the policy or plan.
Unum's LTD contracts standardly include a provision called the Social Security Claimant Advocacy Program. With this feature, claimants can receive expert advice and assistance from us regarding their Social Security Disability claim during the application and appeal process. Social Security advocacy services are provided by GENEX Services, LLC or Brown & Brown Absence Services Group. Referral to one of our advocacy partners is determined by Unum.
Worldwide emergency travel assistance services are provided by Assist America, Inc. Work-life balance employee assistance program services are provided by HealthAdvocate. Services are available with select Unum insurance offerings. Terms and availability of service are subject to change and prior notification requirements. Service providers do not provide legal advice; please consult your attorney for guidance. Services are not valid after coverage terminates. Please contact your Unum representative for details.

This information is not intended to be a complete description of the insurance coverage available. The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations which may affect any benefits payable. For complete details of coverage and availability, please refer to Policy Form C.FP-1 et al. or contact your Unum representative.
Underwritten by:
Unum Life Insurance Company of America, Portland, Maine

ATTACHMENT E
MPERS OPTIONS

MUNICIPAL POLICE EMPLOYEES' RETIREMENT SYSTEM

7722 Office Park Boulevard Suite 200 Baton Rouge, Louisiana 70809-7601
Phone 800.443.4248 / 225.929.7411 **Fax** 225.929.6542 **Web** lampers.org

Maximum Plan - Pays largest monthly benefit retiree is eligible to receive but does not provide for a monthly benefit to be paid to a named beneficiary after the retiree's death; however, in the event the retiree dies before he/she receives in benefits an amount equal to his/her contributions, the beneficiary or estate will be paid the difference in one lump sum payment. I hereby apply for retirement under the Maximum Plan. Spouse must complete form MP-4A.

Option 1 – Retiree paid an allowance slightly reduced from the Maximum. At death of member, a lump sum refund or remaining contributions is paid to the designated beneficiary. After 10-15 years, the contributions are usually exhausted which causes the member to take a reduction for his/her lifetime and the beneficiary does not receive a refund.

Option 2 - Pays the retiree a monthly benefit that is reduced from the Maximum. Pays the same monthly benefit for life to the named retirement beneficiary after the retiree's death. The benefit is based on the ages of the retiree and his/her beneficiary. The beneficiary may not be changed after retirement. I hereby apply for regular retirement under the Option 2 Plan.

Option 2a (formerly 4-1) - Pays the retiree a monthly benefit that is reduced from the Maximum. Pays the same monthly benefit for life to the named retirement beneficiary after the retiree's death. However, if the name beneficiary predeceases the retiree, the benefit amount will convert to the Maximum Plan and benefits will cease upon the death of the retiree. The benefit is based on the ages of the retiree and his/her beneficiary. The retirement beneficiary may not be changed after retirement. I hereby apply for regular retirement under the Option 2a Plan.

Option 3 - Pays the retiree a monthly benefit that is reduced from the Maximum. Pays 50% of the monthly benefit for life to the named retirement beneficiary after the retiree's death. The benefit is based on the ages of the retiree and his/her beneficiary. The beneficiary may not be changed after retirement. I hereby apply for regular retirement under the Option 3 Plan.

Option 3a (formerly 4-2) - Pays the retiree a monthly benefit that is reduced from the Maximum. Pays 50% of the monthly benefit for life to the named retirement beneficiary after the retiree's death. However, if the named beneficiary predeceases the retiree, the benefit amount will convert to the Maximum Plan and benefits will cease upon the death of the retiree. The benefit is based on the ages of the retiree and his/her beneficiary. The retirement beneficiary may not be changed after retirement. I hereby apply for regular retirement under the Option 3a Plan.

Option 4 – Member receives reduced benefit in order for a designated beneficiary to receive a set monthly benefit. Calculated by MPERS Actuary upon request

Auto-COLA Option – If selected, member receives a reduction in benefits in order to receive an annual 2.5% COLA each year, beginning at age 55, in addition to any COLAS declared by the Legislature or Board of Trustees, in very limited circumstances.

Early – Any member who has completed 20 years of creditable service shall be entitled to elect early retirement and receive an actuarially reduced retirement benefit. This reduced benefit is payable for life; it is not re-computed upon attainment of age 50. Additionally, any member retiring early shall not be eligible for a COLA until one full fiscal year after attaining normal retirement eligibility, nor shall the member be eligible to participate in DROP.

Vested – A member may leave covered employment after obtaining the minimum number of years of service credit needed to retire, but before obtaining the required age, and leave his contributions on deposit with MPERS in order to qualify for monthly benefits upon reaching the minimum age for regular retirement. This deferred benefit is not automatic. The inactive member must file the proper application for retirement with MPERS, preferably thirty to sixty days prior to his birthday. Delayed retirement benefits shall not be retroactive under any circumstances.

DROP – In lieu of terminating employment and accepting a service retirement allowance, any member who is eligible to receive a normal retirement allowance may elect to participate in DROP and defer the receipt of benefits until he terminates his employment. AFC and total creditable service shall remain the same as existed on the effective date of commencement of participation in the DROP program. Members who anticipate receiving a significant pay increase should consider all of their retirement options before entering DROP. DROP is not for everyone and should be carefully considered. Monthly deposits are made to the participants account, equal to the monthly retirement benefit that would have been payable had the member elected to terminate employment and receive a benefit as computed under the retirement option plan elected by the participant. Deposits do not earn interest during the period of participation. Participants are not eligible to receive COLAs until their employment has been terminated for at least one full fiscal year.

IBO Option – . Under R.S. 11:2224(F), this option allows a retiring member, who has not participated in DROP, the opportunity to receive an initial lump-sum payment which may equal a total of up to 36 months of the member's regular maximum retirement benefit. In exchange for receiving this initial payment, the member and his beneficiary agree to accept a reduced monthly benefit over their lifetimes. This option is not for everyone and should be carefully considered in view of the fact that the monthly benefit reduction is permanent.

MPERS Retirement Eligibility:

7.03 Eligibility For Retirement

1. Members Not Enrolled in a Subplan [R.S. 11:2220(A)]
    1. Eligibility for regular retirement shall be attained when a member has:
        1. 25 years or more service, at any age;
        2. 20 years or more service, at age 50 or thereafter; or
        3. 12 years or more service, at age 55 or thereafter.
    2. However, any member who has completed 20 years of creditable service shall be entitled to elect early retirement and receive an actuarially reduced retirement benefit. This reduced benefit is payable for life; it is not re-computed upon attainment of age 50. Additionally, any member retiring early shall not be eligible for a COLA until one full fiscal year after attaining normal retirement eligibility, nor shall the member be eligible to participate in DROP.
2. Hazardous Duty Subplan Members [R.S. 11:2241.4]
    1. Any member of this subplan shall be eligible for retirement if he has:
        1. 25 years or more of service, at any age;
        2. 12 years or more of service, at age 55 or thereafter; or
        3. 20 year of service credit at any age, exclusive of unused annual and sick leave and military service other than qualified military service as provided in 26 U.S.C. 414(u) earned on or after December 12, 1994. The benefit, inclusive of military service credit and allowable unused annual and sick leave, will be actuarially reduced from the earliest age that he would normally become eligible for a regular retirement benefit based upon his years of service as of the date of retirement. This reduced benefit is payable for life; it is not re-computed upon attainment of age 55. Any employee who elects to retire early shall not be eligible to participate in DROP or IBO.
3. Nonhazardous Duty Subplan [R.S. 11:2242.4]
    1. Any member of this subplan shall be eligible for retirement if he has:
        1. 30 or more of service, at any age;
        2. 25 years or more of service, at age 55 or thereafter; or
        3. 20 years of service credit at any age, exclusive of unused annual and sick leave and military service other than qualified military service as provided in 26 U.S.C. 414(u) earned on or after December 12, 1994. His benefit, inclusive of military service credit and allowable unused annual and sick leave, shall be actuarially reduced from the earliest age that he would normally become eligible for a regular retirement benefit based upon his years of service as of the date of retirement. This reduced benefit is payable for life; it is not re-computed upon attainment of age 55. Any employee who elects to retire early shall not be eligible to participate in DROP or IBO.
        4. 10 years or more of service, at age 60.
4. Members who establish reciprocal agreements between this system and another public retirement system in the state of Louisiana under R.S. 11:142 must meet the highest minimum age and years of service requirements of each system in which he has membership service credit; however, service in any one system sufficient to meet the eligibility requirements of that system shall qualify the member for benefits from that system. For purposes of benefits payable under the provisions of R.S. 11:142, no member shall be eligible to receive benefits from any system so long as he is contributing to another system.

ATTACHMENT F

UNUM FULL INSURED CONTRIBUTORY DENTAL ER 50% ALL TIERS

Additional Dental Details

Policy Inception Date: January 1, 2017

Rate History:

Silver	2025	2024	2023			
Employee	$13.54	$13.54	$13.54			
Emp & Sp	$27.04	$27.04	$27.04			
Emp & Ch	$29.48	$29.48	$29.48			
Family	$45.96	$45.96	$45.96			

Platinum	2025	2024	2023			
Employee	$32.83	$30.40	$30.40			
Emp & Sp	$65.64	$60.78	$60.78			
Emp & Ch	$78.58	$72.76	$72.76			
Family	$119.86	$110.98	$110.98			

Tech Subsidy/Implementation Credit: None

Commissions: Net of commissions

Plan Changes: None since inception

CITY OF BATON ROUGE PARISH OF EAST BATON ROUGE

00956566

Dental Claims Summary

Date	Certificate Count	Premium	Claims	Loss Ratio
Feb-22	6,232	$312,479	$311,972	100%
Mar-22	6,226	$308,412	$376,494	122%
Apr-22	6,208	$309,023	$338,730	110%
May-22	6,240	$307,935	$316,542	103%
Jun-22	6,269	$299,725	$301,311	101%
Jul-22	6,262	$313,450	$264,377	84%
Aug-22	6,274	$312,534	$342,378	110%
Sep-22	6,263	$266,607	$273,115	102%
Oct-22	6,259	$318,194	$300,935	95%
Nov-22	6,248	$296,052	$298,171	101%
Dec-22	6,239	$294,577	$284,425	97%
Jan-23	6,258	$299,904	$353,191	118%
Sub Total	74,978	$3,638,891	$3,761,640	103%
Feb-23	6,239	$342,480	$287,789	84%
Mar-23	6,233	$312,037	$359,153	115%
Apr-23	6,219	$316,438	$317,268	100%
May-23	6,260	$314,484	$332,794	106%
Jun-23	6,262	$283,546	$307,561	108%
Jul-23	6,241	$312,968	$269,922	86%
Aug-23	6,236	$311,337	$320,427	103%
Sep-23	6,236	$342,480	$250,037	73%
Oct-23	6,249	$342,480	$290,460	85%
Nov-23	6,259	$310,978	$282,662	91%
Dec-23	6,278	$310,281	$281,719	91%
Jan-24	6,279	$342,480	$351,737	103%
Sub Total	74,991	$3,841,989	$3,651,529	95%
Feb-24	6,292	$342,480	$322,025	94%
Mar-24	6,292	$212,293	$293,654	138%
Apr-24	6,286	$342,480	$324,871	95%
May-24	6,315	$342,480	$315,101	92%
Jun-24	6,315	$249,239	$300,734	121%
Jul-24	6,335	$310,656	$332,892	107%
Aug-24	6,336	$310,309	$288,172	93%
Sep-24	6,326	$310,584	$263,050	85%
Oct-24	6,318	$342,480	$348,765	102%
Nov-24	6,301	$309,581	$263,878	85%
Dec-24	6,295	$309,250	$283,708	92%
Jan-25	6,282	$334,980	$321,417	96%
Sub Total	75,693	$3,716,812	$3,658,269	98%
Total	225,662	$11,197,692	$11,071,438	99%

Note: Above data does not include adjustments for trend.

STARMOUNT

GROUP DENTAL INSURANCE CERTIFICATE

Underwritten by: Starmount Life Insurance Company
(called "We," "Our," and "Us")
8485 Goodwood Blvd.
P.O. Box 98100
Baton Rouge, LA 70806

AlwaysCare

Administrator: AlwaysCare Benefits, Inc. (a Starmount Life Insurance company)
8485 Goodwood Blvd., P.O. Box 80139
Baton Rouge, LA 70898-0139

This Certificate explains the dental insurance coverage under the Group Policy (the Policy) issued to the Policyholder. The Policy provides the benefits for the Insured Member (called "You" or "Your") and any Covered Dependents.

The Policyholder and the Policy Number are shown in the Schedule of Benefits.

This, together with the Schedule of Benefits applying to Your Eligible Class, forms Your Certificate of Insurance while covered under the Policy. It replaces any previous Certificates of Insurance issued under the Policy to You.

This Certificate provides a general description of Your dental benefits. All benefits are governed by the terms and conditions of the Policy.

The Policy alone constitutes the entire contract between the Policyholder and Us.

Jeffrey G. Wild, Secretary

Erich Sternberg, Chief Executive Officer

NON-PARTICIPATING

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PART I. DEFINITIONS

Administrator - The entity which will provide complete service and facilities for the writing and servicing of this policy as agreed in a contract with Us.

Calendar Year Plan - Benefits begin anew on January 1 of each Calendar Year.

Claim - A statement signed by an Insured and his treating dentist for a request of payment under a dental benefit plan. It shall include services rendered, dates of services and itemization of costs.

Co-Pay - The fixed amount that an Insured is required to pay directly to a Participating Provider for Covered Expenses. The Co-Pay may vary by Procedure Code. If a Co-Pay applies, it is shown on the Schedule of Benefits.

Covered Dependent – Means an Eligible Dependent who is insured under this Certificate.

Covered Expense - The lesser of the following for a Covered Procedure: (1) the actual charge; or (2) the Maximum Reimbursement.

Covered Procedure - The procedures listed in the Schedule of Covered Procedures. The procedure must be: (1) for performed dental treatment to an Insured while His coverage under this Certificate is in force and (2) for treatment, which in Our opinion has a reasonably favorable prognosis for the patient. The procedure must be performed by a:

1. licensed dentist who is acting within the scope of his or her license;
2. licensed physician performing dental services within the scope of his or her license; or
3. licensed dental hygienist acting under the supervision and direction of a dentist.

Deductible - The Deductible is shown on the Schedule of Benefits. The Individual Deductible is the amount that each Insured must satisfy once each Certificate Year (or lifetime, when applicable) before benefits are payable for Covered Procedures. We apply amounts used to satisfy Individual Deductibles to the Maximum per Family Deductible, if any. Once any Maximum per Family Deductible is satisfied, no further Individual Deductibles are required to be met for that Certificate Year. If multiple procedures are performed on the same date, the Deductibles will be satisfied in order of Procedure Class (that is, toward Procedure Class B, and then C.)

Eligible Class – Means the group of people who are eligible for coverage under the Group Policy. The Members of the Eligible Classes are shown on the Schedule of Benefits. Each Member of the Eligible Class will qualify for insurance on the date He completes the required Eligibility Period, if any.

Eligible Dependent - Means a person listed below:

1. Your spouse ;
2. Your unmarried dependent child under age 26, who is your natural or adopted child, grandchild who is in legal custody of and residing with the grandparent, step-child, foster child, or child for whom you are a legal guardian and who is primarily dependent on You for support and maintenance.
3. Your unmarried dependent child or grandchild who is a full-time student and who develops a mental or nervous condition, problem, or disorder, which renders the child or grandchild, in the opinion of a qualified psychiatrist, subject to a second opinion if deemed necessary by the health insurance issuer or health maintenance organization, unable to attend school as a full-time student and from holding self-sustaining employment, until the age of 26.
4. Your unmarried child who has reached age 26 and who is:
   a. primarily dependent upon You for support and maintenance; and
   b. incapable of self-sustaining employment by reason of mental retardation, mental illness or disorder or physical handicap.

   Proof of the child's incapacity or dependency must be furnished to Us for an already enrolled child who reaches the age limitation, or when You enroll a new disabled child under the plan.

Eligibility Period – The period of time a Member must wait before He is eligible for coverage. The Eligibility Period, if any, is specified in the Policyholder's Group Application and shown in the Schedule of Benefits.

He, Him and His – Refers to the male or female gender.

Initial Term - The period following the group's initial effective date and shown in the Schedule of Benefits. Rates are guaranteed not to change during this period.

In-Network Benefits - The dental benefits provided under this Certificate for Covered Procedures that are provided by a Participating Provider.

Insured – Means You and each Covered Dependent.

Insured Member– Means a person:

1. who is a Member of an Eligible Class; and
2. who has qualified for insurance by completing the Eligibility Period, if any; and
3. for whom insurance under the Policy has become effective.

Late Entrant - Any Member or Eligible Dependent enrolling outside the Policyholder's initial Eligibility Period as indicated in the Schedule of Benefits. Benefits may be limited for Late Entrants as noted under Part VII., A under Limitations.

Maximum Reimbursement – An amount used to determine the Covered Expense. There are 4 types of Maximum Reimbursement, depending on the plan issued:

1. **Maximum Allowable Charge (MAC)**: The MAC may be used if a dentist who is a Non-Participating Provider performs a Covered Procedure. The amount of the MAC is equal to the lesser of: (a) the dentist's actual charge; or (b) the "customary charge" for the dental service or supply. We determine the "customary charge" from within the range of charges made for the same service or supply by other providers of similar training or experience in that general geographic area.
2. **Participating Provider Maximum Allowable Charge (PMAC)**: The PMAC may be used if a dentist who is a Participating Provider performs a Covered Procedure. This is the amount that the dentist has agreed with Us to accept as payment in full for a dental service or supply.
3. **Scheduled Fee (SF)**: Some plans may use a fee schedule to determine the amount payable for a Covered Procedure. This is the maximum charge that We allow for each Covered Procedure, regardless of the fee charged by the dentist. The Scheduled Fee for a Participating Provider may be different than the Scheduled Fee for a Non-Participating Provider.
4. **Indemnity**: The Maximum Allowable Charge (MAC), as explained in (1,) above, is used to determine the amount payable for a Covered Procedure. However, the MAC will be the same, regardless of whether a Participating Provider or Non-Participating Provider is used.

The Schedule of Covered Procedures shows the Type Of Maximum Reimbursement used by the plan.

Member – Means a person who belongs to an Eligible Class of the Policyholder.

Non-Participating Provider - A dentist who is not a Participating Provider. These dentists have not entered into an agreement with us to limit their charges.

Out-of–Network Benefits - The dental benefits provided under this Certificate for Covered Procedures that are not provided by a Participating Provider.

Participating Provider - A dentist who has been selected by Us for inclusion in the Participating Provider Program. These Participating Providers agree to accept Our Participating Provider Maximum Allowed Charges as payment in full for services rendered. When dental care is given by Participating Providers, the Insured will generally incur less out-of-pocket cost for services rendered.

Participating Provider Program - Our program to offer an Insured the opportunity to receive dental care from dentists who are designated by Us as Participating Providers.

Participating Provider Program Directory - The list which consists of selected dentists who:

1. are located in Your area; and
2. have been selected by Us to be Participating Providers and part of the Participating Provider Program.

The list will be periodically updated and is subject to change without notice.

Policyholder - The entity stated on the front page of the Policy.

Policy Year Plan - Benefits begin immediately on the Policyholder's effective date and renew 12 months following the initial effective date.

Re-enrollee - Any Insured who terminated his coverage, and then subsequently re-enrolled for coverage at a later date. Benefits are limited for Re-enrollees under Part VII. Limitations.

You or Your – The Insured Member.

Waiting Period - The period of time during which an Insured's coverage must be in force before benefits may become payable for Covered Procedures. The Waiting Period, if any, for each Covered Procedure is shown in the Schedule of Covered Procedures.

PART II. ELIGIBILITY AND ENROLLMENT

A. ELIGIBILITY

To be eligible for coverage under the Policy, an individual must:

1. be a Member of an Eligible Class of the Policyholder, as defined in the Schedule of Benefits; and
2. satisfy the Eligibility Period, if any.

The Member's Eligible Dependents are also eligible for coverage, provided that Dependent coverage is provided under the Policy.

Dual Eligibility Status: If both a Member and his spouse are in an Eligible Class of the Policyholder, each may enroll individually or as a dependent of the other, but not as both. Any Eligible Dependent child may also only be enrolled by one parent. If the spouse carrying dependent coverage ceases to be eligible, dependent coverage may become effective under the other spouse's coverage.

B. ENROLLMENT

The term "Enrollment" means written or electronic application for coverage on an enrollment form furnished or approved by Us. Coverage will not become effective until the Members have enrolled themselves and their Eligible Dependents, and paid the required premium, if any.

Initial Enrollment: Members should enroll themselves and their Eligible Dependents within thirty-one (31) days of the Eligibility Period. Individuals who enroll after this time are considered Late Entrants.

Open Enrollment: Members may enroll themselves and their Eligible Dependents during an open enrollment period. Open enrollment is a period of time specified by the Policyholder and approved by Us. It usually occurs once each Calendar Year but may, at Our discretion, occur more frequently. Other changes may also be restricted to Open Enrollment periods.

Late Entrants: Members who do not enroll themselves or their Eligible Dependents within the Initial Enrollment period, may not enroll until the next Open Enrollment period unless there is a change in family status, as described below.

Change in Family Status: Members may enroll or change their coverage if a change in family status occurs, provided written application to enroll is made within thirty-one (31) days of the event. A change in family status means any of the following events:

1. Marriage;
2. Divorce or legal separation;
3. Birth or adoption of a child;
4. Death of a spouse or child;
5. Other changes as permitted by the Policyholder.

PART III. INDIVIDUAL EFFECTIVE DATES

Your coverage will be effective on the later of the following dates, provided that any required premium is paid to Us:

1. the Policyholder's Effective Date, shown on the Schedule of Benefits; or
2. the date You meet all the Eligibility and Enrollment requirements.

For Eligible Dependents acquired after Your effective date of coverage, by reason of marriage, birth or adoption, coverage is effective on the first of the month following the date such dependent was acquired. This is subject to our receipt of the required Enrollment and payment of the premium, if any.

Newborn Coverage: Any child born to You or Your Covered Dependent spouse is covered from the moment of birth to thirty-one (31) days. A notice of birth, together with any additional premium, must be submitted to Us within thirty-one (31) days of the birth in order to continue the coverage beyond the initial 31-day period.

Adopted Children: A child adopted by You is covered from the date of placement. Coverage will continue unless the child's placement is disrupted prior to legal adoption. A notice of placement for adoption, together with any additional premium, must be submitted to Us within thirty-one (31) days of the placement in order to continue the coverage beyond the initial 31-day period.

PART IV. INDIVIDUAL TERMINATION DATES

Coverage for You and all Covered Dependents stops on the earliest of the following dates:

1. the date the Policy terminates;
2. the date the Policyholder's coverage terminates under the Policy;
3. the first of the month following the date You are no longer an eligible Member;
4. the date You die;
5. on any premium due date, if full payment for Your insurance is not made within thirty-one (31) days following the premium due date.

In addition, coverage for each Covered Dependent stops on the earliest of:

1. the date he is no longer an Eligible Dependent;
2. the date We receive your request to terminate Covered Dependent coverage. This is subject to any limitation imposed by the Policyholder as to when a change is permitted; e.g. under an Open Enrollment period.

PART V. INDIVIDUAL PREMIUMS

Members may be required to contribute, either in whole or in part, to the cost of their insurance. This is subject to the terms established by the Policyholder. Your premium contributions, if required, are remitted to Us in one of two ways:

1. You contribute to the cost of the insurance through the Policyholder, who then submits payment to Us; or
2. You pay Your premiums directly to Us.

The Schedule of Benefits shows the method of premium payment.

The first premium is due on the Effective Date. Premiums after the first are due on the Premium Due Date or within the grace period.

Grace Period: A grace period of thirty-one (31) days is granted for the payment of each premium due after the first. The coverage stays in force if the premium is paid during this grace period, unless We are given written notice that the insurance is to be ended before the Grace Period.

Right to Change Premiums: We have the right to change the premium rates on any premium due date on or after the Initial Term. After the Initial Term, We will not increase the premium rates more than once in a twelve (12) month period. We will give the Policyholder written notice at least sixty (60) days in advance of any change. All changes in rates are subject to terms outlined in the Policy.

PART VI. DESCRIPTION OF COVERAGE

A. COVERED DENTAL EXPENSES

We determine if benefits are payable under the policy if an Insured incurs expenses for a Covered Procedure. Before we determine benefits, the Insured must satisfy the Deductible and Waiting Period, if any.

The Deductible is shown on the Schedule of Benefits. The Waiting Period is listed separately for each Covered Procedure. It is shown on the Schedule of Covered Procedures.

We then pay the Insurance Percentage of the Covered Expense, minus any Co-Pay. The Insurance Percentage is shown in the Table of Insurance Percentages on the Schedule of Benefits.

The Co-Pay, if any, is listed for each Covered Procedure in the Schedule of Covered Procedures.

The benefit is subject to the following:

1. The Covered Procedure must start and be completed while the Insured's coverage is in force, except as provided in the Takeover Benefits provision, if applicable.
2. Each Covered Procedure may be subject to specific Limitations, as shown on the Schedule of Covered Procedures.
3. A Certificate Year Maximum Annual Benefit may apply to each Insured. This is shown on the Schedule of Benefits.
4. A Maximum Annual and/or Maximum Lifetime Benefit may apply to each Procedure Class. If applicable, these maximums are shown in the Table of Covered Insurance Percentages on the Schedule of Benefits.
5. Other limitations and exclusions that may affect coverage are shown in the "Limitations and Exclusions" provision.

B. WHEN A COVERED PROCEDURE IS STARTED AND COMPLETED

1. We consider a dental treatment to be started as follows:
   a. for a full or partial denture, the date the first impression is taken;
   b. for a fixed bridge, crown, inlay and onlay, the date the teeth are first prepared;
   c. for root canal therapy, on the date the pulp chamber is first opened;
   d. for periodontal surgery, the date the surgery is performed; and
   e. for all other treatment, the date treatment is rendered.

2. We consider a dental treatment to be completed as follows:
   a. for a full or partial denture, the date a final completed prosthesis is first inserted in the mouth;
   b. for a fixed bridge, crown, inlay and onlay, the date the bridge or restoration is cemented in place; and
   c. for root canal therapy, the date a canal is permanently filled.

NOTE: If Orthodontia Services are covered, see Procedure Class D in the Schedule of Covered Procedures for start and completion dates.

C. HOW TO SUBMIT EXPENSES

Expenses submitted to Us must identify the treatment performed in terms of the American Dental Association Uniform Code on Dental Procedures and Nomenclature or by narrative description. We reserve the right to request x-rays, narratives and other diagnostic information, as we see fit, to determine benefits.

D. CHOICE OF PROVIDERS

An Insured may choose a dentist of his choice. An Insured may choose the services of a dentist who is either a Participating Provider or a Non-Participating Provider. Benefits under this Certificate are determined and payable in either case. If a Participating Provider is chosen, the Insured will generally incur less out-of-pocket cost unless the Policyholder has selected a Participating Provider Only plan.

Note: If this is an Indemnity plan, there is no difference in payment between a Participating and Non-Participating Provider.

E. PRE-ESTIMATE

If the charge for any treatment is expected to exceed $300, We suggest that a dental treatment plan be submitted to Us by Your dentist for review before treatment begins. In addition to a dental treatment plan, We may request any of the following information to help Us determine benefits payable for certain services:

1. full mouth dental x-rays;
2. cephalometric x-rays and analysis;
3. study models; and
4. a statement specifying:
    a. degree of overjet, overbite, crowding and open bite;
    b. whether teeth are impacted, in crossbite, or congenitally missing;
    c. length of orthodontic treatment; and
    d. total orthodontic treatment charge.

An estimate of the benefits payable will be sent to You and Your dentist. The pre-estimate is not a guarantee of the amount We will pay. The pre-estimate process lets an Insured know in advance approximately what portion of the expenses We will consider as a Covered Expense. Our estimate may be for a less expensive alternative benefit if it will produce professionally satisfactory results.

F. ALTERNATE BENEFIT PROVISION

Many dental problems can be resolved in more than one way. If: 1) We determine that a less expensive alternative benefit could be provided for the resolution of a dental problem; and 2) that benefit would produce the same resolution of the diagnosed problem within professionally acceptable limits, We may use the less expensive alternative benefit to determine the amount payable under the Certificate. **For example**: When an amalgam filling and a composite filling are both professionally acceptable methods for filling a molar, We may base our benefit on the amalgam filling which is the less expensive alternative benefit. This is the case whether a Participating Provider or Non-participating Provider performs the service.

G. SERVICES PERFORMED OUTSIDE THE U.S.A.

Any Claim submitted for procedures performed outside the U.S.A. must: (1) be for a Covered Procedure, as defined; (2) be supplied in English; (3) use American Dental Association (ADA) codes; and (4) be in U.S. Dollar currency. Reimbursement will be based on the Maximum Allowable Charge, Participating Provider Maximum Allowable Charge, or applicable Scheduled Fee amounts for the Insured's zip code.

PART VII. LIMITATIONS AND EXCLUSIONS

A. LIMITATIONS

1. **LIMITATION FOR LATE ENTRANTS OR RE-ENROLLEES:** Members that waive coverage at initial enrollment (within thirty-one (31) days of effective date) or in the new Member eligibility period will have a twelve (12) month waiting period applied to all basic, major, and orthodontia services upon re-applying. Coverage for a Late Entrant or a Re-enrollee will be limited to those procedures listed under Procedure Class A in the Schedule of Covered Procedures during the first twelve (12) months after the Late Entrant's or Re-Enrollee's Effective Date. The limited coverage also applies to the Late Entrant's or Re-Enrollee's Eligible Dependents, if enrolled.

2. **MISSING TEETH LIMITATION:** We will not pay benefits for replacement of teeth missing on an Insured's effective date of insurance under this Certificate for the purpose of the initial placement of a full denture, partial denture fixed bridge or implant. However, expenses for the replacement of teeth missing on the effective date will be considered for payment as follows:
   a. The initial placement of full or partial dentures, fixed bridge or implant will be considered a Covered Procedure if the placement includes the initial replacement of a functioning natural tooth extracted while the Insured is covered under the policy.
   b. The initial placement of a fixed bridge or implant will be considered a Covered Procedure if the placement includes the initial replacement of a functioning natural tooth extracted while an Insured is covered under the policy. However, the following restrictions will apply:
      (i) Benefits will only be paid for the replacement of the teeth extracted while an Insured is covered under the policy or under the "Prior Extraction" clause;
      (ii) benefits will not be paid for the replacement of other teeth which were missing on the Insured's effective date.
      (iii) missing teeth limitation will be waived after Insured has been covered under this group's plan for three (3) continuous years unless it is a replacement of an existing unserviceable prosthesis.

3. **Other Limitations:** Multiple restorations on one surface are payable as one surface. Multiple surfaces on a single tooth will not be paid as separate restorations. Coverage is limited to two prophylaxis and/or two periodontal maintenance procedures, subject to a maximum total of no more than two (2) procedures per twelve (12) month period. Coverage is limited to one (1) full mouth radiograph or panoramic film per limitation period listed in the Schedule of Covered procedures On any given day, more than seven (7) periapical x-rays or a panoramic film in conjunction with bitewings will be paid as a full mouth radiograph. Additional limitations are noted in the Schedule of Covered Procedures.

B. EXCLUSIONS

No benefits are payable under the Policy for the procedures listed below unless such procedure or service is listed as covered in the Schedule of Covered Procedures. Additionally, the procedures listed below will not be recognized toward satisfaction of any Deductible amount.

1. any service or supply not shown on the Schedule of Covered Procedures;
2. any procedure begun after an Insured's insurance under the Policy terminates, or for any prosthetic dental appliance finally installed or delivered more than thirty (30) days after an Insured's insurance under the Policy terminates;
3. any procedure begun or appliance installed before an Insured became insured under the Policy;
4. any treatment which is elective or primarily cosmetic in nature and not generally recognized as a generally accepted dental practice by the American Dental Association, as well as any replacement of prior cosmetic restorations;
5. the correction of congenital malformations or congenital missing teeth;
6. the replacement of lost or discarded or stolen appliances;
7. replacement of bridges unless the bridge is older than the age allowed in the Schedule of Covered Procedures and cannot be made serviceable;
8. replacement of full or partial dentures unless the prosthetic appliance is older than the age allowed in the Schedule of Covered Procedures and cannot be made serviceable;
9. replacement of implants, crowns, inlays or onlays unless the prior restoration is older than the age

allowed in the Schedule of Covered Procedures and cannot be made serviceable;

10. appliances, services or procedures relating to: (a) the change or maintenance of vertical dimension; (b) restoration of occlusion (unless otherwise noted in the Schedule of Covered Procedures—only for occlusal guards); (c) splinting; (d) correction of attrition, abrasion, erosion or abfraction; (e) bite registration or (f) bite analysis;
11. services provided for any type of temporomandibular joint (TMJ) dysfunctions, muscular, skeletal deficiencies involving TMJ or related structures, myofascial pain;
12. orthognathic surgery;
13. prescribed medications, premedication or analgesia;
14. any instruction for diet, plaque control and oral hygiene;
15. dental disease, defect or injury caused by a declared or undeclared war or any act of war;
16. charges for: implants of any type, and all related procedures, removal of implants, precision or semi-precision attachments, denture duplication, overdentures and any associated surgery, or other customized services or attachments;
17. cast restorations, inlays, onlays and crowns for teeth that are not broken down by extensive decay or accidental injury or for teeth that can be restored by other means (such as an amalgam or composite filling);
18. for treatment of malignancies, cysts and neoplasms;
19. for orthodontic treatment;
20. charges for failure to keep a scheduled visit or for the completion of any Claim forms;
21. any procedure We determine which is not necessary, does not offer a favorable prognosis, or does not have uniform professional endorsement or which is experimental in nature;
22. service or supply rendered by someone who is related to an Insured by blood or by law (e.g., sibling, parent, grandparent, child), marriage (e.g., spouse or in-law) or adoption or is normally a member of the Insured's household;
23. expenses compensable under Workers' Compensation or Employers' Liability Laws or by any coverage provided or required by law (including, but not limited to, group, group-type and individual automobile "No-Fault" coverage);
24. expenses provided or paid for by any governmental program or law, except as to charges which the person is legally obligated to pay or as addressed later under the "Payment of Claims" provision;
25. procedures started but not completed;
26. any duplicate device or appliance;
27. general anesthesia and intravenous sedation except in conjunction with covered complex oral surgery procedures as defined by Us, plus the services of anesthetists or anesthesiologists;
28. the replacement of 3rd molars;
29. crowns, inlays and onlays used to restore teeth with micro fractures or fracture lines, undermined cusps, or existing large restorations without overt pathology.

PART VIII. CLAIM PROVISIONS

Notice Of Claim: Written notice of Claim must be given within thirty (30) days after a loss occurs, or as soon as reasonably possible. The notice must be given to the Administrator. Claims should be sent to:

Starmount Life Insurance Company
c/o AlwaysCare Benefits, Inc. (a Starmount Life Insurance company)
8485 Goodwood Blvd., P.O. Box 80139
Baton Rouge, LA 70898-0139

Claim Forms: When the Administrator receives notice of Claim that does not contain all necessary information or is not on an appropriate Claim form, forms for filing proof of loss will be sent to the claimant along with a request for the missing information. If these forms are not sent within fifteen (15) days after receiving notice of claim, the claimant will meet the proof of loss requirements if the Administrator is given written proof of the nature and extent of the loss.

Proof Of Loss: Written proof of loss must be given to the Administrator within ninety (90) days after the loss begins. We will not deny nor reduce any claim if it was not reasonably possible to give proof of loss in the time required. In any event, proof must be given to the Administrator within one (1) year after it is due, unless You are legally incapable of doing so.

Payment Of Claims: Benefits will be paid to You unless an Assignment of Benefits has been requested by the Insured. Benefits due and unpaid at Your death will be paid to Your estate. Any payment made by Us in good faith pursuant to this provision will fully release Us to the extent of such payment.

If any beneficiary is a minor or mentally incapacitated, We will pay the proper share of Your insurance amount to such beneficiary's court appointed guardian.

Time Payment Of Claims: Benefits will be payable immediately upon receipt of acceptable Proof of Loss.

Recovery Of Overpayments: We reserve the right to deduct from any benefits properly payable under this Policy the amount of any payment that has been made:

1. In error; or
2. pursuant to a misstatement contained in a proof of loss; or
3. pursuant to fraud or misrepresentation made to obtain coverage under this Policy within two (2) years after the date such coverage commences; or
4. with respect to an ineligible person; or
5. pursuant to a claim for which benefits are recoverable under any Policy or act of law providing coverage for occupational injury or disease to the extent that such benefits are recovered.

Such deduction may be against any future claim for benefits under the Policy made by an Insured if claim payments previously were made with respect to an Insured.

PART IX. COORDINATION OF BENEFITS (COB)

This provision applies when an Insured has dental coverage under more than one Plan, as defined below. The benefits payable between the Plans will be coordinated.

A. DEFINITIONS RELATED TO COB

1. **Allowable Expense:** An expense that is considered a covered charge, at least in part, by one or more of the Plans. When a Plan provides benefits by services, reasonable cash value of each service will be treated as both an Allowable Expense and a benefit paid.

2. **Coordination of Benefits:** Taking other Plans into account when We pay benefits.

3. **Plan:** Any plan, including this one that provides benefits or services for dental expenses on either a group or individual basis. "Plan" includes group and blanket insurance and self-insured and prepaid plans. It includes government plans, plans required or provided by statute (except Medicaid), and no fault insurance (when allowed by law). "Plan" shall be treated separately for that part of a plan that reserves the right to coordinate with benefits or services of other plans and that part which does not.

4. **Primary Plan**: The Plan that, according to the rules for the Order of Benefit Determination, pays benefits before all other Plans.

5. **Year:** The Calendar Year, or any part of it, during which a person claiming benefits is covered under this Plan.

B. BENEFIT COORDINATION

Benefits will be adjusted so that the total payment under all Plans is no more than 100 percent of the Insured's Allowable Expense. In no event will total benefits paid exceed the total payable in the absence of COB.

If an Insured's benefits paid under this Plan are reduced due to COB, each benefit will be reduced proportionately. Only the amount of any benefit actually paid will be charged against any applicable benefit maximum.

C. THE ORDER OF BENEFIT DETERMINATION

1. When this is the Primary Plan, We will pay benefits as if there were no other Plans.

2. When a person is covered by a Plan without a COB provision, the Plan without the provision will be the Primary Plan.

3. When a person is covered by more than one Plan with a COB provision, the order of benefit payment is as follows:

   a. **Non-dependent/Dependent.** A Plan that covers a person other than as a dependent will pay before a Plan that covers that person as a dependent.

   b. **Dependent Child/Parents Not Separated or Divorced**. For a dependent child, the Plan of the parent whose birthday occurs first in the Calendar Year will pay benefits first. If both parents have the same birthday, the Plan that has covered the dependent child for the longer period will pay first. If the other Plan uses gender to determine which Plan pays first, We will also use that basis.

   c. **Dependent Child/Separated or Divorced Parents**. If two (2) or more Plans cover a person as a Dependent of separated or divorced parents, benefits for the child are determined in the following order:
      i. The Plan of the parent who has responsibility for providing insurance as determined by a court order;
      ii. The Plan of the parent with custody of the child;
      iii. The Plan of the spouse of the parent with custody; and
      iv. The Plan of the parent without custody of the child.

   d. **Dependent Child/Joint Custody**. If the joint custody court decree does not specifically state which parent is responsible for the child's medical expenses, the rules as shown for Dependent Child/Parents Not Separated or Divorced shall apply.

   e. **Active/Inactive Employee.** The Plan which covers the person as an employee who is neither laid off nor retired (or as that employee's dependent) is Primary over the Plan which covers that person as a laid off or retired employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored.

   f. **Longer/Shorter Length of Coverage**. When an order of payment is not established by the above, the Plan that has covered the person for the longer period of time will pay first.

D. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

We may release to, or obtain from, any other insurance company, organization or person information necessary for COB. This will not require the consent of, or notice to You or any claimant. You are required to give Us information necessary for COB.

E. RIGHT TO MAKE PAYMENTS TO ANOTHER PLAN

COB may result in payments made by another Plan that should have been made by Us. We have the right to pay such other Plan all amounts it paid which would otherwise have been paid by Us. Amounts so paid will be treated as benefits paid under this Plan. We will be discharged from liability to the extent of such payments.

F. RIGHT TO RECOVERY

COB may result in overpayments by Us. We have the right to recover any excess amounts paid from any person, insurance company or other organization to whom, or for whom, payments were made.

PART X. GRIEVANCE PROCEDURE

If a claim for benefits is wholly or partially denied, the Insured will be notified in writing of such denial and of his right to file a grievance and the procedure to follow. The notice of denial will state the specific reason for the denial of benefits. Within sixty (60) days of receipt of such written notice an Insured may file a grievance and make a written request for review to:

Starmount Life Insurance Company
c/o AlwaysCare Benefits, Inc. (a Starmount Life Insurance company)
8485 Goodwood Blvd., P.O. Box 80139
Baton Rouge, LA 70898-0139

We will resolve the grievance within thirty (30) calendar days of receiving it. If We are unable to resolve the grievance within that period, the time period may be extended another thirty (30) calendar days if We notify in writing the person who filed the grievance. The notice will include advice as to when resolution of the grievance can be expected and the reason why additional time is needed.

The Insured or someone on his/her behalf also has the right to appear in person before Our grievance committee to present written or oral information and to question those people responsible for making the determination that resulted in the grievance. The Insured will be informed in writing of the time and place of the meeting at least seven (7) calendar days before the meeting.

For purposes of this Grievance Procedure, a grievance is a written complaint submitted in accordance with the above Grievance Procedure by or on behalf of an Insured regarding dissatisfaction with the administration of claims practices or provision of services of this panel provider plan relative to the Insured.

In situations requiring urgent care, grievances will be resolved within four (4) business days of receiving the grievance.

PART XI. GENERAL PROVISIONS

Cancellation: We may cancel the Policy at any time by providing at least sixty 60 days advance written notice to the Policyholder. The Policyholder may cancel the Policy at any time by providing written notice to Us, effective upon Our receipt on the notice or the date specified in the notice, if later. In the event of such cancellation by either Us or the Policyholder, We shall promptly return on a pro rata basis any unearned premium paid. The Policyholder shall promptly pay on a pro rata basis the earned premium which has not been paid, if any. Such cancellation shall be without prejudice to any claim originating prior to the effective date of such cancellation.

Legal Actions: No legal action may be brought to recover on the Policy before sixty (60) days after written proof of loss has been furnished as required by the Policy. No such action may be brought after three (3) years from the time written proof of loss is required to be furnished.

PART XII. TAKEOVER BENEFITS

The following provisions are applicable if this dental plan is replacing existing group dental plan in force (referred to as "Prior Plan") at the time of application. These are called "Takeover Benefits." The Schedule of Benefits shows if Takeover Benefits apply.

Takeover benefits apply if we are taking over a comparable benefits plan from another carrier and only if there is no break in coverage between the original plan and the takeover date. Takeover is available to those individuals insured under the employer's dental plan in effect at the time of the employer's application. If takeover benefits are included in your benefits, then waiting periods for service will be waived for the individuals currently insured under the employer's previous plan during the month prior to coverage moving to Starmount Life Insurance.

New hires with prior-like dental coverage (lapse in coverage must be less than sixty-three (63) days) will receive takeover credit for the length of time they had with the prior carrier and must provide proof of coverage (including coverage dates) to receive takeover credit (i.e., one page benefit summary, certificate of creditable coverage, etc.).

Waiting Period Credit: When We immediately take over an entire dental group from another carrier, those persons insured by the Prior Plan on the day immediately prior to the takeover effective date will receive Waiting Period credit if they are eligible for coverage on the effective date of Our plan. The Waiting Period credit does not apply to Late Entrants or Re-enrollees.

Annual Maximums And Deductible Credits: For Calendar Year Plans: Deductible credits will be granted for the amount of Deductible satisfied under the Prior Plan during the current Calendar Year. Any benefits paid under the Prior Plan with respect to such replaced coverage will be applied to and deducted from the maximum benefit payable under this Certificate.

For Policy Year Plans: The annual maximums and annual Deductibles will begin on the policy's takeover effective date, which marks the start of a new Policy Year. Deductible credit will not be given. Any benefits paid under the Prior Plan with respect to such replaced coverage will not be applied to or deducted from the maximum benefits payable for services under this Certificate.

Maximum Benefit Credit: All paid benefits applied to the maximum benefit amounts under the Prior Plan will also be applied to the maximum benefit amounts under this Certificate.

If You had orthodontic coverage for Your covered dependent children under the Prior Plan and You have orthodontic coverage under this Certificate, We will not pay benefits for orthodontic expenses unless:

1. You submit proof that the Maximum Lifetime Benefit for Class D Orthodontic Services for this Certificate was not exceeded under the Prior Plan; and
2. orthodontic treatment was started and bands or appliances were inserted while insured under the Prior Plan; and
3. orthodontic treatment is continued while Your covered dependent is insured under this Certificate.

If You submit the required proof, the maximum benefit for orthodontic treatment will be the lesser of this Certificate's Overall Maximum Benefit for Class D Orthodontic Services or the Prior Plan's ortho maximum benefit. The ortho maximum benefit payable under this Certificate will be reduced by the amount paid or payable under the Prior Plan.

Verification: The Policyholder's application must be accompanied by a current month's billing from the current dental carrier, a copy of an in-force certificate, as well as proof of the effective date for each Insured (and dependent), if insured under the Prior Plan.

Prior Carrier's Responsibility: The prior carrier is responsible for costs for procedures begun prior to the effective date of this coverage.

Prior Extractions: If: (1) treatment is performed due to an extraction which occurred before the effective date of this coverage while an Insured was covered under the Prior Plan; and (2) the replacement of the extracted tooth must take place within thirty-six (36) months of extraction; and (3) treatment would have been covered under the Policyholder's Prior Plan; We will apply the expenses to this plan as long as they are Covered Expenses under both this Certificate and the Prior Plan.

Coverage for Treatment in Progress: If an Insured was covered under the Prior Plan on the day before this Certificate replaced the Prior Plan, the Insured may be eligible for benefits for treatment already in progress on the effective date of this Certificate. However, the expenses must be covered dental expenses under both this Certificate and the Prior Plan. This is subject to the following:

1. Extension of Benefits under Prior Plan. We will not pay benefits for treatment if:
   (a) the Prior Plan has an Extension of Benefits provision;
   (b) the treatment expenses were incurred under the Prior Plan; and
   (c) the treatment was completed during the extension of benefits.
2. No Extension of Benefits under Prior Plan. We will pro-rate benefits according to the percentage of treatment performed while insured under the Prior Plan if:
   (a) the Prior Plan has no extension of benefits when that plan terminates;
   (b) the treatment expenses were incurred under the Prior Plan; and
   (c) the treatment was completed while insured under this Certificate.
3. Treatment Not Completed during Extension of Benefits. We will pro-rate benefits according to the

percentage of treatment performed while insured under the Prior Plan and during the extension if:

(a) the Prior Plan has an extension of benefits;
(b) the treatment expenses were incurred under the Prior plan; and
(c) the treatment was not completed during the Prior Plan's extension of benefits.

We will consider only the percentage of treatment completed beyond the extension period to determine any benefits payable under this Certificate.

PART XIII. SCHEDULE OF COVERED PROCEDURES

The following is a complete list of Covered Procedures, their assigned Procedure Class, Waiting Period, and applicable limitations. We will not pay benefits for expenses incurred for any Procedure not listed in the Schedule of Covered Procedures.

Key for Schedule of Covered Procedures

* Procedure Class		Type of Maximum Reimbursement:
A	Preventive/Diagnostic	PMAC – Participating Provider Maximum Allowable Charge
B	Basic	MAC – Maximum Allowable Charge (based on "Customary Charge")
C	Major	SF – Scheduled Fee
D	Orthodontia	Indemnity
E	Not Covered	
F	Other	

¶ Limitations

(a)	Maximum of 1 procedure per 6 months
(b)	Maximum of 1 procedure per 36 months
(c)	Maximum of 4 films per 12 months
(d)	Limited to Dependent Children under age 19
(e)	Maximum of 1 procedure per 12 months
(f)	Limited to Dependent Children under age 14
(g)	Limited to Dependent Children under age 12
(h)	Maximum of 1 procedure per 24 months
(i)	Limited to Dependent Children under age 19
(j)	Applications made to permanent molar teeth only
(k)	Maximum of 2 procedures per arch per 24 months
(l)	Maximum of 1 per 5 year period per tooth
(m)	Maximum of 1 each quadrant per 12 months
(n)	Maximum of 1 each quadrant per 24 months
(o)	Maximum of 1 each tooth per 24 months
(p)	Subject to a yearly and a lifetime maximum
(q)	Maximum of 1 each quadrant per 36 months
(r)	Replacement of existing only if in place for 12 months (insured under age 19)
(s)	Replace existing only if in place for 36 months (insured over age 19)
(t)	Benefits will be based on the benefit for the corresponding non-cosmetic restoration.
(u)	Maximum 1 time per tooth or site
(v)	Maximum of 1 per lifetime
(w)	Only in conjunction with listed complex oral surgery procedures and subject to review.
(x)	Limited to Dependent Children under age 16
(y)	Maximum of 1 per 24 months for age 17+
(z)	Maximum of 1 per 12 months for age 16 & under
(aa)	Limited to those age 25+
(bb)	6 months must have passed since initial placement
(cc)	Maximum of 1 per 7 year period when existing appliance/restoration is not serviceable
(dd)	Maximum of 1 per 10 year period
(ee)	Maximum of 1 per 3 year period
(ff)	Maximum of 1 per 4 year period
(gg)	Maximum of 1 per 5 year period
(hh)	In lieu of a single tooth replacement when a 2 or 3 unit bridge has been approved for coverage
(ii)	Maximum of 2 procedures per 12 months
(jj)	Only for those age 40 and over who demonstrate risk factors for oral cancer and/or a suspicious lesion
(kk)	One additional prophylaxis or periodontal maintenance per year if Member is in second or third trimester of pregnancy. Written verification of pregnancy and due date from patient's physician and claim narrative from dentist must be submitted at the time of claim.
(ll)	Two additional cleanings (either prophylaxis or periodontal maintenance) per year if Member has been diagnosed with diabetes mellitus and periodontal disease. Written verification of diabetes mellitus from patient's physician and claim narrative must be submitted at the time of the claim.
(mm)	Covered only if provided on different date of service than other covered treatment or exam
(nn)	Subject to review
(oo)	In lieu of Topical Application of Fluoride for a child
(pp)	Limited to 2 oral evaluation procedures, in any combination (D0120, D0145, D0150) per 12 month period

Covered Procedures	Procedure Class*	Waiting Period (Months)	Limitation	Maximum Reimbursement	
				In-Network PMAC	Out-of-Network MAC
Comprehensive or Periodic Oral Exam	A	(0)	(pp)	PMAC	MAC
Oral Evaluation – Patient under 3 yrs of age	A	(0)	(pp)	PMAC	MAC
Problem Focused Exam	B	(0)	(e)	PMAC	MAC
Comprehensive Periodontal Exam	A	(0)	(e)	PMAC	MAC
Emergency Palliative Treatment	A	(0)	(e)	PMAC	MAC
Single Film	A	(0)		PMAC	MAC
Additional Films	A	(0)		PMAC	MAC
Intra-Oral Occlusal Film	A	(0)		PMAC	MAC
Bitewings (single or multiple films)	A	(0)	(c) (e)	PMAC	MAC
Panoramic Film or Full Mouth X-Ray	A	(0)	(h)	PMAC	MAC
Prophylaxis – Adult (age 16 and above)	A	(0)	(ii) (kk)	PMAC	MAC
Prophylaxis – Child	A	(0)	(x) (ii)	PMAC	MAC
Adjunctive Pre-Diagnostic Oral Cancer Screening	A	(0)	(e) (jj)	Up to $45	Up to $45
Topical Application of Fluoride – Child	A	(0)	(e) (x)	PMAC	MAC
Sealant	A	(0)	(b) (x) (j)	PMAC	MAC
Space Maintainer – Fixed Unilateral	A	(0)	(x) (o)	PMAC	MAC
Space Maintainer – Fixed Bilateral	A	(0)	(x) (o)	PMAC	MAC
Space Maintainer – Removable Unilateral	A	(0)	(x) (o)	PMAC	MAC
Space Maintainer – Removable Bilateral	A	(0)	(x) (o)	PMAC	MAC
FILLINGS					
One Surface Amalgam	B	(0)	(r) (s)	PMAC	MAC
Two Surface Amalgam	B	(0)	(r) (s)	PMAC	MAC
Three Surface Amalgam	B	(0)	(r) (s)	PMAC	MAC
Four + Surface Amalgam	B	(0)	(r) (s)	PMAC	MAC
One Surface Resin – Anterior	B	(0)	(r) (s)	PMAC	MAC
Two Surface Resin – Anterior	B	(0)	(r) (s)	PMAC	MAC
Three Surface Resin – Anterior	B	(0)	(r) (s)	PMAC	MAC
Four + Surface or Incisal Resin – Anterior	B	(0)	(r) (s)	PMAC	MAC
Protective Restoration	B	(0)	(o)	PMAC	MAC
ORAL SURGERY					
Extraction, erupted tooth or exposed root	B	(0)		PMAC	MAC
Extraction, Coronal Remnants	B	(0)		PMAC	MAC
Surgical Extraction	B	(0)		PMAC	MAC
Impacted (soft tissue)	B	(0)		PMAC	MAC
Impacted (partial bony)	B	(0)		PMAC	MAC
Impacted (complete bony)	B	(0)		PMAC	MAC
Surgical Removal of Root	B	(0)		PMAC	MAC
Alveoplasty (with extraction) – per quadrant	B	(0)		PMAC	MAC
Alveoplasty (without extraction) – per quadrant	B	(0)		PMAC	MAC
Incision and Drainage of Abscess – Intraoral	B	(0)		PMAC	MAC
General Anesthesia/Intravenous Sedation	B	(0)	(w)	PMAC	MAC
CROWN AND BRIDGE REPAIR					
Inlay Recementation	B	(0)	(bb)	PMAC	MAC
Crown Recementation	B	(0)	(bb)	PMAC	MAC
Bridge Repair	B	(0)	(bb)	PMAC	MAC
Crown Repair	B	(0)	(bb)	PMAC	MAC
Inlay repair	B	(0)	(bb)	PMAC	MAC
Onlay repair	B	(0)	(bb)	PMAC	MAC
Veneer repair	B	(0)	(bb)	PMAC	MAC
Bridge Recementation	B	(0)	(bb)	PMAC	MAC

Covered Procedures	Procedure Class*	Waiting Period (Months)	Limitation	Maximum Reimbursement	
				In-Network PMAC	Out-of-Network MAC
DENTURE REPAIR					
Repair Denture Base	B	(0)	(e) (bb)	PMAC	MAC
Repair Teeth – per tooth	B	(0)	(e) (bb)	PMAC	MAC
Repair Partial Base	B	(0)	(e) (bb)	PMAC	MAC
Repair Partial Framework	B	(0)	(e) (bb)	PMAC	MAC
Repair Broken Clasp	B	(0)	(e) (bb)	PMAC	MAC
Add Tooth to Existing Partial Denture	B	(0)	(e) (bb)	PMAC	MAC
Add Clasp to Existing Partial Denture	B	(0)	(e) (bb)	PMAC	MAC
Replace Teeth – per tooth	B	(0)	(e) (bb)	PMAC	MAC
Reline Upper Denture	B	(0)	(e) (bb)	PMAC	MAC
Reline Lower Partial Denture	B	(0)	(h) (bb)	PMAC	MAC
Reline Upper Denture (Lab)	B	(0)	(h) (bb)	PMAC	MAC
Reline Lower Denture (Lab)	B	(0)	(h) (bb)	PMAC	MAC
Reline Upper Partial Denture (Lab)	B	(0)	(h) (bb)	PMAC	MAC
Reline Lower Partial Denture (Lab)	B	(0)	(h) (bb)	PMAC	MAC
Rebase Complete Denture – Upper	B	(0)	(h) (bb)	PMAC	MAC
Rebase Complete Denture – Lower	B	(0)	(h) (bb)	PMAC	MAC
Rebase Partial Denture – Lower	B	(0)	(h) (bb)	PMAC	MAC
Tissue Conditioning – Upper	B	(0)	(h) (bb)	PMAC	MAC
Tissue Conditioning – Lower	B	(0)	(k) (bb)	PMAC	MAC
Denture Adjustment Maxillary – Upper	B	(0)	(k) (bb)	PMAC	MAC
Denture Adjustment Mandibular – Lower	B	(0)	(a) (bb)	PMAC	MAC
Partial Adjustment Maxillary – Upper	B	(0)	(a) (bb)	PMAC	MAC
Partial Adjustment Mandibular – Lower	B	(0)	(a) (bb)	PMAC	MAC
PERIODONTICS (Non-surgical)					
Scaling and Root Planing–per quadrant	B	(0)	(n)	PMAC	MAC
Periodontal Debridement (full mouth)	B	(0)	(v)	PMAC	MAC
Periodontal Maintenance Procedure	B	(0)	(ii) (kk)	PMAC	MAC
ENDODONTICS					
Vital Pulpotomy – primary teeth only	B	(0)	(f)	PMAC	MAC
Root Canal – Anterior	B	(0)		PMAC	MAC
Root Canal – Bicuspid	B	(0)		PMAC	MAC
Root Canal – Molar	B	(0)		PMAC	MAC
Apicoectomy – Anterior	B	(0)	(u)	PMAC	MAC
Apicoectomy – Bicuspid	B	(0)	(u)	PMAC	MAC
Apicoectomy – Molar	B	(0)	(u)	PMAC	MAC
Retrograde Filling	B	(0)	(u)	PMAC	MAC
Root Amputation	B	(0)	(u)	PMAC	MAC
MISCELLANEOUS					
Occlusal Guard	E				
PERIODONTICS (Surgical)					
Gingivectomy or Gingivoplasty – per quadrant	B	(0)	(n)	PMAC	MAC
Gingivectomy or gingivoplasty – per tooth	B	(0)	(o)	PMAC	MAC
Gingival Flap Procedure – per quadrant	B	(0)	(n)	PMAC	MAC
Osseous Surgery – per quadrant	B	(0)	(n)	PMAC	MAC
Pedicle Soft Tissue Grafts	B	(0)	(n)	PMAC	MAC
Free Soft Tissue Graft, first tooth	B	(0)	(n)	PMAC	MAC
Free Soft Tissue Graft, additional tooth	B	(0)	(n)	PMAC	MAC
Subepithelial Connective Tissue Graft	B	(0)	(n)	PMAC	MAC
CROWN					
Crown Resin – resin with high noble metal	C	(12)	(l) (t)	PMAC	MAC
Crown Resin – resin with noble metal	C	(12)	(l) (t)	PMAC	MAC

Covered Procedures	Procedure Class*	Waiting Period (Months)	Limitation	Maximum Reimbursement	
				In-Network PMAC	Out-of-Network MAC
Crown Resin – resin with predominately base metal	C	(12)	(l) (t)	PMAC	MAC
Crown – porcelain/ceramic substrate	C	(12)	(l) (t)	PMAC	MAC
Crown - porcelain fused to high noble metal	C	(12)	(l) (t)	PMAC	MAC
Crown – porcelain fused to noble metal	C	(12)	(l) (t)	PMAC	MAC
Crown –porcelain fused to predominantly base metal	C	(12)	(l) (t)	PMAC	MAC
Crown – full cast high noble metal	C	(12)	(l) (t)	PMAC	MAC
Crown – ¾ cast high noble metal	C	(12)	(l) (t)	PMAC	MAC
Crown – full cast predominantly base metal	C	(12)	(l)	PMAC	MAC
Crown Prefabricated Stainless Steel	C	(12)	(l)	PMAC	MAC
Cast Post and Core – In Addition to Crown	C	(12)	(l)	PMAC	MAC
Prefabricated Post and Core – In Addition to Crown	C	(12)	(l)	PMAC	MAC
Inlay	C	(12)	(l)	PMAC	MAC
Onlay	C	(12)	(l)	PMAC	MAC
Veneers – excluding cosmetic; restorative only	C	(12)	(l)	PMAC	MAC
BRIDGE					
Pontic Cast High Noble Metal	C	(12)	(l) (t)	PMAC	MAC
Pontic Cast Noble Metal	C	(12)	(l) (t)	PMAC	MAC
Pontic Cast Predominantly Base Metal	C	(12)	(l)	PMAC	MAC
Pontic Porcelain Fused to High Noble Metal	C	(12)	(l) (t)	PMAC	MAC
Pontic Porcelain Fused to Noble Metal	C	(12)	(l) (t)	PMAC	MAC
Pontic Porcelain Fused to Predominantly Base Metal	C	(12)	(l) (t)	PMAC	MAC
Pontic Resin with High Noble Metal	C	(12)	(l) (t)	PMAC	MAC
Pontic Resin with Noble Metal	C	(12)	(l) (t)	PMAC	MAC
Pontic Resin with Predominantly Base Metal	C	(12)	(l)	PMAC	MAC
Crown Resin with High Noble Metal	C	(12)	(l) (t)	PMAC	MAC
Crown Resin with Noble Metal	C	(12)	(l) (t)	PMAC	MAC
Crown Resin with Predominantly Base Metal	C	(12)	(l) (t)	PMAC	MAC
Crown Porcelain / Ceramic; Porcelain Fused to High Noble Metal	C	(12)	(l) (t)	PMAC	MAC
Crown Porcelain Fused to Noble / High Noble Metal	C	(12)	(l) (t)	PMAC	MAC
Crown Porcelain Fused to Predominantly Base Metal	C	(12)	(l) (t)	PMAC	MAC
Crown Porcelain Fused to Noble Metal; Full Cast High Noble Metal	C	(12)	(l) (t)	PMAC	MAC
Crown ¾ Cast High Noble Metal	C	(12)	(l) (t)	PMAC	MAC
Crown Full Cast Noble Metal	C	(12)	(l) (t)	PMAC	MAC
Crown Full Cast Predominantly Base Metal	C	(12)	(l)	PMAC	MAC
Core Build-up (including any pins)	C	(12)	(l)	PMAC	MAC
DENTURES					
Complete Upper Denture	C	(12)	(l)	PMAC	MAC
Complete Lower Denture	C	(12)	(l)	PMAC	MAC
Immediate Upper Denture	C	(12)	(l)	PMAC	MAC
Immediate Lower Denture	C	(12)	(l)	PMAC	MAC
Maxillary (Upper) Partial – Resin Base	C	(12)	(l)	PMAC	MAC
Mandibular (Lower) Partial – Resin Base	C	(12)	(l)	PMAC	MAC
Maxillary (Upper)Partial – Cast Metal Framework with Resin Base	C	(12)	(l)	PMAC	MAC

Covered Procedures	Procedure Class*	Waiting Period (Months)	Limitation	Maximum Reimbursement	
				In-Network PMAC	Out-of-Network MAC
Mandibular (Lower) Partial – Cast Metal Framework with Resin Base	C	(12)	(l)	PMAC	MAC
Removable Unilateral Partial Denture	C	(12)	(l)	PMAC	MAC
OTHER					
Endosteal Implants	C	(12)	(hh) (v)	PMAC	MAC
Cosmetic	E				
TMJ	E				
ORTHODONTIA **					
Initial Orthodontic Examination	D	(12)	(d) (p)	PMAC	MAC
Initial Placement of Braces or Appliances	D	(12)	(d) (p)	PMAC	MAC
Continuing Treatment for Braces or Appliances including retention	D	(12)	(d) (p)	PMAC	MAC

*** Orthodontia Services**

If covered, We will pay benefits for the orthodontic services listed above when the date started for the orthodontic service occurs while the person is insured under this Certificate. No payment will be made for orthodontic treatment if the appliances or bands are inserted prior to becoming insured except as provided in the Takeover Benefits provision. We consider orthodontic treatment to be started on the date the bands or appliances are inserted. Any other orthodontic treatment that can be completed on the same day it is rendered is considered to be started and completed on the date the orthodontic treatment is rendered.

We will pay the Insurance Percentage shown in the Schedule of Benefits after any required deductible for orthodontic services has been satisfied for the Certificate Year. The maximum benefit payable to each Covered Dependent child, while insured under the policy, for orthodontic services is shown in the Schedule of Benefits. Those Insureds who are eligible for Orthodontia coverage are indicated in the Schedule of Benefits. The maximum benefit will apply even if coverage is interrupted.

We will make a payment for covered orthodontic services related to the initial orthodontic treatment which consists of diagnosis, evaluation, pre-care and insertion of bands or appliances. After the payment for the initial orthodontic treatment, benefits for covered orthodontic services will be paid in monthly installments as claims are submitted over the course of the remaining orthodontic treatment. The benefit payment schedule for the initial orthodontic treatment and monthly installments will be determined as follows:

1. We will determine the lesser of the MAC and the orthodontist's fee and multiply that amount by the Insurance Percentage shown in the Schedule.
2. The lesser of the amount from number 1 or the Overall Maximum Benefit for orthodontic services shown in the Schedule of Benefits will be the maximum benefit payable. An initial amount of 25% of the Overall Maximum Benefit payable will be paid for the initial orthodontic treatment. This amount will be payable as of the date appliances or bands are inserted.
3. The remaining 75% of the Overall Maximum Benefit payable will be paid at the applicable co-insurance on a monthly basis as claims are submitted. The subsequent monthly payments will be made only if Your dependent remains insured under this Certificate and provides proof to Us that orthodontic treatment continues. If orthodontic treatment continues after the Overall Maximum Benefit payable has been paid, no further benefits will be paid.
4. The lifetime maximum is equal to the member's lifetime maximum and is inclusive with the prior carrier, if applicable.

PART XIV. SCHEDULE OF BENEFITS

Policyholder: City of Baton Rouge & Parish of East Baton Rouge
- Platinum Plan

Policyholder's Address: 1755 Florida Blvd.
Baton Rouge, LA. 70802

Effective Date: January 1, 2017

Initial Term: 36 Months

Eligible Classes: ALL FULL TIME EMPLOYEES WORKING AT LEAST 30 HOURS PER WEEK

Eligibility Period: First of the month following the first day of Active Work

Mode of Premium Payment: MONTHLY

Method of Premium Payment: Remitted by Policyholder

Premium Due Date: 1st of every month

Certificate Year: Your Certificate Year is on a Calendar Year Plan

Deductible: In-Network: $50 Individual Deductible.
Maximum per Family Deductible: 3
Applies to Classes: B, C

Out-of-Network: $50 Individual Deductible.
Maximum per Family Deductible: 3
Applies to Classes: B, C

Co-Pay: See Schedule of Covered Procedures

Certificate Year Maximum Annual Benefit: Per Insured

In-Network

Year 1	Year 2	Year 3 & Forward
$1,500	$1,500	$1,500

Out-of- Network

Year 1	Year 2	Year 3 &Forward
$1,500	$1,500	$1,500

Waiting Periods See Schedule of Covered Procedures

TABLE OF INSURANCE PERCENTAGES:

Certificate Year 1:

	Insurance Percentage In-Network	Insurance Percentage Out-of-Network	Subject to Certificate Year Maximum Benefit	Maximum Benefit Annual/Lifetime
Class A	100%	100%	Yes	None/None
Class B	80%	80%	Yes	None/None
Class C	0%	0%	Yes	None/None
Class D	0%	0%	No	$750/$1,500

Certificate Year 2:

	Insurance Percentage In-Network	Insurance Percentage Out-of-Network	Subject to Certificate Year Maximum Benefit	Maximum Benefit Annual/Lifetime
Class A	100%	100%	Yes	None/None
Class B	80%	80%	Yes	None/None
Class C	60%	60%	Yes	None/None
Class D	60%	60%	No	$750/$1,500

Certificate Year 3 and later:

	Insurance Percentage In-Network	Insurance Percentage Out-of-Network	Subject to Certificate Year Maximum Benefit	Maximum Benefit Annual/Lifetime
Class A	100%	100%	Yes	None/None
Class B	80%	80%	Yes	None/None
Class C	60%	60%	Yes	None/None
Class D	60%	60%	No	$750/$1,500

Takeover Benefits: Do takeover benefits apply for Employees who currently have dental coverage? Yes

Plan Type: ☐ Indemnity: No participating provider network

☑ Participating Provider Program:

☑ In and Out-of-Network Benefits
☐ In-Network Benefit only

☐ Scheduled Fee Plan

Starmount Life Insurance Company

8485 Goodwood Blvd., PO Box 98100
Baton Rouge, LA 70806-7878

Carryover Benefits Rider

Attached to and made part of this Policyholder's Group Dental Policy and each Certificate of Insurance issued under such policy. It is hereby agreed that the policy and certificate is amended by adding the Carryover Benefits provision as defined below:

Effective Date: This rider is effective on January 1, 2017.

Policyholder Status:
This is a Takeover group. Carryover Benefits will be accumulated based on the claim activity from the first complete Benefit Year this rider was in-force.

Benefits Description:
An Insured may be eligible for carryover of a portion of his or her unused Certificate Year Maximum Benefit, as follows:

If an Insured submits Qualifying Claims for Covered Expenses during a Benefit Year and, in that Benefit Year, receives benefits that are in excess of any deductible or co-pay fees, and that, in total, do not exceed the Threshold Limit, the Insured will be credited a Carryover Benefit for that Benefit Year. In addition, the Insured must have at least one cleaning and one routine exam per year.

Carryover Benefits will be accrued and stored in the Insured's Carryover Account. If an Insured reaches his or her Certificate Year Maximum Benefit, We will pay a benefit from the Insured's Carryover Account up to the amount stored in the Insured's Carryover Account. The accrued Carryover Benefits stored in the Carryover Account may not be greater than the Carryover Account Limit.

An Insured's Carryover Account will be eliminated, and the accrued Carryover Benefits lost, if the Insured has a break in coverage of any length of time, for any reason.

The Threshold Limit, Carryover Benefit, and Carryover Account Limits for this Policy/Certificate are:

- Threshold Limit: $700
- Carryover Benefit: $350
- Carryover Account Limit: $1,250

Eligibility for a Carryover Benefit will be established or reestablished at the time the first Qualifying Claim in a Benefit Year is received for Covered Expenses incurred during that Benefit Year.

In order to properly calculate the Carryover Benefit, claims should be submitted timely in accordance with the Proof of Loss provision found within the Claims Provision. You have the right to request review of prior Carryover Benefit calculations. The request for review must be within 12 months from the date the Carryover Benefit was established.

Other Specifications:
Calendar Year Plans: If this plan's dental coverage first becomes effective on any date other than January 1, this rider will not become effective until January 1 of the first full Calendar Year. And, if the effective date of an Insured's dental coverage is in October, November or December, this rider will not apply to the Insured until January 1 of the next Calendar Year. In either case:

- Only claims incurred on or after January 1 will count toward the Threshold Limit;
- Requirement of 1 cleaning and 1 exam incurred after January 1; and
- Carryover Benefits will not be applied to an Insured's Carryover Account until the Calendar Year that starts one year from the date the rider first applies.

If Covered Insurance Percentages increase each Benefit Year for certain Covered Procedures, this rider will not apply to the Insured until all Covered Insurance Percentages reach the ultimate level. And, if the Covered Insurance Percentages reach the ultimate level within the three months prior to the start of this plan's next Benefit Year, this rider will not apply to the Insured until the next Benefit Year, and:

- Only claims incurred on or after the start of the next Benefit Year will count toward the Threshold Limit; and
- Carryover Benefits will not be applied to an Insured's Carryover Account until the Benefit Year that starts one year from the date the rider first applies.

Definitions:

- "Benefit Year" means Calendar Year or Policy Year, according to the type of plan applicable under the Policy/Certificate to which this rider is attached.
- "Carryover Account" means the amount of an Insured's accrued Carryover Benefits.
- "Carryover Account Limit" means the maximum amount of cumulative Carryover Benefits that an Insured can store in his or her Carryover Account.
- "Carryover Benefit" means the dollar amount, which will be added to an Insured's Carryover Account when he or she receives benefits in a Benefit Year that do not exceed the Threshold Limit.
- Qualifying Claim means a claim under Procedure Classes A, B, C, and D, (Orthodontia) and must include 1 exam and 1 cleaning. .
- "Threshold Limit" means the maximum amount of benefits that an Insured can receive during a Benefit Year and still be entitled to receive the Carryover Benefit. This includes all claims processed under all Procedure Classes.

This Rider takes effect on the date shown on Page 1 of this Rider and expires with the Policy/Certificate to which it is attached. It is subject to all the terms, conditions, limitations and exclusions of the Policy/Certificate that are not inconsistent with it. Nothing contained in this Rider will be held to change, waive or extend any provisions of the Policy/Certificate except as stated in this Rider.

Signed for Starmount Life Insurance Company, at its Home Office, 8485 Goodwood Blvd., Baton Rouge, LA 70806-7878.

Jeffrey G. Wild

Jeffrey G. Wild, Secretary

Erich Sternberg

Erich Sternberg, Chief Executive Officer

STARMOUNT

GROUP DENTAL INSURANCE CERTIFICATE

Underwritten by: Starmount Life Insurance Company
(called "We," "Our," and "Us")
8485 Goodwood Blvd.
P.O. Box 98100
Baton Rouge, LA 70806

AlwaysCare

Administrator: AlwaysCare Benefits, Inc. (a Starmount Life Insurance company)
8485 Goodwood Blvd., P.O. Box 80139
Baton Rouge, LA 70898-0139

This Certificate explains the dental insurance coverage under the Group Policy (the Policy) issued to the Policyholder. The Policy provides the benefits for the Insured Member (called "You" or "Your") and any Covered Dependents.

The Policyholder and the Policy Number are shown in the Schedule of Benefits.

This, together with the Schedule of Benefits applying to Your Eligible Class, forms Your Certificate of Insurance while covered under the Policy. It replaces any previous Certificates of Insurance issued under the Policy to You.

This Certificate provides a general description of Your dental benefits. All benefits are governed by the terms and conditions of the Policy.

The Policy alone constitutes the entire contract between the Policyholder and Us.

Jeffrey G. Wild, Secretary

Erich Sternberg, Chief Executive Officer

NON-PARTICIPATING

TABLE OF CONTENTS

PART I. DEFINITIONS

Administrator - The entity which will provide complete service and facilities for the writing and servicing of this policy as agreed in a contract with Us.

Calendar Year Plan - Benefits begin anew on January 1 of each Calendar Year.

Claim - A statement signed by an Insured and his treating dentist for a request of payment under a dental benefit plan. It shall include services rendered, dates of services and itemization of costs.

Co-Pay - The fixed amount that an Insured is required to pay directly to a Participating Provider for Covered Expenses. The Co-Pay may vary by Procedure Code. If a Co-Pay applies, it is shown on the Schedule of Benefits.

Covered Dependent – Means an Eligible Dependent who is insured under this Certificate.

Covered Expense - The lesser of the following for a Covered Procedure: (1) the actual charge; or (2) the Maximum Reimbursement.

Covered Procedure - The procedures listed in the Schedule of Covered Procedures. The procedure must be: (1) for performed dental treatment to an Insured while His coverage under this Certificate is in force and (2) for treatment, which in Our opinion has a reasonably favorable prognosis for the patient. The procedure must be performed by a:

1. licensed dentist who is acting within the scope of his or her license;
2. licensed physician performing dental services within the scope of his or her license; or
3. licensed dental hygienist acting under the supervision and direction of a dentist.

Deductible - The Deductible is shown on the Schedule of Benefits. The Individual Deductible is the amount that each Insured must satisfy once each Certificate Year (or lifetime, when applicable) before benefits are payable for Covered Procedures. We apply amounts used to satisfy Individual Deductibles to the Maximum per Family Deductible, if any. Once any Maximum per Family Deductible is satisfied, no further Individual Deductibles are required to be met for that Certificate Year. If multiple procedures are performed on the same date, the Deductibles will be satisfied in order of Procedure Class (that is, toward Procedure Class B, and then C.)

Eligible Class – Means the group of people who are eligible for coverage under the Group Policy. The Members of the Eligible Classes are shown on the Schedule of Benefits. Each Member of the Eligible Class will qualify for insurance on the date He completes the required Eligibility Period, if any.

Eligible Dependent - Means a person listed below:

1. Your spouse ;
2. Your unmarried dependent child under age 26, who is your natural or adopted child, grandchild who is in legal custody of and residing with the grandparent, step-child, foster child, or child for whom you are a legal guardian and who is primarily dependent on You for support and maintenance.
3. Your unmarried dependent child or grandchild who is a full-time student and who develops a mental or nervous condition, problem, or disorder, which renders the child or grandchild, in the opinion of a qualified psychiatrist, subject to a second opinion if deemed necessary by the health insurance issuer or health maintenance organization, unable to attend school as a full-time student and from holding self-sustaining employment, until the age of 26.
4. Your unmarried child who has reached age 26 and who is:
   a. primarily dependent upon You for support and maintenance; and
   b. incapable of self-sustaining employment by reason of mental retardation, mental illness or disorder or physical handicap.

   Proof of the child's incapacity or dependency must be furnished to Us for an already enrolled child who reaches the age limitation, or when You enroll a new disabled child under the plan.

Eligibility Period – The period of time a Member must wait before He is eligible for coverage. The Eligibility Period, if any, is specified in the Policyholder's Group Application and shown in the Schedule of Benefits.

He, Him and His – Refers to the male or female gender.

Initial Term - The period following the group's initial effective date and shown in the Schedule of Benefits. Rates are guaranteed not to change during this period.

In-Network Benefits - The dental benefits provided under this Certificate for Covered Procedures that are provided by a Participating Provider.

Insured – Means You and each Covered Dependent.

Insured Member– Means a person:

1. who is a Member of an Eligible Class; and
2. who has qualified for insurance by completing the Eligibility Period, if any; and
3. for whom insurance under the Policy has become effective.

Late Entrant - Any Member or Eligible Dependent enrolling outside the Policyholder's initial Eligibility Period as indicated in the Schedule of Benefits. Benefits may be limited for Late Entrants as noted under Part VII., A under Limitations.

Maximum Reimbursement – An amount used to determine the Covered Expense. There are 4 types of Maximum Reimbursement, depending on the plan issued:

1. **Maximum Allowable Charge (MAC)**: The MAC may be used if a dentist who is a Non-Participating Provider performs a Covered Procedure. The amount of the MAC is equal to the lesser of: (a) the dentist's actual charge; or (b) the "customary charge" for the dental service or supply. We determine the "customary charge" from within the range of charges made for the same service or supply by other providers of similar training or experience in that general geographic area.
2. **Participating Provider Maximum Allowable Charge (PMAC)**: The PMAC may be used if a dentist who is a Participating Provider performs a Covered Procedure. This is the amount that the dentist has agreed with Us to accept as payment in full for a dental service or supply.
3. **Scheduled Fee (SF)**: Some plans may use a fee schedule to determine the amount payable for a Covered Procedure. This is the maximum charge that We allow for each Covered Procedure, regardless of the fee charged by the dentist. The Scheduled Fee for a Participating Provider may be different than the Scheduled Fee for a Non-Participating Provider.
4. **Indemnity**: The Maximum Allowable Charge (MAC), as explained in (1,) above, is used to determine the amount payable for a Covered Procedure. However, the MAC will be the same, regardless of whether a Participating Provider or Non-Participating Provider is used.

The Schedule of Covered Procedures shows the Type Of Maximum Reimbursement used by the plan.

Member – Means a person who belongs to an Eligible Class of the Policyholder.

Non-Participating Provider - A dentist who is not a Participating Provider. These dentists have not entered into an agreement with us to limit their charges.

Out-of–Network Benefits - The dental benefits provided under this Certificate for Covered Procedures that are not provided by a Participating Provider.

Participating Provider - A dentist who has been selected by Us for inclusion in the Participating Provider Program. These Participating Providers agree to accept Our Participating Provider Maximum Allowed Charges as payment in full for services rendered. When dental care is given by Participating Providers, the Insured will generally incur less out-of-pocket cost for services rendered.

Participating Provider Program - Our program to offer an Insured the opportunity to receive dental care from dentists who are designated by Us as Participating Providers.

Participating Provider Program Directory - The list which consists of selected dentists who:

1. are located in Your area; and
2. have been selected by Us to be Participating Providers and part of the Participating Provider Program.

The list will be periodically updated and is subject to change without notice.

Policyholder - The entity stated on the front page of the Policy.

Policy Year Plan - Benefits begin immediately on the Policyholder's effective date and renew 12 months following the initial effective date.

Re-enrollee - Any Insured who terminated his coverage, and then subsequently re-enrolled for coverage at a later date. Benefits are limited for Re-enrollees under Part VII. Limitations.

You or Your – The Insured Member.

Waiting Period - The period of time during which an Insured's coverage must be in force before benefits may become payable for Covered Procedures. The Waiting Period, if any, for each Covered Procedure is shown in the Schedule of Covered Procedures.

PART II. ELIGIBILITY AND ENROLLMENT

A. ELIGIBILITY

To be eligible for coverage under the Policy, an individual must:

1. be a Member of an Eligible Class of the Policyholder, as defined in the Schedule of Benefits; and
2. satisfy the Eligibility Period, if any.

The Member's Eligible Dependents are also eligible for coverage, provided that Dependent coverage is provided under the Policy.

Dual Eligibility Status: If both a Member and his spouse are in an Eligible Class of the Policyholder, each may enroll individually or as a dependent of the other, but not as both. Any Eligible Dependent child may also only be enrolled by one parent. If the spouse carrying dependent coverage ceases to be eligible, dependent coverage may become effective under the other spouse's coverage.

B. ENROLLMENT

The term "Enrollment" means written or electronic application for coverage on an enrollment form furnished or approved by Us. Coverage will not become effective until the Members have enrolled themselves and their Eligible Dependents, and paid the required premium, if any.

Initial Enrollment: Members should enroll themselves and their Eligible Dependents within thirty-one (31) days of the Eligibility Period. Individuals who enroll after this time are considered Late Entrants.

Open Enrollment: Members may enroll themselves and their Eligible Dependents during an open enrollment period. Open enrollment is a period of time specified by the Policyholder and approved by Us. It usually occurs once each Calendar Year but may, at Our discretion, occur more frequently. Other changes may also be restricted to Open Enrollment periods.

Late Entrants: Members who do not enroll themselves or their Eligible Dependents within the Initial Enrollment period, may not enroll until the next Open Enrollment period unless there is a change in family status, as described below.

Change in Family Status: Members may enroll or change their coverage if a change in family status occurs, provided written application to enroll is made within thirty-one (31) days of the event. A change in family status means any of the following events:

1. Marriage;
2. Divorce or legal separation;
3. Birth or adoption of a child;
4. Death of a spouse or child;
5. Other changes as permitted by the Policyholder.

PART III. INDIVIDUAL EFFECTIVE DATES

Your coverage will be effective on the later of the following dates, provided that any required premium is paid to Us:

1. the Policyholder's Effective Date, shown on the Schedule of Benefits; or
2. the date You meet all the Eligibility and Enrollment requirements.

For Eligible Dependents acquired after Your effective date of coverage, by reason of marriage, birth or adoption, coverage is effective on the first of the month following the date such dependent was acquired. This is subject to our receipt of the required Enrollment and payment of the premium, if any.

Newborn Coverage: Any child born to You or Your Covered Dependent spouse is covered from the moment of birth to thirty-one (31) days. A notice of birth, together with any additional premium, must be submitted to Us within thirty-one (31) days of the birth in order to continue the coverage beyond the initial 31-day period.

Adopted Children: A child adopted by You is covered from the date of placement. Coverage will continue unless the child's placement is disrupted prior to legal adoption. A notice of placement for adoption, together with any additional premium, must be submitted to Us within thirty-one (31) days of the placement in order to continue the coverage beyond the initial 31-day period.

PART IV. INDIVIDUAL TERMINATION DATES

Coverage for You and all Covered Dependents stops on the earliest of the following dates:

1. the date the Policy terminates;
2. the date the Policyholder's coverage terminates under the Policy;
3. the first of the month following the date You are no longer an eligible Member;
4. the date You die;
5. on any premium due date, if full payment for Your insurance is not made within thirty-one (31) days following the premium due date.

In addition, coverage for each Covered Dependent stops on the earliest of:

1. the date he is no longer an Eligible Dependent;
2. the date We receive your request to terminate Covered Dependent coverage. This is subject to any limitation imposed by the Policyholder as to when a change is permitted; e.g. under an Open Enrollment period.

PART V. INDIVIDUAL PREMIUMS

Members may be required to contribute, either in whole or in part, to the cost of their insurance. This is subject to the terms established by the Policyholder. Your premium contributions, if required, are remitted to Us in one of two ways:

1. You contribute to the cost of the insurance through the Policyholder, who then submits payment to Us; or
2. You pay Your premiums directly to Us.

The Schedule of Benefits shows the method of premium payment.

The first premium is due on the Effective Date. Premiums after the first are due on the Premium Due Date or within the grace period.

Grace Period: A grace period of thirty-one (31) days is granted for the payment of each premium due after the first. The coverage stays in force if the premium is paid during this grace period, unless We are given written notice that the insurance is to be ended before the Grace Period.

Right to Change Premiums: We have the right to change the premium rates on any premium due date on or after the Initial Term. After the Initial Term, We will not increase the premium rates more than once in a twelve (12) month period. We will give the Policyholder written notice at least sixty (60) days in advance of any change. All changes in rates are subject to terms outlined in the Policy.

PART VI. DESCRIPTION OF COVERAGE

A. COVERED DENTAL EXPENSES

We determine if benefits are payable under the policy if an Insured incurs expenses for a Covered Procedure. Before we determine benefits, the Insured must satisfy the Deductible and Waiting Period, if any.

The Deductible is shown on the Schedule of Benefits. The Waiting Period is listed separately for each Covered Procedure. It is shown on the Schedule of Covered Procedures.

We then pay the Insurance Percentage of the Covered Expense, minus any Co-Pay. The Insurance Percentage is shown in the Table of Insurance Percentages on the Schedule of Benefits.

The Co-Pay, if any, is listed for each Covered Procedure in the Schedule of Covered Procedures.

The benefit is subject to the following:

1. The Covered Procedure must start and be completed while the Insured's coverage is in force, except as provided in the Takeover Benefits provision, if applicable.
2. Each Covered Procedure may be subject to specific Limitations, as shown on the Schedule of Covered Procedures.
3. A Certificate Year Maximum Annual Benefit may apply to each Insured. This is shown on the Schedule of Benefits.
4. A Maximum Annual and/or Maximum Lifetime Benefit may apply to each Procedure Class. If applicable, these maximums are shown in the Table of Covered Insurance Percentages on the Schedule of Benefits.
5. Other limitations and exclusions that may affect coverage are shown in the "Limitations and Exclusions" provision.

B. WHEN A COVERED PROCEDURE IS STARTED AND COMPLETED

1. We consider a dental treatment to be started as follows:
   a. for a full or partial denture, the date the first impression is taken;
   b. for a fixed bridge, crown, inlay and onlay, the date the teeth are first prepared;
   c. for root canal therapy, on the date the pulp chamber is first opened;
   d. for periodontal surgery, the date the surgery is performed; and
   e. for all other treatment, the date treatment is rendered.

2. We consider a dental treatment to be completed as follows:
   a. for a full or partial denture, the date a final completed prosthesis is first inserted in the mouth;
   b. for a fixed bridge, crown, inlay and onlay, the date the bridge or restoration is cemented in place; and
   c. for root canal therapy, the date a canal is permanently filled.

NOTE: If Orthodontia Services are covered, see Procedure Class D in the Schedule of Covered Procedures for start and completion dates.

C. HOW TO SUBMIT EXPENSES

Expenses submitted to Us must identify the treatment performed in terms of the American Dental Association Uniform Code on Dental Procedures and Nomenclature or by narrative description. We reserve the right to request x-rays, narratives and other diagnostic information, as we see fit, to determine benefits.

D. CHOICE OF PROVIDERS

An Insured may choose a dentist of his choice. An Insured may choose the services of a dentist who is either a Participating Provider or a Non-Participating Provider. Benefits under this Certificate are determined and payable in either case. If a Participating Provider is chosen, the Insured will generally incur less out-of-pocket cost unless the Policyholder has selected a Participating Provider Only plan.

Note: If this is an Indemnity plan, there is no difference in payment between a Participating and Non-Participating Provider.

E. PRE-ESTIMATE

If the charge for any treatment is expected to exceed $300, We suggest that a dental treatment plan be submitted to Us by Your dentist for review before treatment begins. In addition to a dental treatment plan, We may request any of the following information to help Us determine benefits payable for certain services:

1. full mouth dental x-rays;
2. cephalometric x-rays and analysis;
3. study models; and
4. a statement specifying:
    a. degree of overjet, overbite, crowding and open bite;
    b. whether teeth are impacted, in crossbite, or congenitally missing;
    c. length of orthodontic treatment; and
    d. total orthodontic treatment charge.

An estimate of the benefits payable will be sent to You and Your dentist. The pre-estimate is not a guarantee of the amount We will pay. The pre-estimate process lets an Insured know in advance approximately what portion of the expenses We will consider as a Covered Expense. Our estimate may be for a less expensive alternative benefit if it will produce professionally satisfactory results.

F. ALTERNATE BENEFIT PROVISION

Many dental problems can be resolved in more than one way. If: 1) We determine that a less expensive alternative benefit could be provided for the resolution of a dental problem; and 2) that benefit would produce the same resolution of the diagnosed problem within professionally acceptable limits, We may use the less expensive alternative benefit to determine the amount payable under the Certificate. **For example**: When an amalgam filling and a composite filling are both professionally acceptable methods for filling a molar, We may base our benefit on the amalgam filling which is the less expensive alternative benefit. This is the case whether a Participating Provider or Non-participating Provider performs the service.

G. SERVICES PERFORMED OUTSIDE THE U.S.A.

Any Claim submitted for procedures performed outside the U.S.A. must: (1) be for a Covered Procedure, as defined; (2) be supplied in English; (3) use American Dental Association (ADA) codes; and (4) be in U.S. Dollar currency. Reimbursement will be based on the Maximum Allowable Charge, Participating Provider Maximum Allowable Charge, or applicable Scheduled Fee amounts for the Insured's zip code.

PART VII. LIMITATIONS AND EXCLUSIONS

A. LIMITATIONS

1. **LIMITATION FOR LATE ENTRANTS OR RE-ENROLLEES:** Members that waive coverage at initial enrollment (within thirty-one (31) days of effective date) or in the new Member eligibility period will have a twelve (12) month waiting period applied to all basic, major, and orthodontia services upon re-applying. Coverage for a Late Entrant or a Re-enrollee will be limited to those procedures listed under Procedure Class A in the Schedule of Covered Procedures during the first twelve (12) months after the Late Entrant's or Re-Enrollee's Effective Date. The limited coverage also applies to the Late Entrant's or Re-Enrollee's Eligible Dependents, if enrolled.

2. **MISSING TEETH LIMITATION:** We will not pay benefits for replacement of teeth missing on an Insured's effective date of insurance under this Certificate for the purpose of the initial placement of a full denture, partial denture fixed bridge or implant. However, expenses for the replacement of teeth missing on the effective date will be considered for payment as follows:
   a. The initial placement of full or partial dentures, fixed bridge or implant will be considered a Covered Procedure if the placement includes the initial replacement of a functioning natural tooth extracted while the Insured is covered under the policy.
   b. The initial placement of a fixed bridge or implant will be considered a Covered Procedure if the placement includes the initial replacement of a functioning natural tooth extracted while an Insured is covered under the policy. However, the following restrictions will apply:
      (i) Benefits will only be paid for the replacement of the teeth extracted while an Insured is covered under the policy or under the "Prior Extraction" clause;
      (ii) benefits will not be paid for the replacement of other teeth which were missing on the Insured's effective date.
      (iii) missing teeth limitation will be waived after Insured has been covered under this group's plan for three (3) continuous years unless it is a replacement of an existing unserviceable prosthesis.

3. **Other Limitations:** Multiple restorations on one surface are payable as one surface. Multiple surfaces on a single tooth will not be paid as separate restorations. Coverage is limited to two prophylaxis and/or two periodontal maintenance procedures, subject to a maximum total of no more than two (2) procedures per twelve (12) month period. Coverage is limited to one (1) full mouth radiograph or panoramic film per limitation period listed in the Schedule of Covered procedures On any given day, more than seven (7) periapical x-rays or a panoramic film in conjunction with bitewings will be paid as a full mouth radiograph. Additional limitations are noted in the Schedule of Covered Procedures.

B. EXCLUSIONS

No benefits are payable under the Policy for the procedures listed below unless such procedure or service is listed as covered in the Schedule of Covered Procedures. Additionally, the procedures listed below will not be recognized toward satisfaction of any Deductible amount.

1. any service or supply not shown on the Schedule of Covered Procedures;
2. any procedure begun after an Insured's insurance under the Policy terminates, or for any prosthetic dental appliance finally installed or delivered more than thirty (30) days after an Insured's insurance under the Policy terminates;
3. any procedure begun or appliance installed before an Insured became insured under the Policy;
4. any treatment which is elective or primarily cosmetic in nature and not generally recognized as a generally accepted dental practice by the American Dental Association, as well as any replacement of prior cosmetic restorations;
5. the correction of congenital malformations or congenital missing teeth;
6. the replacement of lost or discarded or stolen appliances;
7. replacement of bridges unless the bridge is older than the age allowed in the Schedule of Covered Procedures and cannot be made serviceable;
8. replacement of full or partial dentures unless the prosthetic appliance is older than the age allowed in the Schedule of Covered Procedures and cannot be made serviceable;
9. replacement of implants, crowns, inlays or onlays unless the prior restoration is older than the age

allowed in the Schedule of Covered Procedures and cannot be made serviceable;

10. appliances, services or procedures relating to: (a) the change or maintenance of vertical dimension; (b) restoration of occlusion (unless otherwise noted in the Schedule of Covered Procedures—only for occlusal guards); (c) splinting; (d) correction of attrition, abrasion, erosion or abfraction; (e) bite registration or (f) bite analysis;
11. services provided for any type of temporomandibular joint (TMJ) dysfunctions, muscular, skeletal deficiencies involving TMJ or related structures, myofascial pain;
12. orthognathic surgery;
13. prescribed medications, premedication or analgesia;
14. any instruction for diet, plaque control and oral hygiene;
15. dental disease, defect or injury caused by a declared or undeclared war or any act of war;
16. charges for: implants of any type, and all related procedures, removal of implants, precision or semi-precision attachments, denture duplication, overdentures and any associated surgery, or other customized services or attachments;
17. cast restorations, inlays, onlays and crowns for teeth that are not broken down by extensive decay or accidental injury or for teeth that can be restored by other means (such as an amalgam or composite filling);
18. for treatment of malignancies, cysts and neoplasms;
19. for orthodontic treatment;
20. charges for failure to keep a scheduled visit or for the completion of any Claim forms;
21. any procedure We determine which is not necessary, does not offer a favorable prognosis, or does not have uniform professional endorsement or which is experimental in nature;
22. service or supply rendered by someone who is related to an Insured by blood or by law (e.g., sibling, parent, grandparent, child), marriage (e.g., spouse or in-law) or adoption or is normally a member of the Insured's household;
23. expenses compensable under Workers' Compensation or Employers' Liability Laws or by any coverage provided or required by law (including, but not limited to, group, group-type and individual automobile "No-Fault" coverage);
24. expenses provided or paid for by any governmental program or law, except as to charges which the person is legally obligated to pay or as addressed later under the "Payment of Claims" provision;
25. procedures started but not completed;
26. any duplicate device or appliance;
27. general anesthesia and intravenous sedation except in conjunction with covered complex oral surgery procedures as defined by Us, plus the services of anesthetists or anesthesiologists;
28. the replacement of 3rd molars;
29. crowns, inlays and onlays used to restore teeth with micro fractures or fracture lines, undermined cusps, or existing large restorations without overt pathology.

PART VIII. CLAIM PROVISIONS

Notice Of Claim: Written notice of Claim must be given within thirty (30) days after a loss occurs, or as soon as reasonably possible. The notice must be given to the Administrator. Claims should be sent to:

Starmount Life Insurance Company
c/o AlwaysCare Benefits, Inc. (a Starmount Life Insurance company)
8485 Goodwood Blvd., P.O. Box 80139
Baton Rouge, LA 70898-0139

Claim Forms: When the Administrator receives notice of Claim that does not contain all necessary information or is not on an appropriate Claim form, forms for filing proof of loss will be sent to the claimant along with a request for the missing information. If these forms are not sent within fifteen (15) days after receiving notice of claim, the claimant will meet the proof of loss requirements if the Administrator is given written proof of the nature and extent of the loss.

Proof Of Loss: Written proof of loss must be given to the Administrator within ninety (90) days after the loss begins. We will not deny nor reduce any claim if it was not reasonably possible to give proof of loss in the time required. In any event, proof must be given to the Administrator within one (1) year after it is due, unless You are legally incapable of doing so.

Payment Of Claims: Benefits will be paid to You unless an Assignment of Benefits has been requested by the Insured. Benefits due and unpaid at Your death will be paid to Your estate. Any payment made by Us in good faith pursuant to this provision will fully release Us to the extent of such payment.

If any beneficiary is a minor or mentally incapacitated, We will pay the proper share of Your insurance amount to such beneficiary's court appointed guardian.

Time Payment Of Claims: Benefits will be payable immediately upon receipt of acceptable Proof of Loss.

Recovery Of Overpayments: We reserve the right to deduct from any benefits properly payable under this Policy the amount of any payment that has been made:

1. In error; or
2. pursuant to a misstatement contained in a proof of loss; or
3. pursuant to fraud or misrepresentation made to obtain coverage under this Policy within two (2) years after the date such coverage commences; or
4. with respect to an ineligible person; or
5. pursuant to a claim for which benefits are recoverable under any Policy or act of law providing coverage for occupational injury or disease to the extent that such benefits are recovered.

Such deduction may be against any future claim for benefits under the Policy made by an Insured if claim payments previously were made with respect to an Insured.

PART IX. COORDINATION OF BENEFITS (COB)

This provision applies when an Insured has dental coverage under more than one Plan, as defined below. The benefits payable between the Plans will be coordinated.

A. DEFINITIONS RELATED TO COB

1. **Allowable Expense:** An expense that is considered a covered charge, at least in part, by one or more of the Plans. When a Plan provides benefits by services, reasonable cash value of each service will be treated as both an Allowable Expense and a benefit paid.

2. **Coordination of Benefits:** Taking other Plans into account when We pay benefits.

3. **Plan:** Any plan, including this one that provides benefits or services for dental expenses on either a group or individual basis. "Plan" includes group and blanket insurance and self-insured and prepaid plans. It includes government plans, plans required or provided by statute (except Medicaid), and no fault insurance (when allowed by law). "Plan" shall be treated separately for that part of a plan that reserves the right to coordinate with benefits or services of other plans and that part which does not.

4. **Primary Plan**: The Plan that, according to the rules for the Order of Benefit Determination, pays benefits before all other Plans.

5. **Year:** The Calendar Year, or any part of it, during which a person claiming benefits is covered under this Plan.

B. BENEFIT COORDINATION

Benefits will be adjusted so that the total payment under all Plans is no more than 100 percent of the Insured's Allowable Expense. In no event will total benefits paid exceed the total payable in the absence of COB.

If an Insured's benefits paid under this Plan are reduced due to COB, each benefit will be reduced proportionately. Only the amount of any benefit actually paid will be charged against any applicable benefit maximum.

C. THE ORDER OF BENEFIT DETERMINATION

1. When this is the Primary Plan, We will pay benefits as if there were no other Plans.

2. When a person is covered by a Plan without a COB provision, the Plan without the provision will be the Primary Plan.

3. When a person is covered by more than one Plan with a COB provision, the order of benefit payment is as follows:

   a. **Non-dependent/Dependent.** A Plan that covers a person other than as a dependent will pay before a Plan that covers that person as a dependent.

   b. **Dependent Child/Parents Not Separated or Divorced**. For a dependent child, the Plan of the parent whose birthday occurs first in the Calendar Year will pay benefits first. If both parents have the same birthday, the Plan that has covered the dependent child for the longer period will pay first. If the other Plan uses gender to determine which Plan pays first, We will also use that basis.

   c. **Dependent Child/Separated or Divorced Parents**. If two (2) or more Plans cover a person as a Dependent of separated or divorced parents, benefits for the child are determined in the following order:
      i. The Plan of the parent who has responsibility for providing insurance as determined by a court order;
      ii. The Plan of the parent with custody of the child;
      iii. The Plan of the spouse of the parent with custody; and
      iv. The Plan of the parent without custody of the child.

   d. **Dependent Child/Joint Custody**. If the joint custody court decree does not specifically state which parent is responsible for the child's medical expenses, the rules as shown for Dependent Child/Parents Not Separated or Divorced shall apply.

   e. **Active/Inactive Employee.** The Plan which covers the person as an employee who is neither laid off nor retired (or as that employee's dependent) is Primary over the Plan which covers that person as a laid off or retired employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored.

   f. **Longer/Shorter Length of Coverage**. When an order of payment is not established by the above, the Plan that has covered the person for the longer period of time will pay first.

D. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

We may release to, or obtain from, any other insurance company, organization or person information necessary for COB. This will not require the consent of, or notice to You or any claimant. You are required to give Us information necessary for COB.

E. RIGHT TO MAKE PAYMENTS TO ANOTHER PLAN

COB may result in payments made by another Plan that should have been made by Us. We have the right to pay such other Plan all amounts it paid which would otherwise have been paid by Us. Amounts so paid will be treated as benefits paid under this Plan. We will be discharged from liability to the extent of such payments.

F. RIGHT TO RECOVERY

COB may result in overpayments by Us. We have the right to recover any excess amounts paid from any person, insurance company or other organization to whom, or for whom, payments were made.

PART X. GRIEVANCE PROCEDURE

If a claim for benefits is wholly or partially denied, the Insured will be notified in writing of such denial and of his right to file a grievance and the procedure to follow. The notice of denial will state the specific reason for the denial of benefits. Within sixty (60) days of receipt of such written notice an Insured may file a grievance and make a written request for review to:

Starmount Life Insurance Company
c/o AlwaysCare Benefits, Inc. (a Starmount Life Insurance company)
8485 Goodwood Blvd., P.O. Box 80139
Baton Rouge, LA 70898-0139

We will resolve the grievance within thirty (30) calendar days of receiving it. If We are unable to resolve the grievance within that period, the time period may be extended another thirty (30) calendar days if We notify in writing the person who filed the grievance. The notice will include advice as to when resolution of the grievance can be expected and the reason why additional time is needed.

The Insured or someone on his/her behalf also has the right to appear in person before Our grievance committee to present written or oral information and to question those people responsible for making the determination that resulted in the grievance. The Insured will be informed in writing of the time and place of the meeting at least seven (7) calendar days before the meeting.

For purposes of this Grievance Procedure, a grievance is a written complaint submitted in accordance with the above Grievance Procedure by or on behalf of an Insured regarding dissatisfaction with the administration of claims practices or provision of services of this panel provider plan relative to the Insured.

In situations requiring urgent care, grievances will be resolved within four (4) business days of receiving the grievance.

PART XI. GENERAL PROVISIONS

Cancellation: We may cancel the Policy at any time by providing at least sixty 60 days advance written notice to the Policyholder. The Policyholder may cancel the Policy at any time by providing written notice to Us, effective upon Our receipt on the notice or the date specified in the notice, if later. In the event of such cancellation by either Us or the Policyholder, We shall promptly return on a pro rata basis any unearned premium paid. The Policyholder shall promptly pay on a pro rata basis the earned premium which has not been paid, if any. Such cancellation shall be without prejudice to any claim originating prior to the effective date of such cancellation.

Legal Actions: No legal action may be brought to recover on the Policy before sixty (60) days after written proof of loss has been furnished as required by the Policy. No such action may be brought after three (3) years from the time written proof of loss is required to be furnished.

PART XII. TAKEOVER BENEFITS

The following provisions are applicable if this dental plan is replacing existing group dental plan in force (referred to as "Prior Plan") at the time of application. These are called "Takeover Benefits." The Schedule of Benefits shows if Takeover Benefits apply.

Takeover benefits apply if we are taking over a comparable benefits plan from another carrier and only if there is no break in coverage between the original plan and the takeover date. Takeover is available to those individuals insured under the employer's dental plan in effect at the time of the employer's application. If takeover benefits are included in your benefits, then waiting periods for service will be waived for the individuals currently insured under the employer's previous plan during the month prior to coverage moving to Starmount Life Insurance.

New hires with prior-like dental coverage (lapse in coverage must be less than sixty-three (63) days) will receive takeover credit for the length of time they had with the prior carrier and must provide proof of coverage (including coverage dates) to receive takeover credit (i.e., one page benefit summary, certificate of creditable coverage, etc.).

Waiting Period Credit: When We immediately take over an entire dental group from another carrier, those persons insured by the Prior Plan on the day immediately prior to the takeover effective date will receive Waiting Period credit if they are eligible for coverage on the effective date of Our plan. The Waiting Period credit does not apply to Late Entrants or Re-enrollees.

Annual Maximums And Deductible Credits: For Calendar Year Plans: Deductible credits will be granted for the amount of Deductible satisfied under the Prior Plan during the current Calendar Year. Any benefits paid under the Prior Plan with respect to such replaced coverage will be applied to and deducted from the maximum benefit payable under this Certificate.

For Policy Year Plans: The annual maximums and annual Deductibles will begin on the policy's takeover effective date, which marks the start of a new Policy Year. Deductible credit will not be given. Any benefits paid under the Prior Plan with respect to such replaced coverage will not be applied to or deducted from the maximum benefits payable for services under this Certificate.

Maximum Benefit Credit: All paid benefits applied to the maximum benefit amounts under the Prior Plan will also be applied to the maximum benefit amounts under this Certificate.

If You had orthodontic coverage for Your covered dependent children under the Prior Plan and You have orthodontic coverage under this Certificate, We will not pay benefits for orthodontic expenses unless:

1. You submit proof that the Maximum Lifetime Benefit for Class D Orthodontic Services for this Certificate was not exceeded under the Prior Plan; and
2. orthodontic treatment was started and bands or appliances were inserted while insured under the Prior Plan; and
3. orthodontic treatment is continued while Your covered dependent is insured under this Certificate.

If You submit the required proof, the maximum benefit for orthodontic treatment will be the lesser of this Certificate's Overall Maximum Benefit for Class D Orthodontic Services or the Prior Plan's ortho maximum benefit. The ortho maximum benefit payable under this Certificate will be reduced by the amount paid or payable under the Prior Plan.

Verification: The Policyholder's application must be accompanied by a current month's billing from the current dental carrier, a copy of an in-force certificate, as well as proof of the effective date for each Insured (and dependent), if insured under the Prior Plan.

Prior Carrier's Responsibility: The prior carrier is responsible for costs for procedures begun prior to the effective date of this coverage.

Prior Extractions: If: (1) treatment is performed due to an extraction which occurred before the effective date of this coverage while an Insured was covered under the Prior Plan; and (2) the replacement of the extracted tooth must take place within thirty-six (36) months of extraction; and (3) treatment would have been covered under the Policyholder's Prior Plan; We will apply the expenses to this plan as long as they are Covered Expenses under both this Certificate and the Prior Plan.

Coverage for Treatment in Progress: If an Insured was covered under the Prior Plan on the day before this Certificate replaced the Prior Plan, the Insured may be eligible for benefits for treatment already in progress on the effective date of this Certificate. However, the expenses must be covered dental expenses under both this Certificate and the Prior Plan. This is subject to the following:

1. Extension of Benefits under Prior Plan. We will not pay benefits for treatment if:
   (a) the Prior Plan has an Extension of Benefits provision;
   (b) the treatment expenses were incurred under the Prior Plan; and
   (c) the treatment was completed during the extension of benefits.
2. No Extension of Benefits under Prior Plan. We will pro-rate benefits according to the percentage of treatment performed while insured under the Prior Plan if:
   (a) the Prior Plan has no extension of benefits when that plan terminates;
   (b) the treatment expenses were incurred under the Prior Plan; and
   (c) the treatment was completed while insured under this Certificate.
3. Treatment Not Completed during Extension of Benefits. We will pro-rate benefits according to the

percentage of treatment performed while insured under the Prior Plan and during the extension if:

(a) the Prior Plan has an extension of benefits;
(b) the treatment expenses were incurred under the Prior plan; and
(c) the treatment was not completed during the Prior Plan's extension of benefits.

We will consider only the percentage of treatment completed beyond the extension period to determine any benefits payable under this Certificate.

PART XIII. SCHEDULE OF COVERED PROCEDURES

The following is a complete list of Covered Procedures, their assigned Procedure Class, Waiting Period, and applicable limitations. We will not pay benefits for expenses incurred for any Procedure not listed in the Schedule of Covered Procedures.

Key for Schedule of Covered Procedures

* Procedure Class		Type of Maximum Reimbursement:
A	Preventive/Diagnostic	PMAC – Participating Provider Maximum Allowable Charge
B	Basic	MAC – Maximum Allowable Charge (based on "Customary Charge")
C	Major	SF – Scheduled Fee
D	Orthodontia	Indemnity
E	Not Covered	
F	Other	

¶ Limitations

(a) Maximum of 1 procedure per 6 months
(b) Maximum of 1 procedure per 36 months
(c) Maximum of 4 films per 12 months
(d) Limited to Dependent Children under age 19
(e) Maximum of 1 procedure per 12 months
(f) Limited to Dependent Children under age 14
(g) Limited to Dependent Children under age 12
(h) Maximum of 1 procedure per 24 months
(i) Limited to Dependent Children under age 19
(j) Applications made to permanent molar teeth only
(k) Maximum of 2 procedures per arch per 24 months
(l) Maximum of 1 per 5 year period per tooth
(m) Maximum of 1 each quadrant per 12 months
(n) Maximum of 1 each quadrant per 24 months
(o) Maximum of 1 each tooth per 24 months
(p) Subject to a yearly and a lifetime maximum
(q) Maximum of 1 each quadrant per 36 months
(r) Replacement of existing only if in place for 12 months (insured under age 19)
(s) Replace existing only if in place for 36 months (insured over age 19)
(t) Benefits will be based on the benefit for the corresponding non-cosmetic restoration.
(u) Maximum 1 time per tooth or site
(v) Maximum of 1 per lifetime
(w) Only in conjunction with listed complex oral surgery procedures and subject to review.
(x) Limited to Dependent Children under age 16
(y) Maximum of 1 per 24 months for age 17+
(z) Maximum of 1 per 12 months for age 16 & under
(aa) Limited to those age 25+
(bb) 6 months must have passed since initial placement
(cc) Maximum of 1 per 7 year period when existing appliance/restoration is not serviceable
(dd) Maximum of 1 per 10 year period
(ee) Maximum of 1 per 3 year period
(ff) Maximum of 1 per 4 year period
(gg) Maximum of 1 per 5 year period
(hh) In lieu of a single tooth replacement when a 2 or 3 unit bridge has been approved for coverage
(ii) Maximum of 2 procedures per 12 months
(jj) Only for those age 40 and over who demonstrate risk factors for oral cancer and/or a suspicious lesion
(kk) One additional prophylaxis or periodontal maintenance per year if Member is in second or third trimester of pregnancy. Written verification of pregnancy and due date from patient's physician and claim narrative from dentist must be submitted at the time of claim.
(ll) Two additional cleanings (either prophylaxis or periodontal maintenance) per year if Member has been diagnosed with diabetes mellitus and periodontal disease. Written verification of diabetes mellitus from patient's physician and claim narrative must be submitted at the time of the claim.
(mm) Covered only if provided on different date of service than other covered treatment or exam
(nn) Subject to review
(oo) In lieu of Topical Application of Fluoride for a child
(pp) Limited to 2 oral evaluation procedures, in any combination (D0120, D0145, D0150) per 12 month period

Covered Procedures	Procedure Class*	Waiting Period (Months)	Limitation	Maximum Reimbursement	
				In-Network PMAC	Out-of-Network MAC
Comprehensive or Periodic Oral Exam	A	(0)	(pp)	PMAC	PMAC
Oral Evaluation – Patient under 3 yrs of age	A	(0)	(pp)	PMAC	PMAC
Problem Focused Exam	B	(0)	(e)	PMAC	PMAC
Comprehensive Periodontal Exam	A	(0)	(e)	PMAC	PMAC
Emergency Palliative Treatment	B	(0)	(e)	PMAC	PMAC
Single Film	A	(0)		PMAC	PMAC
Additional Films	A	(0)		PMAC	PMAC
Intra-Oral Occlusal Film	A	(0)		PMAC	PMAC
Bitewings (single or multiple films)	A	(0)	(c) (e)	PMAC	PMAC
Panoramic Film or Full Mouth X-Ray	B	(0)	(h)	PMAC	PMAC
Prophylaxis – Adult (age 16 and above)	A	(0)	(ii) (kk)	PMAC	PMAC
Prophylaxis – Child	A	(0)	(x) (ii)	PMAC	PMAC
Adjunctive Pre-Diagnostic Oral Cancer Screening	A	(0)	(e) (jj)	Up to $45	Up to $45
Topical Application of Fluoride – Child	A	(0)	(e) (x)	PMAC	PMAC
Sealant	A	(0)	(b) (x) (j)	PMAC	PMAC
Space Maintainer – Fixed Unilateral	A	(0)	(x) (o)	PMAC	PMAC
Space Maintainer – Fixed Bilateral	A	(0)	(x) (o)	PMAC	PMAC
Space Maintainer – Removable Unilateral	A	(0)	(x) (o)	PMAC	PMAC
Space Maintainer – Removable Bilateral	A	(0)	(x) (o)	PMAC	PMAC
FILLINGS					
One Surface Amalgam	B	(0)	(r) (s)	PMAC	PMAC
Two Surface Amalgam	B	(0)	(r) (s)	PMAC	PMAC
Three Surface Amalgam	B	(0)	(r) (s)	PMAC	PMAC
Four + Surface Amalgam	B	(0)	(r) (s)	PMAC	PMAC
One Surface Resin – Anterior	B	(0)	(r) (s)	PMAC	PMAC
Two Surface Resin – Anterior	B	(0)	(r) (s)	PMAC	PMAC
Three Surface Resin – Anterior	B	(0)	(r) (s)	PMAC	PMAC
Four + Surface or Incisal Resin – Anterior	B	(0)	(r) (s)	PMAC	PMAC
Protective Restoration	B	(0)	(o)	PMAC	PMAC
ORAL SURGERY					
Extraction, erupted tooth or exposed root	B	(0)		PMAC	PMAC
Extraction, Coronal Remnants	B	(0)		PMAC	PMAC
Surgical Extraction	B	(0)		PMAC	PMAC
Impacted (soft tissue)	B	(0)		PMAC	PMAC
Impacted (partial bony)	B	(0)		PMAC	PMAC
Impacted (complete bony)	B	(0)		PMAC	PMAC
Surgical Removal of Root	B	(0)		PMAC	PMAC
Alveoplasty (with extraction) – per quadrant	B	(0)		PMAC	PMAC
Alveoplasty (without extraction) – per quadrant	B	(0)		PMAC	PMAC
Incision and Drainage of Abscess – Intraoral	B	(0)		PMAC	PMAC
General Anesthesia/Intravenous Sedation	B	(0)	(w)	PMAC	PMAC
CROWN AND BRIDGE REPAIR					
Inlay Recementation	B	(0)	(bb)	PMAC	PMAC
Crown Recementation	B	(0)	(bb)	PMAC	PMAC
Bridge Repair	B	(0)	(bb)	PMAC	PMAC
Crown Repair	B	(0)	(bb)	PMAC	PMAC
Inlay repair	B	(0)	(bb)	PMAC	PMAC
Onlay repair	B	(0)	(bb)	PMAC	PMAC
Veneer repair	B	(0)	(bb)	PMAC	PMAC
Bridge Recementation	B	(0)	(bb)	PMAC	PMAC

Covered Procedures	Procedure Class*	Waiting Period (Months)	Limitation	Maximum Reimbursement	
				In-Network PMAC	Out-of-Network MAC
DENTURE REPAIR					
Repair Denture Base	B	(0)	(e) (bb)	PMAC	PMAC
Repair Teeth – per tooth	B	(0)	(e) (bb)	PMAC	PMAC
Repair Partial Base	B	(0)	(e) (bb)	PMAC	PMAC
Repair Partial Framework	B	(0)	(e) (bb)	PMAC	PMAC
Repair Broken Clasp	B	(0)	(e) (bb)	PMAC	PMAC
Add Tooth to Existing Partial Denture	B	(0)	(e) (bb)	PMAC	PMAC
Add Clasp to Existing Partial Denture	B	(0)	(e) (bb)	PMAC	PMAC
Replace Teeth – per tooth	B	(0)	(e) (bb)	PMAC	PMAC
Reline Upper Denture	B	(0)	(h) (bb)	PMAC	PMAC
Reline Lower Partial Denture	B	(0)	(h) (bb)	PMAC	PMAC
Reline Upper Denture (Lab)	B	(0)	(h) (bb)	PMAC	PMAC
Reline Lower Denture (Lab)	B	(0)	(h) (bb)	PMAC	PMAC
Reline Upper Partial Denture (Lab)	B	(0)	(h) (bb)	PMAC	PMAC
Reline Lower Partial Denture (Lab)	B	(0)	(h) (bb)	PMAC	PMAC
Rebase Complete Denture – Upper	B	(0)	(h) (bb)	PMAC	PMAC
Rebase Complete Denture – Lower	B	(0)	(h) (bb)	PMAC	PMAC
Rebase Partial Denture – Lower	B	(0)	(h) (bb)	PMAC	PMAC
Tissue Conditioning – Upper	B	(0)	(k) (bb)	PMAC	PMAC
Tissue Conditioning – Lower	B	(0)	(k) (bb)	PMAC	PMAC
Denture Adjustment Maxillary – Upper	B	(0)	(a) (bb)	PMAC	PMAC
Denture Adjustment Mandibular – Lower	B	(0)	(a) (bb)	PMAC	PMAC
Partial Adjustment Maxillary – Upper	B	(0)	(a) (bb)	PMAC	PMAC
Partial Adjustment Mandibular – Lower	B	(0)	(a) (bb)	PMAC	PMAC
PERIODONTICS (Non-surgical)					
Scaling and Root Planing–per quadrant	C	(0)	(n)	PMAC	PMAC
Periodontal Debridement (full mouth)	C	(0)	(v)	PMAC	PMAC
Periodontal Maintenance Procedure	C	(0)	(ii) (kk)	PMAC	PMAC
ENDODONTICS					
Vital Pulpotomy – primary teeth only	C	(0)	(f)	PMAC	PMAC
Root Canal – Anterior	C	(0)		PMAC	PMAC
Root Canal – Bicuspid	C	(0)		PMAC	PMAC
Root Canal – Molar	C	(0)		PMAC	PMAC
Apicoectomy – Anterior	C	(0)	(u)	PMAC	PMAC
Apicoectomy – Bicuspid	C	(0)	(u)	PMAC	PMAC
Apicoectomy – Molar	C	(0)	(u)	PMAC	PMAC
Retrograde Filling	C	(0)	(u)	PMAC	PMAC
Root Amputation	C	(0)	(u)	PMAC	PMAC
MISCELLANEOUS					
Occlusal Guard	E				
PERIODONTICS (Surgical)					
Gingivectomy or Gingivoplasty – per quadrant	C	(0)	(n)	PMAC	PMAC
Gingivectomy or gingivoplasty – per tooth	C	(0)	(o)	PMAC	PMAC
Gingival Flap Procedure – per quadrant	C	(0)	(n)	PMAC	PMAC
Osseous Surgery – per quadrant	C	(0)	(n)	PMAC	PMAC
Pedicle Soft Tissue Grafts	C	(0)	(n)	PMAC	PMAC
Free Soft Tissue Graft, first tooth	C	(0)	(n)	PMAC	PMAC
Free Soft Tissue Graft, additional tooth	C	(0)	(n)	PMAC	PMAC
Subepithelial Connective Tissue Graft	C	(0)	(n)	PMAC	PMAC
CROWN					
Crown Resin – resin with high noble metal	C	(0)	(l) (t)	PMAC	PMAC
Crown Resin – resin with noble metal	C	(0)	(l) (t)	PMAC	PMAC

Covered Procedures	Procedure Class*	Waiting Period (Months)	Limitation	Maximum Reimbursement	
				In-Network PMAC	Out-of-Network MAC
Crown Resin – resin with predominately base metal	C	(0)	(l) (t)	PMAC	PMAC
Crown – porcelain/ceramic substrate	C	(0)	(l) (t)	PMAC	PMAC
Crown - porcelain fused to high noble metal	C	(0)	(l) (t)	PMAC	PMAC
Crown – porcelain fused to noble metal	C	(0)	(l) (t)	PMAC	PMAC
Crown –porcelain fused to predominantly base metal	C	(0)	(l) (t)	PMAC	PMAC
Crown – full cast high noble metal	C	(0)	(l) (t)	PMAC	PMAC
Crown – ¾ cast high noble metal	C	(0)	(l) (t)	PMAC	PMAC
Crown – full cast predominantly base metal	C	(0)	(l)	PMAC	PMAC
Crown Prefabricated Stainless Steel	C	(0)	(l)	PMAC	PMAC
Cast Post and Core – In Addition to Crown	C	(0)	(l)	PMAC	PMAC
Prefabricated Post and Core – In Addition to Crown	C	(0)	(l)	PMAC	PMAC
Inlay	C	(0)	(l)	PMAC	PMAC
Onlay	C	(0)	(l)	PMAC	PMAC
Veneers – excluding cosmetic; restorative only	C	(0)	(l)	PMAC	PMAC
BRIDGE					
Pontic Cast High Noble Metal	C	(0)	(l) (t)	PMAC	PMAC
Pontic Cast Noble Metal	C	(0)	(l) (t)	PMAC	PMAC
Pontic Cast Predominantly Base Metal	C	(0)	(l)	PMAC	PMAC
Pontic Porcelain Fused to High Noble Metal	C	(0)	(l) (t)	PMAC	PMAC
Pontic Porcelain Fused to Noble Metal	C	(0)	(l) (t)	PMAC	PMAC
Pontic Porcelain Fused to Predominantly Base Metal	C	(0)	(l) (t)	PMAC	PMAC
Pontic Resin with High Noble Metal	C	(0)	(l) (t)	PMAC	PMAC
Pontic Resin with Noble Metal	C	(0)	(l) (t)	PMAC	PMAC
Pontic Resin with Predominantly Base Metal	C	(0)	(l)	PMAC	PMAC
Crown Resin with High Noble Metal	C	(0)	(l) (t)	PMAC	PMAC
Crown Resin with Noble Metal	C	(0)	(l) (t)	PMAC	PMAC
Crown Resin with Predominantly Base Metal	C	(0)	(l) (t)	PMAC	PMAC
Crown Porcelain / Ceramic; Porcelain Fused to High Noble Metal	C	(0)	(l) (t)	PMAC	PMAC
Crown Porcelain Fused to Noble / High Noble Metal	C	(0)	(l) (t)	PMAC	PMAC
Crown Porcelain Fused to Predominantly Base Metal	C	(0)	(l) (t)	PMAC	PMAC
Crown Porcelain Fused to Noble Metal; Full Cast High Noble Metal	C	(0)	(l) (t)	PMAC	PMAC
Crown ¾ Cast High Noble Metal	C	(0)	(l) (t)	PMAC	PMAC
Crown Full Cast Noble Metal	C	(0)	(l) (t)	PMAC	PMAC
Crown Full Cast Predominantly Base Metal	C	(0)	(l)	PMAC	PMAC
Core Build-up (including any pins)	C	(0)	(l)	PMAC	PMAC
DENTURES					
Complete Upper Denture	C	(0)	(l)	PMAC	PMAC
Complete Lower Denture	C	(0)	(l)	PMAC	PMAC
Immediate Upper Denture	C	(0)	(l)	PMAC	PMAC
Immediate Lower Denture	C	(0)	(l)	PMAC	PMAC
Maxillary (Upper) Partial – Resin Base	C	(0)	(l)	PMAC	PMAC
Mandibular (Lower) Partial – Resin Base	C	(0)	(l)	PMAC	PMAC
Maxillary (Upper)Partial – Cast Metal Framework with Resin Base	C	(0)	(l)	PMAC	PMAC

Covered Procedures	Procedure Class*	Waiting Period (Months)	Limitation	Maximum Reimbursement	
				In-Network PMAC	Out-of-Network MAC
Mandibular (Lower) Partial – Cast Metal Framework with Resin Base	C	(0)	(l)	PMAC	PMAC
Removable Unilateral Partial Denture	C	(0)	(l)	PMAC	PMAC
OTHER					
Endosteal Implants	C	(0)	(hh) (v)	PMAC	PMAC
Cosmetic	E				
TMJ	E				
ORTHODONTIA **					
Initial Orthodontic Examination	E				
Initial Placement of Braces or Appliances	E				
Continuing Treatment for Braces or Appliances including retention	E				

*** Orthodontia Services**

If covered, We will pay benefits for the orthodontic services listed above when the date started for the orthodontic service occurs while the person is insured under this Certificate. No payment will be made for orthodontic treatment if the appliances or bands are inserted prior to becoming insured except as provided in the Takeover Benefits provision. We consider orthodontic treatment to be started on the date the bands or appliances are inserted. Any other orthodontic treatment that can be completed on the same day it is rendered is considered to be started and completed on the date the orthodontic treatment is rendered.

We will pay the Insurance Percentage shown in the Schedule of Benefits after any required deductible for orthodontic services has been satisfied for the Certificate Year. The maximum benefit payable to each Covered Dependent child, while insured under the policy, for orthodontic services is shown in the Schedule of Benefits. Those Insureds who are eligible for Orthodontia coverage are indicated in the Schedule of Benefits. The maximum benefit will apply even if coverage is interrupted.

We will make a payment for covered orthodontic services related to the initial orthodontic treatment which consists of diagnosis, evaluation, pre-care and insertion of bands or appliances. After the payment for the initial orthodontic treatment, benefits for covered orthodontic services will be paid in monthly installments as claims are submitted over the course of the remaining orthodontic treatment. The benefit payment schedule for the initial orthodontic treatment and monthly installments will be determined as follows:

1. We will determine the lesser of the MAC and the orthodontist's fee and multiply that amount by the Insurance Percentage shown in the Schedule.
2. The lesser of the amount from number 1 or the Overall Maximum Benefit for orthodontic services shown in the Schedule of Benefits will be the maximum benefit payable. An initial amount of 25% of the Overall Maximum Benefit payable will be paid for the initial orthodontic treatment. This amount will be payable as of the date appliances or bands are inserted.
3. The remaining 75% of the Overall Maximum Benefit payable will be paid at the applicable co-insurance on a monthly basis as claims are submitted. The subsequent monthly payments will be made only if Your dependent remains insured under this Certificate and provides proof to Us that orthodontic treatment continues. If orthodontic treatment continues after the Overall Maximum Benefit payable has been paid, no further benefits will be paid.
4. The lifetime maximum is equal to the member's lifetime maximum and is inclusive with the prior carrier, if applicable.

PART XIV. SCHEDULE OF BENEFITS

Policyholder: City of Baton Rouge & Parish of East Baton Rouge
- Silver Plan

Policyholder's Address: 1755 Florida Blvd.
Baton Rouge, LA. 70802

Effective Date: January 1, 2017

Initial Term: 36 Months

Eligible Classes: ALL FULL TIME EMPLOYEES WORKING AT LEAST 30 HOURS PER WEEK

Eligibility Period: First of the month following the first day of Active Work

Mode of Premium Payment: MONTHLY

Method of Premium Payment: Remitted by Policyholder

Premium Due Date: 1st of every month

Certificate Year: Your Certificate Year is on a Calendar Year Plan

Deductible: $0 Individual Deductible.
Maximum per Family Deductible: No Limit
Applies to Classes: A, B, C

Co-Pay: See Schedule of Covered Procedures

Certificate Year Maximum Annual Benefit: Per Insured

In-Network

Year 1	Year 2	Year 3 & Forward
N/A	N/A	N/A

Out-of- Network

Year 1	Year 2	Year 3 &Forward
N/A	N/A	N/A

Waiting Periods See Schedule of Covered Procedures

TABLE OF INSURANCE PERCENTAGES:

Certificate Year 1 (with credit for coverage under Your Prior Plan):

	Insurance Percentage In-Network	Insurance Percentage Out-of-Network	Subject to Certificate Year Maximum Benefit	Maximum Benefit Annual/Lifetime
Class A	80%	N/A	Yes	None/None
Class B	60%	N/A	Yes	None/None
Class C	30%	N/A	Yes	None/None

Certificate Year 2 (with credit for coverage under Your Prior Plan):

	Insurance Percentage In-Network	Insurance Percentage Out-of-Network	Subject to Certificate Year Maximum Benefit	Maximum Benefit Annual/Lifetime
Class A	80%	N/A	Yes	None/None
Class B	60%	N/A	Yes	None/None
Class C	30%	N/A	Yes	None/None

Certificate Year 3 and later (with credit for coverage under Your Prior Plan):

	Insurance Percentage In-Network	Insurance Percentage Out-of-Network	Subject to Certificate Year Maximum Benefit	Maximum Benefit Annual/Lifetime
Class A	80%	N/A	Yes	None/None
Class B	60%	N/A	Yes	None/None
Class C	30%	N/A	Yes	None/None

Takeover Benefits: Do takeover benefits apply for Employees who currently have dental coverage? Yes

Plan Type: ☐ Indemnity: No participating provider network

√ Participating Provider Program:

☐ In and Out-of-Network Benefits
√ In-Network Benefit only

☐ Scheduled Fee Plan

City of Baton Rouge

Unum Dental™

Dental Insurance can help you pay for dental exams, cleanings and other services.

For more information, scan the QR code or visit https://flimp.live/COBR_Unum_Benefits

How does it work?

Good dental care is critical to your overall well-being. With Unum Dental insurance, you can get the attention your teeth need—at a cost you can afford.

Unum Dental allows you to see any dentist you choose.

To get the most from your benefits and reduce out-of-pocket costs, choose an in-network provider by utilizing our large national network. These providers have agreed to file your claims and uphold the highest quality standards. You can find in-network providers at unumdentalcare.com.

Why is this coverage so valuable?

- Routine dental care keeps your mouth and whole body healthy.
- Your plan is backed by Unum's commitment to excellence in customer service.
- Personalized website to manage your benefits including claims information, ID cards and more.
- There's no waiting period for preventive and basic services.

What else is included?

Wellness benefits

Oral cancer screenings for patients 40 and older with high risk factors.

Unumdentalcare.com

Use unumdentalcare.com to search for providers, manage your benefits and learn about good dental health. Features include easy access to ID Cards, claims history and coverage information.

Virtual Dental Visits

24/7 dental care for dental emergencies when an in-person visit isn't an option. Available for active dental members*. Visit unumdentalcare.com and click Virtual Dental Visits to get started.

Carryover benefits

Members who take care of their teeth, but use only part of their annual maximum benefit during a benefit period are rewarded with extra benefits in future years! Carryover benefits will be accrued and stored in the insured's carryover account to be used in the next benefit year.

The limits for this policy/certificate are:	Platinum Plan
Carryover benefit	$350
Threshold limit	$700
Carryover account limit	$1,250

*Virtual dental visits are a preventive service and subject to policy year benefit maximum.

Coverage details and costs

Overview	Silver Plan		Platinum Plan	
Benefit Year Maximum*	None		$1,500	
Deductible**	$0 in-network and out-of-network Unlimited		$50 in-network and out-of-network Maximum 3 per family	
Plan Coinsurance	**In-network**	**Out-of-Network**	**In-network**	**Out-of-Network**
Class A Preventive	80%	N/A	100%	100%
Class B Basic	60%	N/A	80%	80%
Class C Major	30%	N/A	60%	60%
Class D Orthodontics	N/A	N/A	60%	60%

*Applies to Class A, B and C Services, if applicable
**Waived for Class A (applies to Class B and C Services)

Dental Coverage	Silver Plan PPO	Platinum Plan
	Monthly cost†	Monthly cost†
You	$13.54	$32.83
You and your spouse	$27.04	$65.64
You and your children	$29.48	$78.58
Family	$45.96	$119.86

†Rates guaranteed for 12 months from the effective date.

Dental carryover benefit and how it works

Each benefit year a member must have:

- One cleaning,
- One regular exam, and
- Total dental claims for preventive, basic and major covered procedures paid during the year below the threshold limit.
- If all three criteria above are met, a portion of the annual maximum will carry over to the next year.

Other Specifications:

- Each covered family member receives their own carryover benefit.
- Group carryover benefit rider must be in effect for one benefit year before any members can utilize carryover benefits.
- A member must be on the plan for a minimum of three months before accruing carryover benefits.
- Carryover benefit may be used toward preventive, basic and major covered services only
- A member's carryover account will be eliminated, and the accrued carryover benefits lost if the insured has a break in coverage for any length of time or any reason.

Dependent children

Dependent age guidelines vary by state. Please refer to your policy certificate or call our Contact Center at (888) 400-9304.

Services not listed

If you expect to require a dental service not included on this brochure, it may still be covered. Please call our Contact Center at (888) 400-9304 to confirm your exact benefits.

Alternate treatment

Unum covers the least expensive most commonly used and accepted American Dental Association treatments. Plan members may elect a more expensive treatment, but will be responsible for the cost difference resulting from the more expensive procedure.

Covered Procedures & Waiting Periods	Silver Plan	Platinum Plan
CLASS A PREVENTIVE SERVICES	Waiting Period: None • Routine exams (2 per 12 months) • Prophylaxis (2 per 12 months) • Bitewing x-rays (maximum of 4 films; 1 per 12 months) • Fluoride treatment for children up to age 16 (1 per 12 months) • Sealants for children up to age 16 (permanent molars, 1 per 36 months) • Space Maintainers for children up to age 16 (1 per 24 months) • Adjunctive pre-diagnostic oral cancer screening (1 per 12 months for ages 40+)	Waiting Period: None • Routine exams (2 per 12 months) • Prophylaxis (2 per 12 months) • Bitewing x-rays (maximum of 4 films; 1 per 12 months) • Fluoride treatment for children up to age 16 (1 per 12 months) • Sealants for children up to age 16 (permanent molars, 1 per 36 months) • Space Maintainers for children up to age 16 (1 per 24 months) • Emergency Treatment (1 per 12 months) • Full mouth/panoramic x-rays (1 per 24 months) • Adjunctive pre-diagnostic oral cancer screening (1 per 12 months for ages 40+)
CLASS B BASIC SERVICES	Waiting Period: None • Emergency Treatment (1 per 12 months) • Full mouth/panoramic x-rays (1 per 24 months) • Simple restorative services (fillings; Benefit allowed for amalgam restorations on posterior teeth) • Simple extractions • Oral Surgery (extractions and impacted teeth) • Anesthesia (subject to review, covered with complex oral surgery) • Repair of crown, denture or bridge	Waiting Period: None • Simple restorative services (fillings; Benefit allowed for amalgam restorations on posterior teeth) • Simple extractions • Oral Surgery (extractions and impacted teeth) • Anesthesia (subject to review, covered with complex oral surgery) • Repair of crown, denture or bridge • Non-Surgical periodontics • Surgical periodontics (gum treatments) • Endodontics (root canals)
CLASS C MAJOR SERVICES	Waiting Period: None • Inlays and onlays • Non-Surgical periodontics • Surgical periodontics (gum treatments) • Endodontics (root canals) • Crowns, bridges, dentures and endosteal implants (in lieu of a 2 or 3—unit bridge)	Waiting Period: 12 months†† • Inlays and onlays • Crowns, bridges, dentures and endosteal implants (in lieu of a 2 or 3—unit bridge)
CLASS D ORTHODONTICS		Waiting Period: 12 months†† • Separate Lifetime Maximum: $1,500 • Up to 25% of lifetime allowance may be payable on initial banding • Dependent children to age 19 only

Refer to your certificate of coverage for the services covered under your plan.

Exclusions and Limitations

Unum members whose dental plan includes coverage of crowns and bridges will have the option of choosing an endosteal implant to replace a missing tooth instead of a conventional fixed 3-unit bridge, when a 3-unit bridge is approved for coverage. Crowns placed on implants will also be covered. Other implants or implant related services are not covered.The following dental services are not covered unless stated otherwise in the Certificate of Coverage:

- any treatment which is elective or primarily cosmetic in nature and not generally recognized as a generally accepted dental practice by the American Dental Association, as well as any replacement of prior elective or cosmetic restorations;
- the correction of congenital malformations;
- replacement of a removable device or appliance that is lost, missing or stolen, and for the replacement of removable appliances that have been damaged due to abuse, misuse, or neglect. This may include but not be limited to removable partial dentures or dentures;
- replacement of any permanent or removeable device or appliance unless the device or appliance is no longer functional and is older than the limitation in the Schedule of Covered Procedures. This may include but not be limited to bridges, dentures and crowns;
- any appliance, service, or procedure performed for the purpose of splinting, to alter vertical dimension or to restore occlusion;
- any appliance, service or procedure performed for the purpose of correcting attrition, abrasion, erosion, abfraction, bite registration, or bite analysis;
- charges for implants (except noted above), removal of implants, precision or semi-precision attachments, denture duplication, or dentures and any associated surgery, or other customized services or attachments;
- services provided for any type of temporomandibular joint (TMJ) dysfunction, muscular, skeletal deficiencies involving TMJ or related structures, myofascial pain.

Limitations:

- Multiple restorations on one surface are payable as one surface. Multiple surfaces on a single tooth will not be paid as separate restorations. On any given day, more than 8 periapical x-rays or a panoramic film in conjunction with bitewings will be paid as a full mouth radiograph. Pre-estimates are recommended for any treatment expected to exceed $300.

Takeover benefits:

Takeover benefits apply if we are taking over a comparable benefits plan from another carrier and only if there is no break in coverage between the original plan and the takeover date. Takeover is available to those individuals insured under the employer's dental plan in effect at the time of the employer's application. If takeover benefits are included in your benefits, then waiting periods for service will be waived for the individuals currently insured under the employer's previous plan during the month prior to coverage moving to us. Application of takeover benefits is subject to Underwriting review and approval. New hires with prior-like dental coverage (lapse in coverage must be less than 63 days) will receive takeover credit for the length of time they had with the prior carrier and must provide proof of coverage (including coverage dates) to receive takeover credit (i.e. one page benefit summary, Certificate of Creditable Coverage, etc.).

Late entrants:

Employees that waive coverage at initial enrollment (within 31 days of effective date) or in the new employee eligibility period and/or terminate coverage with Unum will have a twelve (12) month waiting period applied to basic and major services and orthodontia upon re-applying. The prior carrier is responsible for reimbursement of costs for procedures begun prior to the effective date.

††Subject to takeover benefits

A Network Access plan is available.

THIS POLICY PROVIDES LIMITED BENEFITS

Better benefits at work.™

unum.com

This brochure is not intended to be a complete description of the insurance coverage available. The policies or their provisions may vary or be unavailable in some states. The policies have exclusions and limitations which may affect any benefits payable. For complete details of coverage and availability, please refer to Policy Form Series Dental DN-2002, DN-2007 and DN-2015 or contact your Unum Dental representative.

Underwritten by Starmount Life Insurance Company, Baton Rouge, LA.

EN-2026 FOR EMPLOYEES (2-23)

ATTACHMENT G

ALLSTATE 100% VOLUNTARY UNIVERSAL LIFE

Additional Universal Life Details

Policy Inception Date: January 1, 2021

Rate History: Unchanged since inception

Tech Subsidy/Implementation Credit: 4.5% sunsidy

Commissions: Flat 5% paid to Amerilife

Plan Changes: None since inception

PartnerProfile

Block Experience

Prepared for

City of Baton Rouge

As of

March 31, 2025

Allstate BENEFITS

Allstate BENEFITS

City of Baton Rouge

Report Assumptions and Definitions

- The utilization and participation data is current as of: March 31, 2025
- Persistency data as of: December 31, 2024

Persistency and Participation :

- Persistency is the proportion of the premium that remained inforce for at least one (1) and/or two (2) year(s) past issue. Persistency is a continuous measure that may include account(s) and/or product(s) no longer active.
- Allstate Benefits products are supported on two different policy administration systems – Life70 and Genelco. Insured policy counts are tracked independently by administration system.
    - o The Life70 administration system supports the Accident, Critical Illness, Short Term Disability, and Permanent Life products. The Genelco administration system supports the Hospital Indemnity plan, employer-paid Critical Illness, and true group Short Term Disability.
    - o The Number of Insured Employees is tracked independently by administration system
        - Life70: The admin system is able to determine that employee Tom Smith has purchased both Accident and Universal Life, which is recorded as 2 policies but just 1 insured employee
        - Genelco: The admin system records employee Tom Smith has purchased both Hospital Indemnity and true group Short Term Disability as 2 policies and 1 insured employee
        - Allstate is unable to reconcile insured employees between the Life70 and Genelco systems, so Tom Smith would be reported as 2 insured employees versus 1 insured employee. Tom Smith would be recorded as 4 policies.

Claims Utilization :

- Claims utilization is presented from January 1, 2022 - March 31, 2025.
- The utilization data in this Claims Utilization Report represents claims paid in the period, rather than incurred.
- A claimant may be counted multiple times if he or she had claims paid on multiple benefits for the same product.
- The benefit claim count is calculated by counting the number of distinct policies in a year that submit a claim that is paid on the benefit.
- The utilization data in the report will include ported policies.
- Year-over-year change is presented as the change between the last two (2) full calendar years.

Allstate BENEFITS

City of Baton Rouge

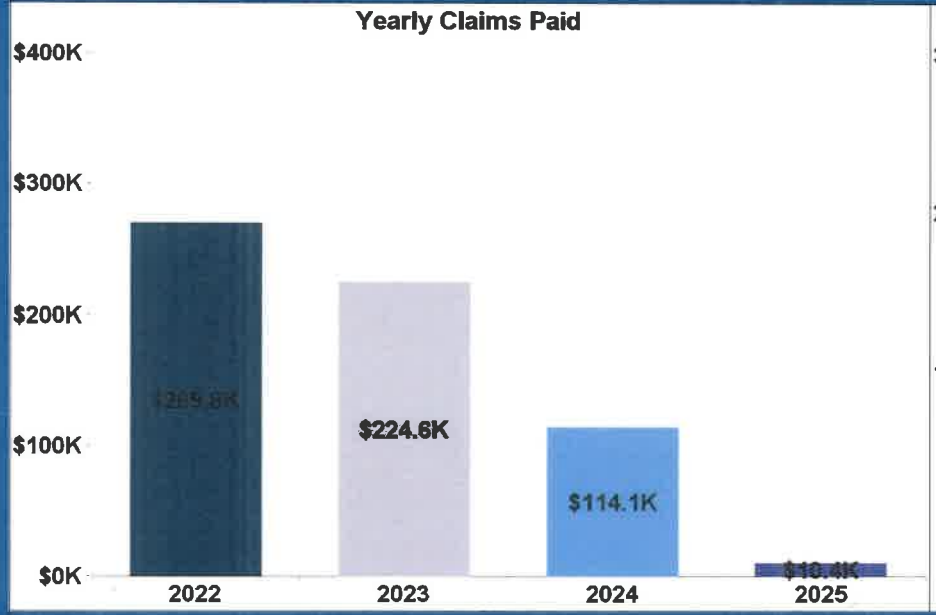
Overview

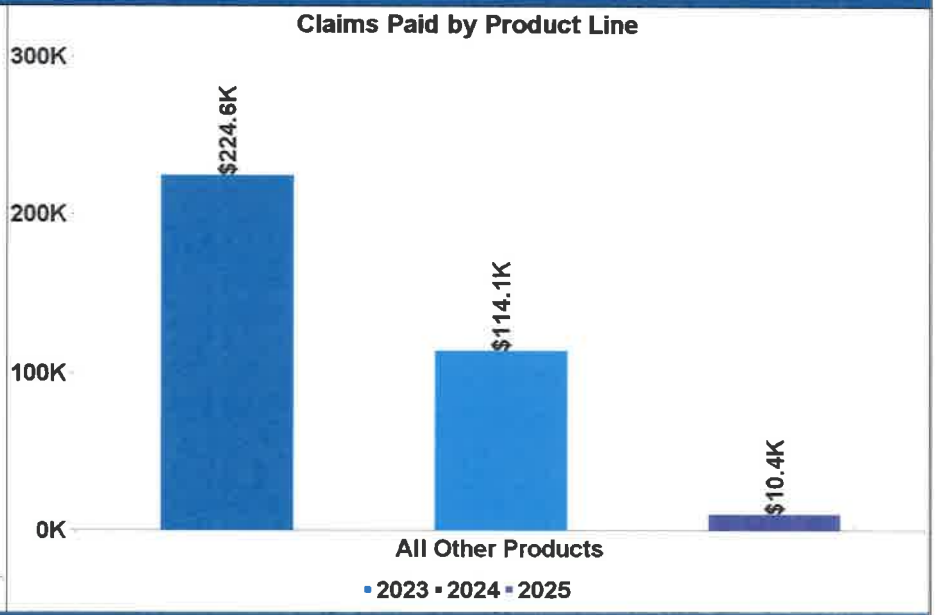
Claim Paid: $618.93K

Inforce Policies: 2K

Overall Saturation Rate: 53%

Block Paid Claims Utilization - Paid Amount





Paid Claims Utilization by Top Benefit Type - Paid Amount

January 1, 2022 - March 31, 2025

Accident

Benefit Type	% of Total	Year over Year Change

Critical Illness

Benefit Type	% of Total	Year over Year Change

Hospital Indemnity

Benefit Type	% of Total	Year over Year Change

All Other Products

Benefit Type	% of Total	Year over Year Change
DEATH	69.39%	-63.19%
DISABILITY	30.61%	-6.82%

Allstate BENEFITS

City of Baton Rouge

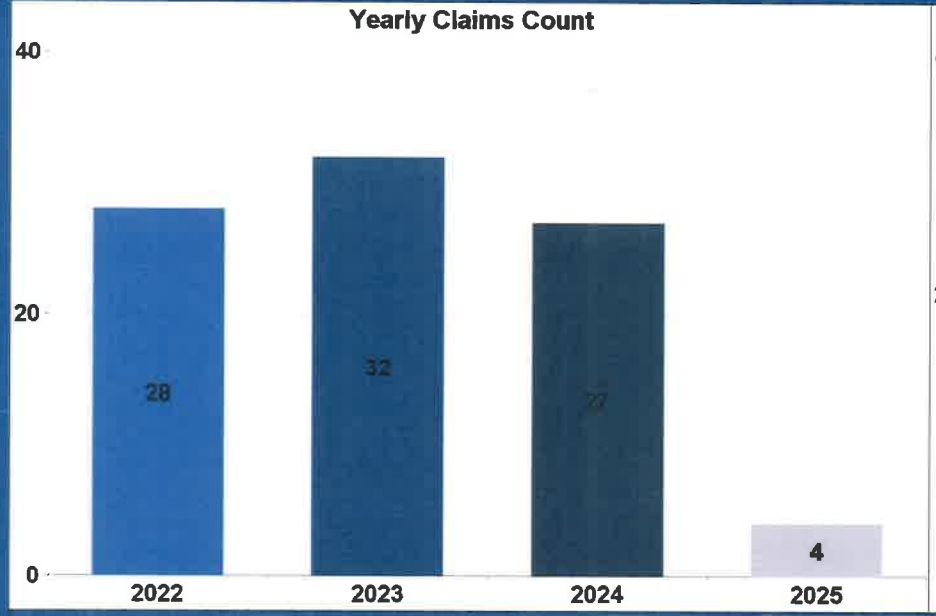
Overview

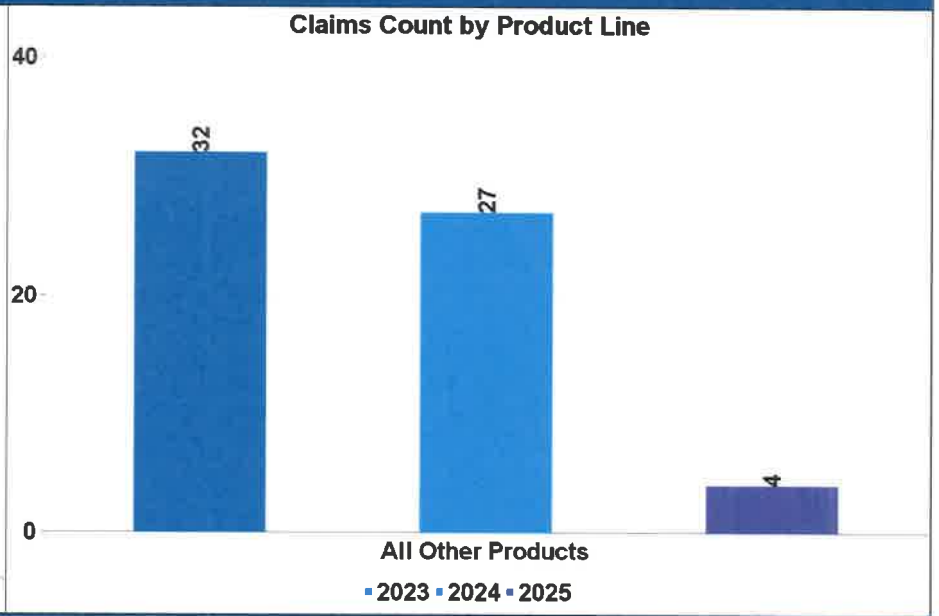
Claim Count: 91

Inforce Policies: 2K

Overall Saturation Rate: 53%

Block Paid Claims Utilization - Claim Count





Paid Claims Utilization by Top Benefit Type - Claim Count

January 1, 2022 - March 31, 2025

Accident

Benefit Type	% of Total	Year over Year Change

Critical Illness

Benefit Type	% of Total	Year over Year Change

Hospital Indemnity

Benefit Type	% of Total	Year over Year Change

All Other Products

Benefit Type	% of Total	Year over Year Change
DISABILITY	81.32%	-14.81%
DEATH	18.68%	-20.00%

All Other Products

Benefit	2022		2023		2024		2025	
	Paid Amount	Claim Count	Paid Amount	Claim Count	Paid Amount	Claim Count	Paid Amount	Claim Count
DEATH	$198,606	8	$168,774	5	$62,122	4	$0	0
DISABILITY	$71,163	20	$55,832	27	$52,022	23	$10,407	4
Total	$269,770	28	$224,606	32	$114,144	27	$10,407	4

Allstate BENEFITS

City of Baton Rouge

As Of 3/31/2025

Group Detail

Inforce Group Numbers:	Total Annualized Inforce Premium:	Total Annualized New Sales Premium:	Total Eligible Employees:
3	$909,489	$81,730	3,000

Group Number	Group Name	Product	Eligible	Inforce Policies As of 03/31/23	Inforce Policies As of 03/31/24	Inforce Policies As of 03/31/25	New Sales Policies 04/22 - 03/23	New Sales Policies 04/23 - 03/24	New Sales Policies 04/24 - 03/25
V5708	CITY OF BATON ROUGE/CORONER'S	Disability	2,700	1	N/A	N/A	N/A	N/A	N/A
V5708	CITY OF BATON ROUGE/CORONER'S	Universal Life	2,700	2	N/A	N/A	N/A	N/A	N/A
V5708	Sub Total			3	N/A	N/A	N/A	N/A	N/A
V5704	CITY OF BATON ROUGE/DISTRICT	Disability	3,000	11	8	11	N/A	N/A	4
V5704	CITY OF BATON ROUGE/DISTRICT	Universal Life	3,000	30	28	26	N/A	1	N/A
V5704	Sub Total			41	36	37	N/A	1	4
V4629	CITY OF BATON ROUGE/PARISH OF EAST	Disability	3,000	499	533	499	88	110	42
V4629	CITY OF BATON ROUGE/PARISH OF EAST	Universal Life	3,000	1,276	1,433	1,447	154	263	97
V4629	Sub Total			1,775	1,966	1,946	242	373	139
V5311	CITY OF BATON ROUGE/PARISH OF EAST	Disability	3,000	2	2	2	N/A	N/A	N/A
V5311	CITY OF BATON ROUGE/PARISH OF EAST	Universal Life	3,000	3	2	2	N/A	N/A	N/A
V5311	Sub Total			5	4	4	N/A	N/A	N/A
	GRAND TOTALS			1,824	2,006	1,987	242	374	143

Allstate BENEFITS

City of Baton Rouge

As Of 3/31/2025

Group Number	Group Name	Product	Eligible	Inforce Premium As of 03/31/23	Inforce Premium As of 03/31/24	Inforce Premium As of 03/31/25	New Sales Premium 04/22 - 03/23	New Sales Premium 04/23 - 03/24	New Sales Premium 04/24 - 03/25
V5708	CITY OF BATON ROUGE/CORONER'S	Disability	2,700	$351	N/A	N/A	N/A	N/A	N/A
V5708	CITY OF BATON ROUGE/CORONER'S	Universal Life	2,700	$710	N/A	N/A	N/A	N/A	N/A
V5708	Sub Total			$1,061	N/A	N/A	N/A	N/A	N/A
V5704	CITY OF BATON ROUGE/DISTRICT	Disability	3,000	$7,108	$5,231	$5,973	N/A	N/A	$2,231
V5704	CITY OF BATON ROUGE/DISTRICT	Universal Life	3,000	$10,726	$9,308	$8,755	N/A	$633	N/A
V5704	Sub Total			$17,834	$14,539	$14,728	N/A	$633	$2,231
V4629	CITY OF BATON ROUGE/PARISH OF EAST	Disability	3,000	$235,694	$253,491	$245,372	$39,464	$57,111	$25,153
V4629	CITY OF BATON ROUGE/PARISH OF EAST	Universal Life	3,000	$543,648	$635,596	$648,306	$76,317	$133,467	$54,346
V4629	Sub Total			$779,342	$889,087	$893,677	$115,780	$190,577	$79,499
V5311	CITY OF BATON ROUGE/PARISH OF EAST	Disability	3,000	$749	$749	$749	N/A	N/A	N/A
V5311	CITY OF BATON ROUGE/PARISH OF EAST	Universal Life	3,000	$607	$335	$335	N/A	N/A	N/A
V5311	Sub Total			$1,355	$1,083	$1,083	N/A	N/A	N/A
	GRAND TOTALS			$799,593	$904,709	$909,489	$115,780	$191,210	$81,730

AMERICAN HERITAGE LIFE INSURANCE COMPANY

Jacksonville, Florida
(the "Company")

Amendment No. 1 to Group Policy No. V4629
issued to
CITY OF BATON ROUGE
(the "Policyholder")

It is hereby agreed that, effective January 1, 2025, the group policy is amended as follows:

All references to Domestic Partner are deleted.

This amendment will be attached to and form a part of the group policy, and will not be held to alter or affect any of the terms of such policy other than as specifically stated, but not unless both the company and the policyholder have executed this amendment.

Signed on August 30, 2024
(Date)

AMERICAN HERITAGE LIFE INSURANCE COMPANY

by Karen S Millard Secretary
(Signature of Officer) (Title)

Signed on _____
(Date)

CITY OF BATON ROUGE

by _____
(Authorized Representative) (Title)

AMERICAN HERITAGE LIFE INSURANCE COMPANY

HOME OFFICE:
1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224-6687
www.allstatebenefits.com
(904) 992-1776

A Stock Company

GROUP FLEXIBLE PREMIUM ADJUSTABLE LIFE INSURANCE POLICY

POLICYHOLDER:	CITY OF BATON ROUGE
POLICY NUMBER:	V4629, V5311, V5704-V5711
POLICY EFFECTIVE DATE:	January 1, 2021
POLICY ANNIVERSARY DATE:	January 1, 2022 and the first day of January each calendar year thereafter.
GOVERNING JURISDICTION:	Louisiana

American Heritage Life Insurance Company (referred to as we, us, or our) agrees to pay the benefits described in this policy, subject to all of the definitions, terms, conditions, and provisions in this policy, the certificates, and any attached rider(s).

We issue this policy, the certificates, and any attached rider(s) based on the policyholder's and the employee's or member's applications and enrollment forms and in return for the payment of required premiums. Premiums are payable to us. The first premium is due on the effective date of this policy.

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.

This policy may include enrollment, risk management, and other support services related to the policyholder's benefit program.

This 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).

PLEASE READ THIS POLICY CAREFULLY!

This policy is a legal contract between American Heritage Life Insurance Company and the policyholder. The policyholder should read this policy carefully and contact us promptly with any questions.

RIGHT TO EXAMINE POLICY

If for any reason you are not satisfied with this policy, return it to us or to our agent. If this policy is returned within 31 days after you receive it, we will return all premiums paid and this policy is void. If you return this policy, please note on it in writing: This policy is returned for rescission and refund of premium. If you have a complaint, an inquiry, or need to obtain information regarding this policy, you may call us toll-free at 1-800-521-3535.

Signed for American Heritage Life Insurance Company at its home office in Jacksonville, Florida.

Secretary

President

GROUP FLEXIBLE PREMIUM ADJUSTABLE LIFE INSURANCE
FLEXIBLE PREMIUMS PAYABLE DURING THE LIFE OF THE INSURED UNTIL MATURITY DATE
NET SURRENDER VALUE, IF ANY, PAID TO THE CERTIFICATE HOLDER ON THE MATURITY DATE IF THE INSURED IS LIVING ON THAT DATE
DEATH BENEFIT PAYABLE AT DEATH OF INSURED PRIOR TO MATURITY DATE
NON-PARTICIPATING – NO DIVIDENDS

TABLE OF CONTENTS

POLICY SPECIFICATIONS

POLICY EFFECTIVE DATE:	This policy will take effect on the effective date shown on page 1.
ELIGIBLE CLASS(ES):	All full-time active employees of the policyholder who work 30 or more hours a week. **Eligible Dependents:** Spouse and Child(ren) of eligible employees or members.
ELIGIBILITY WAITING PERIOD:	The period commencing with the employee's or member's date of employment and ending with the first day of the month immediately following, or coinciding with, the employee's or member's completion of 30 days of continuous active employment.
LIFE INSURANCE BENEFIT:	Amount selected by the employee or member – Up to $250,000
ADDITIONAL BENEFITS:	
Other Support Services	This policy includes enrollment, risk management, and other support services related to the policyholder's benefit program.
ADDITIONAL RIDERS:	
Accelerated Death Benefit for Terminal Illness Rider	75% of Insured's Life Insurance, up to $100,000
Accelerated Death Benefit for Long Term Care Rider	Confinement: 4% of Insured's Life Insurance Non-Confined Care: 4% of Insured's Life Insurance
Extension of Benefits Rider	Confinement: 4% of Insured's Life Insurance Non-Confined Care: 4% of Insured's Life Insurance
OPTIONAL RIDERS:	None

POLICY SPECIFICATIONS (Continued)

ISSUE LIMITS: Subject to a minimum life insurance amount of $10,000

Guaranteed Issue (GI) Limits: (subject to eligibility requirements)

Employee or Member	Spouse	Spouse	Child(ren)
$28.00 per week subject to an overall maximum life insurance amount of $200,000	N/A	N/A	N/A

Contingent Guaranteed Issue (CGI) Limits: (subject to contingent guaranteed issue eligibility requirements)

Employee or Member	Spouse	Spouse	Child(ren)
N/A	$11.00 per week subject to an overall maximum life insurance amount of $100,000	$5.00 per week subject to an overall maximum life insurance amount of $10,000	$3.00 per week subject to an overall maximum life insurance amount of $50,000

Simplified Issue (SI) Limits: (subject to simplified issue eligibility requirements and evidence of insurability)

Employee or Member	Spouse	Non – Working Spouse	Child(ren)
Subject to an overall maximum amount of $250,000 Issue Ages: 18 - 80	Subject to an overall maximum amount of $150,000 Issue Ages: 18 - 80	Subject to an overall maximum amount of $150,000 Issue Ages: 18 - 80	Subject to an overall maximum amount of $150,000 Issue Ages: 0 - 24

POLICY SPECIFICATIONS (Continued)

PREMIUM DUE: January 1, 2021 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.

TOBACCO RATING BASIS: Tobacco/Non-Tobacco

MINIMUM PARTICIPATION REQUIREMENT
The minimum participation required by the governing jurisdiction or a minimum of 5 insured employees or members, whichever is greater, is required to issue this policy.

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	Location (City and State)
None	

DEFINITIONS

(May contain definitions that are not included in the coverage selected)

Active employment or **actively employed** means the employee or member is working for his or her 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 coverage, the employee or member:

1. must be working at least the minimum number of hours as described under Eligible Class(es); and
2. will be deemed to be in active employment on weekends or employer approved vacations, holidays, or business closures if the employee or member was actively employed on the last scheduled work day preceding such time off.

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

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

Normal vacation is considered active employment. However, if vacation days are used to cover disability, sickness, or injury, those days are not considered active employment.

Beneficiary means any person or entity named by the certificate holder in our records or under the terms of this policy to receive the benefits payable under this policy and any attached rider(s).

Certificate means a document that describes the terms of the coverage made available to the eligible employees or members of the policyholder and their eligible dependents. It provides evidence of the coverage provided to an insured under this policy.

Certificate anniversary date means the same day and month each year as the certificate effective date for each succeeding year the certificate remains in force.

Certificate effective date means the effective date of coverage under the certificate and is the date upon which certificate years, certificate anniversary dates, and premium due dates are based. The certificate effective date is shown in the certificate.

Certificate debt means the sum of all unpaid certificate loans plus unpaid accrued certificate loan interest.

Certificate grace period means the period where the certificate remains in force, but where the certificate may terminate as described in the End of a Certificate Grace Period provision in the certificate if timely premium payments and/or loan repayments are not received by us. During the certificate grace period, the death benefit and all certificate provisions remain in effect.

Certificate holder means the employee or member to whom all rights and privileges under the certificate and any attached rider(s) belong during the lifetime of the insured. The certificate holder may be someone other than the insured. The certificate holder is designated on the enrollment form and/or evidence of insurability form as the owner.

Certificate month means a one-month period which begins on a monthly date and ends the day before the next monthly date. The first certificate month begins on the certificate effective date.

Certificate year means the period from the certificate effective date to the first certificate anniversary date or from one certificate anniversary date to the next. A certificate year does not include the certificate anniversary date at the end of the certificate year.

DEFINITIONS (Continued)

Child means an unmarried person under age 19, or under age 25 if a full-time student, who is a citizen or resident alien of the United States or one of its territories, and who is the employee's or member's:
1. natural child;
2. stepchild, which means a child of the employee's or member's spouse by a past marriage or relationship;
3. legally dependent grandchild; or
4. adopted child.

He or she cannot be covered as a child or a rider insured child if he or she is an insured under a certificate.

Death benefit means the amount payable to the beneficiary. The death benefit is equal to the death benefit amount minus certificate debt.

Death benefit amount means the amount described in the certificate, which depends on the death benefit option selected.

Eligible dependents means the person(s) listed in the Policy Specifications.

Employee means a person who is a citizen or resident alien of the United States or one of its territories and in active employment with the policyholder. The employee may exercise all applicable rights provided by his or her certificate and any attached rider(s).

Enrollment form means any form or electronic process acceptable to us that is used to enroll for benefits under this policy.

Evidence of insurability means a statement or proof of a person's medical history on a form or electronic process approved by us that will be used to determine whether the person is approved for the coverage requested.

Fund value means the current accumulation of value as described in the certificate.

In force means coverage that remains in effect and has not terminated.

Insured means the person accepted for coverage by us and whose name is shown in the certificate.

Material and substantial duties means duties that:
1. are normally required for the performance of the employee's or member's regular occupation; and
2. cannot be reasonably omitted or modified. 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 satisfy that requirement if he or she is working or has the capacity to work 40 hours per week.

Maturity date means the certificate anniversary date on or immediately following the insured's 95th birthday and is shown in the certificate. It is possible that coverage may not continue to the maturity date, even if scheduled premiums are paid in a timely manner.

Member means an actively employed member in good standing in the labor union or association named as the policyholder and who is a citizen or resident alien of the United States or one of its territories.

Monthly date means the same day of each month as the certificate anniversary date. If this date is not a day in the calendar, the monthly date is the first day of the next month.

Net surrender value means the surrender value minus any certificate debt.

Policy means this group contract, which governs the coverage made available to eligible employees or members of the policyholder and their eligible dependents.

Policy anniversary date means the same day and month each year as the policy effective date for each succeeding year this policy remains in force.

DEFINITIONS (Continued)

Policy grace period means a period of 31 days following each premium due date, after the first premium payment.

Policyholder means the entity through which we make this group coverage available. The policyholder is shown on page 1 of this policy.

Rider means additional or optional benefit(s) elected by the policyholder and attached to this policy. No coverage is available under a rider unless elected and attached as an additional or optional benefit to the certificate.

Rider insured means the person whose life is insured under a rider.

Spouse means the person who is a citizen or resident alien of the United States or one of its territories and to whom the employee or member is legally married or who is required to be covered as the employee's or member's spouse under the civil union, domestic partnership, or other family or domestic relations laws of the employee's or member's state of residence.

Domestic partnership means a relationship where both the employee or member and his or her same-sex or opposite-sex partner are considered domestic partners according to the law of the employee's or member's state of residence. If the employee's or member's state of residence has no domestic partnership law, the relationship must satisfy the definition of domestic partnership as defined by the policyholder.

A spouse must be at least age 18, but not older than age 80 to be eligible for coverage.

He or she cannot be covered as a spouse or a rider insured if he or she is an insured under this policy.

Surrender value means the fund value less the surrender charge.

We, **us**, or **our** mean American Heritage Life Insurance Company.

Written or **writing** means a record which is on or transmitted by paper, electronic or telephonic media, and which is consistent with applicable law and acceptable by us.

You or **your** means the policyholder as shown in the Application for Group Insurance form.

(This space intentionally left blank.)

POLICYHOLDER PROVISIONS

APPLICATION FOR GROUP INSURANCE
You must submit to us an executed Application for Group Insurance form electing to participate in this Group Flexible Premium Adjustable Life Insurance Policy.

POLICYHOLDER DUTIES
Your duties include, but are not limited to, the following:
1. Provide to us any and all information we determine is necessary for the enrollment and determination of eligibility of your employees or members and their eligible dependents. You must also provide us with all information necessary to underwrite the coverage, to calculate premiums, to maintain necessary administrative records, and to manage claims.
2. Maintain records pertaining to the insurance provided under this policy, for which we may reasonably require information while this policy is in force and for 2 years after this policy terminates. You must also allow us to examine these records at any reasonable time during normal business hours.
3. Upon our request, you will deliver any required notices regarding this insurance to certificate holders.

ENTIRE POLICY
The entire policy consists of this group contract; any attached rider(s), amendment(s), or endorsement(s); any schedule(s); and the Application for Group Insurance form. For all purposes related to the coverage issued under this policy, you act as an agent of the certificate holder. Therefore, you do not act as our agent for any purposes related to coverage provided under this policy.

POLICY INCONTESTABILITY
Any statement made by you will be considered a representation and not a warranty. We rely on the statements made in the Application for Group Insurance form for this policy. We will not use any statement you make to void this policy after it has been in force for 2 years from the date of issue.

CLERICAL ERROR
If any clerical error is made by us or you, the premiums and/or benefits will be adjusted according to the correct data. An error will not end insurance validly in force, nor will it continue insurance validly terminated. Complete proof must be supplied by you documenting any clerical errors.

TIME PERIODS
All periods affecting this policy begin and end at 12:01 a.m. at your address of record.

All periods affecting the certificate holder's coverage begin and end at 12:01 a.m. at his or her address of record.

CHANGE(S) IN THIS POLICY
The terms of this policy may not be changed unless one of our executive officers approves it in writing. Any approved change will be added to this policy in writing.

This policy will automatically comply with any state or federal law or regulation, including tax law, as of the effective date of such law or regulation, even if we have not notified you of the change or this policy has not been amended.

EFFECTIVE DATE OF CHANGES
Unless we agree otherwise in writing, the effective date of any change in benefits offered under this policy will be the first day of the month that immediately follows the date we send notice of the change in benefits and corresponding change in premium rates.

POLICYHOLDER PROVISIONS (Continued)

COMPLIANCE WITH FEDERAL LAWS
We reserve the right to amend this policy to comply with:
1. requirements of the Internal Revenue Code (IRC);
2. any regulations or rulings issued by the Internal Revenue Service (IRS); and
3. any other requirements imposed by the IRS.

We will give the policyholder a copy of any such amendment(s).

This policy is intended to qualify as life insurance under the IRC. Accordingly, the provisions of this policy are to be interpreted, and will be administered by us, to ensure tax qualification.

TERMINATION OF THIS POLICY
This policy and all attached rider(s) will terminate at the earliest of the following events:
1. if any premium payable is not paid within the policy grace period, this policy will terminate on the 32nd day after the premium due date;
2. if you submit a 60-day advance notice to us to terminate this policy, this policy will terminate on the date specified in such request;
3. if we give you a 60-day advance written notice that we intend to terminate this policy, this policy will terminate on the day specified in such notice;
4. if you fail to comply with any of the terms of this policy, or fail to fulfill any obligations under or pertaining to this insurance, or fail to comply with or cooperate with us in satisfying the requirements of any applicable law or regulation pertaining to this insurance, this policy will terminate on the 32nd day after we have given you notice of our intent to terminate; or
5. if the number of employees or members who become insured under this policy during any 12-month period does not meet the minimum participation requirement shown in the Policy Specifications, we have the right to terminate this policy on the 32nd day after we have given you written notice of our intent to terminate.

If this policy ends, you are responsible for giving written notice of the termination to all certificate holders as soon as reasonably possible.

If this policy ends, all premiums due must be paid. Our acceptance of premium after this policy ends will not act to reinstate this policy. We will refund any unearned premium.

INSPECTION OF THIS POLICY
You must make this policy available for inspection by your employees or members at all reasonable times during normal business hours.

CERTIFICATES
We will provide to you a certificate for delivery to each certificate holder. 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 a certificate or any attached certificate rider(s) and the provisions of this policy or any attached policy rider(s), the provisions of this policy and any attached policy rider(s) govern.

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

We may construe disputed or seemingly inconsistent provisions of this policy, a certificate, and any attached rider(s), and make decisions regarding eligibility and/or entitlement to coverage or benefits.

PREMIUMS

PAYMENT OF PREMIUMS

You must pay to us the sum of all premiums collected and due for each insured covered under this policy. Premiums are due and payable to us on each premium due date, subject to the Policy Grace Period provision. The first premium due date is the policy effective date.

POLICY GRACE PERIOD

This policy will remain in force during the policy grace period unless you have given us advance written notice of intent to end coverage under this policy in accordance with the terms of this policy. You will be liable to us for the payment of premium through the end of the policy grace period.

If you replace this policy with another policy but do not give us written notice of intent to end this policy, this provision will apply.

We may extend the policy grace period by giving to you written notice of such intent. Such notice will specify the date this policy will end if the premium remains unpaid. Premiums must be paid for any policy grace period, any extension of such period, and any period for which coverage under this policy was in force and premium was not paid.

NON-PAYMENT OF PREMIUM

Unless all required premium payments are made, this policy and all attached rider(s) will terminate, subject to the Policy Grace Period provision. In no event will any additional benefit(s) or rider(s) continue beyond the termination date set forth in those benefit(s) and/or rider(s).

CHANGE IN PREMIUM RATES

We have the right to change the premium rates on any premium due date after the first, subject to any premium rate guarantee you have with us. We will provide you with a 60-day advance written notice of any change in premium rates.

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ELIGIBILITY

EVIDENCE OF INSURABILITY
We may ask for evidence of insurability if the employee or member:
1. is applying for an amount of coverage over the applicable Guaranteed Issue Limit or Contingent Guaranteed Issue Limit;
2. is applying for coverage, or an increase in the amount of coverage, at any time after his or her initial enrollment period;
3. does not enroll an eligible spouse for coverage within 31 days of eligibility;
4. does not enroll an eligible child for coverage within 31 days of eligibility.

The cost of providing such evidence will be at our expense.

ELIGIBILITY OF AN EMPLOYEE OR MEMBER FOR COVERAGE
An employee or member is eligible to enroll for coverage under this policy, if he or she:
1. meets the definition of an employee or member; and
2. has completed any eligibility waiting period as shown in the Policy Specifications.

ELIGIBILITY OF A SPOUSE FOR COVERAGE
An employee or member will be eligible to enroll for coverage on his or her spouse on the later of the date his or her spouse:
1. first becomes eligible and the employee or member applies for his or her own coverage under this policy; or
2. first meets the definition of spouse.

ELIGIBILITY OF CHILD(REN) FOR COVERAGE
An employee or member will be eligible to enroll for coverage on his or her child(ren) on the later of the date his or her child:
1. first becomes eligible and the employee or member applies for his or her own coverage under this policy; or
2. first meets the definition of child.

In the event that an employee or member and his or her spouse are both covered under this policy as insureds, any child or children will, if otherwise eligible, be covered as a child of one parent only.

EFFECTIVE DATE OF COVERAGE

Coverage for each eligible employee or member will be effective at 12:01 a.m. on the effective date shown in the certificate issued to him or her provided that he or she is actively employed on that date.

If the employee or member is not actively employed on that date due to a temporary layoff, leave of absence, or Family and Medical Leave of Absence, coverage begins on the date he or she returns to active employment.

Coverage for each eligible dependent will be effective at 12:01 a.m. on the effective date shown in the certificate issued to the certificate holder provided that the employee or member is actively employed on that date.

Coverage for certificate rider(s) added after the effective date that are subject to evidence of insurability will be effective on the date we approve the addition of the certificate rider(s).

Coverage for certificate rider(s) added after the effective date that are not subject to evidence of insurability will be effective on the monthly date after we receive the request to add the certificate rider(s).

Coverage changes to remove rider(s) will take effect on the monthly date that immediately follows the date the employee or member requests the removal but will not affect a payable claim that occurs prior to the effective date of the removal.

CERTIFICATE PROVISIONS MADE PART OF THIS POLICY

The remainder of this policy consists of the provisions that will appear in the certificate, including any rider(s), endorsement(s), or amendment(s). The certificate describes the insurance made available under this policy to your employees or members and their eligible dependents.

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AMERICAN HERITAGE LIFE INSURANCE COMPANY
HOME OFFICE:
1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224-6687
www.allstatebenefits.com
(904) 992-1776

A Stock Company

AMERICAN HERITAGE LIFE INSURANCE COMPANY

ACCELERATED DEATH BENEFIT FOR TERMINAL ILLNESS RIDER

Provides for the Advance of a Portion of the Death Benefit due to Terminal Illness
The benefit you receive under this rider may be taxable.
Consult with your personal tax advisor.

This rider is issued in consideration of the enrollment form for this rider. Benefits are subject to the provisions of this rider and the certificate. All terms defined in the certificate and used in this rider apply to this rider, unless otherwise defined in this rider.

DEFINITIONS

Current Discount Rate. The greater of the 90 day Treasury Bill or Moody's Corporate Bond Yield Average-Monthly Average.

Death Benefit Advance. The advance, during the insured's lifetime, of a portion of the death benefit amount.

Certificate. The certificate to which this rider is attached.

Rider Date. The effective date of this rider. The rider date is the certificate date, unless this rider is applied for at a later date. If this rider is applied for at a later date, the rider date is the effective date assigned by our Home Office in accordance with our dating rules in effect at the time this rider is issued.

Terminal Illness. An illness or physical condition:

1. expected to result in the insured's death within 12 months; and
2. for which there is no reasonable prospect for recovery.

PAYMENT OF BENEFITS

If the insured incurs a terminal illness while coverage under this rider is in effect, you may request a death benefit advance. We agree to pay to you the death benefit advance amount upon our receipt of all of the following:

1. your written election of the death benefit advance; and
2. the written consent of any irrevocable beneficiary or any assignee, that you may elect the death benefit advance; and
3. a written opinion of the insured's physician that states the diagnosis of the insured's medical condition and that such medical condition is a terminal illness as defined in this rider; and
4. approval by our medical director.

The death benefit advance can only be elected on certificates (excluding term riders) that are more than 2 years away from their termination date(s) on the date we receive the written election.

If death benefit option 2 is in effect, we will change it to death benefit option 1 prior to making the death benefit advance.

The death benefit advance can only be elected once, per certificate, subject to the limits outlined in the calculation of payment provision.

Your election of the death benefit advance is automatically voided and no benefit is payable under this rider if the insured dies after the above requirements are met and before we have paid the benefit.

Any amount later payable under the certificate as a death benefit is reduced by the amount of the death benefit advance before reductions for pro-rata loans and the current discount.

Any amount later payable under the certificate from the fund value or as a surrender, or available for certificate loan, is reduced by the same proportion as the death benefit amount.

Calculation of Payment. The amount available for death benefit advance is 75% of the death benefit amount for the certificate (excluding any term riders and accidental death benefit rider) on the insured's life subject to a maximum of $100,000.

The death benefit advance amount payable to you is reduced:

1. first by any pro-rata loan; then
2. the remaining sum is discounted at the current discount rate.

The death benefit advance and any remaining death benefit amount for the certificate will be determined at the time the claim is made.

If you elect this benefit on more than one certificate that the insured has with us, we retain the right to utilize the death benefit of one certificate completely prior to using another certificate.

Waiver of Monthly Deductions Benefit. We waive monthly deductions for the certificate and any riders attached to the certificate if the death benefit advance is paid. This waiver of monthly deductions benefit is in addition to any other premium waiver benefit provided by the certificate or a rider attached to the certificate.

Waiver of monthly deductions will:

1. begin on the monthly date on or next following the date you provide us with satisfactory evidence of terminal illness as defined in this rider; and
2. continue until the certificate terminates.

TERMINATION

This rider terminates and is no longer in force on the earliest of:

1. the monthly date on or next following the date we receive a written termination request by the owner; or
2. the date the insured attains age 93; or
3. the date the certificate matures, expires, is surrendered or otherwise terminates.

GENERAL

This rider is a part of the certificate to which it is attached. This rider has no cash or loan value. It does not affect any net single premium that may be referred to in the certificate.

Signed for American Heritage Life Insurance Company at its Home Office in Jacksonville, Florida.

Secretary

President

Home Office
American Heritage Life Insurance Company
1776 American Heritage Life Drive
Jacksonville, Florida 32224

AMERICAN HERITAGE LIFE INSURANCE COMPANY
HOME OFFICE:
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A Stock Company

GROUP FLEXIBLE PREMIUM ADJUSTABLE LIFE INSURANCE CERTIFICATE

This certificate is issued to you as evidence of your insurance under the policy issued to the policyholder. This certificate summarizes and explains the parts of the policy that apply to you. You may view the policy at the policyholder's office during normal business hours.

This certificate may include enrollment, risk management, and other support services related to the policyholder's benefit program.

The 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 any amendments.

PLEASE READ THIS CERTIFICATE CAREFULLY!

RIGHT TO EXAMINE COVERAGE

If for any reason you are not satisfied with this coverage, return it to us or to our agent. If this certificate is returned within 31 days after you receive it, we will return all premiums paid and the coverage is void. If you return this certificate, please note on it in writing: This coverage is returned for rescission and refund of premium. If you have a complaint, an inquiry, or need to obtain information regarding this coverage, you may call us toll-free at 1-800-521-3535.

Signed for American Heritage Life Insurance Company at its home office in Jacksonville, Florida.

Secretary

President

GROUP FLEXIBLE PREMIUM ADJUSTABLE LIFE INSURANCE
FLEXIBLE PREMIUMS PAYABLE DURING THE LIFE OF THE INSURED UNTIL MATURITY DATE
NET SURRENDER VALUE, IF ANY, PAID TO THE CERTIFICATE HOLDER ON THE MATURITY DATE IF THE INSURED IS LIVING ON THAT DATE
DEATH BENEFIT PAYABLE AT DEATH OF INSURED PRIOR TO MATURITY DATE
NON-PARTICIPATING – NO DIVIDENDS

TABLE OF CONTENTS

AMERICAN HERITAGE LIFE INSURANCE COMPANY

1776 American Heritage Life Drive, Jacksonville, Florida 32224

CERTIFICATE SPECIFICATIONS

DESCRIPTION OF BENEFITS	BENEFIT AMOUNT	NUMBER OF YEARS PREMIUM PAYABLE	ANNUAL PREMIUM AMOUNT
LIFE INSURANCE		54	$2,147.40
ACCIDENTAL DEATH BENEFIT RIDER	$200,000		$218.00
TOTAL DISABILITY PAYOR WAIVER OF PREMIUM RIDER DISABILITY BENEFIT AMOUNT:	$200.00 MONTHLY		$114.24
ACCELERATED DEATH BENEFIT FOR TERMINAL ILLNESS RIDER			
OTHER INSURED PERSON LEVEL TERM RIDER ISSUE AGE 41, FEMALE PREMIUM CLASS: NON-TOBACCO	$100,000		$737.00
CHILDREN'S TERM RIDER	$10,000		$54.60
ACCELERATED DEATH BENEFIT FOR LONG TERM CARE RIDER CONFINEMENT PERCENTAGE 4% NON-CONFINED CARE PERCENTAGE 4%			$114.00
EXTENSION OF BENEFITS RIDER			$84.00

*IT IS POSSIBLE THAT COVERAGE MAY NOT CONTINUE TO THE MATURITY DATE EVEN IF SCHEDULED PREMIUMS ARE PAID IN A TIMELY MANNER. IF COVERAGE CONTINUES TO THE MATURITY DATE,THERE MAY BE LITTLE OR NO NET SURRENDER VALUE.

SEE PAGE 3A FOR ADDITIONAL CERTIFICATE SPECIFICATIONS.

The effective date and issue age of each benefit is the Certificate Effective Date and Issue Age of this Certificate unless otherwise specified.

TOTAL PREMIUMS

The Total Premiums include the charge for any additional benefits.

MONTHLY PLANNED PERIODIC PREMIUM: $200.00

Premium Payment Method: PAYROLL ALLOTMENT Premium Class: NON-TOBACCO

INSURED: APP TEST CERTIFICATE NUMBER: DF39088U

CERTIFICATE EFFECTIVE DATE: JULY 01, 2021 ISSUE AGE: M 41

INITIAL SPECIFIED AMOUNT: $200,000 *MATURITY DATE: JULY 01, 2075

MINIMUM SPECIFIED AMOUNT: $10,000 DEATH BENEFIT OPTION - 1

INITIAL MINIMUM MONTHLY PREMIUM: $157.55 POLICY NUMBER: V4629
MINIMUM MONTHLY PREMIUM PERIOD: 5 YEARS
BENEFICIARY: AS NAMED AT ENROLLMENT OR AS LATER CHANGED.

AMERICAN HERITAGE LIFE INSURANCE COMPANY

1776 American Heritage Life Drive, Jacksonville, Florida 32224

CERTIFICATE SPECIFICATIONS

CERTIFICATE VALUES WILL VARY AND COVERAGE MAY CEASE PRIOR TO THE MATURITY DATE DEPENDING ON CHANGES IN INTEREST RATES, COST OF INSURANCE RATES, AND THE FREQUENCY, TIMING, AND AMOUNT OF YOUR PREMIUM PAYMENTS. EVEN IF COVERAGE CONTINUES TO THE MATURITY DATE, THERE MAY BE LITTLE OR NO NET SURRENDER VALUE.

GUARANTEED MINIMUM INTEREST RATE:
MONTHLY RATE: 0.24663%
ANNUAL RATE: 3.000%

DEATH BENEFIT DISCOUNT FACTOR: 1.0024663

MONTHLY FEE: $2.00 FOR ALL YEARS

MAXIMUM PERCENT OF PREMIUM CHARGE: 7.5%

MONTHLY PER THOUSAND CHARGE: SEE PAGE 14

THE SURRENDER CHARGES FOR THE INITIAL SPECIFIED AMOUNT ARE AS FOLLOWS:

YEAR 1	$3,000.00
YEAR 2	$3,000.00
YEAR 3	$3,000.00
YEAR 4	$2,400.00
YEAR 5	$1,800.00
YEAR 6	$1,500.00
YEAR 7	$1,500.00
YEAR 8	$1,500.00
YEAR 9	$1,500.00
YEAR 10	$1,500.00
YEAR 11	$1,500.00
YEAR 12	$1,500.00
YEAR 13	$1,350.00
YEAR 14	$1,200.00
YEAR 15	$1,050.00
YEAR 16	$900.00
YEAR 17	$750.00
YEAR 18	$600.00
YEAR 19	$300.00
YEARS 20+	$0.00

PARTIAL SURRENDER SERVICE CHARGE: $25.00

GUIDELINE SINGLE PREMIUM: $48,445.69
GUIDELINE LEVEL PREMIUM: $3,795.92

ASSUMING MAXIMUM COST OF INSURANCE RATES ARE CHARGED, THE MINIMUM INTEREST RATE IS CREDITED AND THE PLANNED PERIODIC PREMIUM IS PAID, YOUR CERTIFICATE WILL LAPSE IN THE CERTIFICATE YEAR WHICH ENDS IN 2041.

BASIS OF RESERVES ON THE CERTIFICATE EFFECTIVE DATE: 2017 COMMISSIONERS STANDARD ORDINARY, AGE LAST BIRTHDAY, NON-SMOKER, 3.50% INTEREST

LOAN INTEREST RATE: 8.00%

TABLE OF GUARANTEED MAXIMUM MONTHLY COST OF INSURANCE RATES
TOBACCO USER RATES

ATTAINED AGE	RATE PER $1000	ATTAINED AGE	RATE PER $1000	ATTAINED AGE	RATE PER $1000	ATTAINED AGE	RATE PER $1000
0	0.0200	24	0.0825	48	0.3475	72	3.4725
1	0.0125	25	0.0825	49	0.3750	73	3.8325
2	0.0100	26	0.0825	50	0.4025	74	4.2050
3	0.0100	27	0.0825	51	0.4350	75	4.5825
4	0.0075	28	0.0800	52	0.4725	76	4.9575
5	0.0075	29	0.0800	53	0.5150	77	5.3325
6	0.0075	30	0.0825	54	0.5625	78	5.7150
7	0.0075	31	0.0875	55	0.6150	79	6.1250
8	0.0075	32	0.0925	56	0.6750	80	6.5725
9	0.0075	33	0.1000	57	0.7450	81	7.0525
10	0.0075	34	0.1075	58	0.8225	82	7.6675
11	0.0075	35	0.1175	59	0.9125	83	8.4750
12	0.0100	36	0.1275	60	1.0175	84	9.4025
13	0.0150	37	0.1400	61	1.1350	85	10.4675
14	0.0225	38	0.1550	62	1.2675	86	11.6825
15	0.0350	39	0.1750	63	1.4125	87	13.0500
16	0.0475	40	0.1975	64	1.5750	88	14.5400
17	0.0650	41	0.2200	65	1.7500	89	16.1200
18	0.0650	42	0.2400	66	1.9375	90	17.7525
19	0.0700	43	0.2600	67	2.1350	91	19.3900
20	0.0725	44	0.2725	68	2.3450	92	21.0075
21	0.0750	45	0.2875	69	2.5775	93	22.5625
22	0.0775	46	0.3050	70	2.8400	94	23.9800
23	0.0800	47	0.3250	71	3.1400		

GUARANTEED BASIS OF VALUES

Cost of Insurance Rates: 2017 Commissioners' Standard Ordinary Mortality Table, Male Smoker

Interest Rate: 3.0%

TABLE OF GUARANTEED MAXIMUM MONTHLY COST OF INSURANCE RATES
NON-TOBACCO USER RATES

ATTAINED AGE	RATE PER $1000	ATTAINED AGE	RATE PER $1000	ATTAINED AGE	RATE PER $1000	ATTAINED AGE	RATE PER $1000
0	0.0200	24	0.0675	48	0.1750	72	1.4950
1	0.0125	25	0.0650	49	0.1825	73	1.6975
2	0.0100	26	0.0550	50	0.1925	74	1.9250
3	0.0100	27	0.0500	51	0.2100	75	2.1750
4	0.0075	28	0.0500	52	0.2300	76	2.4525
5	0.0075	29	0.0450	53	0.2500	77	2.7600
6	0.0075	30	0.0450	54	0.2725	78	3.1075
7	0.0075	31	0.0475	55	0.2925	79	3.5075
8	0.0075	32	0.0500	56	0.3125	80	3.9750
9	0.0075	33	0.0550	57	0.3325	81	4.5125
10	0.0075	34	0.0650	58	0.3525	82	5.1325
11	0.0075	35	0.0750	59	0.3800	83	5.8550
12	0.0100	36	0.0875	60	0.4150	84	6.7050
13	0.0150	37	0.1000	61	0.4575	85	7.7025
14	0.0225	38	0.1075	62	0.5100	86	8.8650
15	0.0350	39	0.1150	63	0.5675	87	10.2150
16	0.0475	40	0.1200	64	0.6325	88	11.7350
17	0.0650	41	0.1275	65	0.7000	89	13.4025
18	0.0650	42	0.1375	66	0.7750	90	15.1900
19	0.0675	43	0.1450	67	0.8550	91	17.0425
20	0.0700	44	0.1500	68	0.9450	92	18.9325
21	0.0700	45	0.1550	69	1.0500	93	20.8025
22	0.0675	46	0.1600	70	1.1750	94	22.5625
23	0.0675	47	0.1675	71	1.3225		

GUARANTEED BASIS OF VALUES

Cost of Insurance Rates: 2017 Commissioners' Standard Ordinary Mortality Table, Male Non-Smoker

Interest Rate: 3.0%

TABLE OF REDUCED PAID-UP NET SINGLE PREMIUMS
TOBACCO USER

ATTAINED AGE	NET SINGLE PREMIUM	ATTAINED AGE	NET SINGLE PREMIUM	ATTAINED AGE	NET SINGLE PREMIUM	ATTAINED AGE	NET SINGLE PREMIUM
0	N/A	24	$0.23468	48	$0.43850	72	$0.72324
1	N/A	25	$0.24096	49	$0.44934	73	$0.73410
2	N/A	26	$0.24743	50	$0.46040	74	$0.74467
3	N/A	27	$0.25410	51	$0.47166	75	$0.75497
4	N/A	28	$0.26098	52	$0.48310	76	$0.76507
5	N/A	29	$0.26810	53	$0.49473	77	$0.77506
6	N/A	30	$0.27543	54	$0.50652	78	$0.78502
7	N/A	31	$0.28297	55	$0.51848	79	$0.79502
8	N/A	32	$0.29072	56	$0.53057	80	$0.80510
9	N/A	33	$0.29865	57	$0.54279	81	$0.81528
10	N/A	34	$0.30677	58	$0.55511	82	$0.82564
11	N/A	35	$0.31508	59	$0.56751	83	$0.83605
12	N/A	36	$0.32358	60	$0.57995	84	$0.84632
13	N/A	37	$0.33226	61	$0.59240	85	$0.85646
14	N/A	38	$0.34111	62	$0.60483	86	$0.86647
15	N/A	39	$0.35013	63	$0.61719	87	$0.87638
16	N/A	40	$0.35928	64	$0.62948	88	$0.88628
17	N/A	41	$0.36855	65	$0.64165	89	$0.89639
18	N/A	42	$0.37796	66	$0.65370	90	$0.90705
19	$0.20563	43	$0.38752	67	$0.66563	91	$0.91881
20	$0.21114	44	$0.39727	68	$0.67745	92	$0.93247
21	$0.21679	45	$0.40724	69	$0.68915	93	$0.94924
22	$0.22260	46	$0.41744	70	$0.70072	94	$0.97087
23	$0.22856	47	$0.42786	71	$0.71210		

The Table of Reduced Paid-Up Net Single Premiums is based on the 2017 Commissioners Standard Ordinary (CSO) mortality table, age last birthday, male, smoker, as applicable, using an interest rate of 3.00%. The Table of Reduced Paid-Up Net Single Premiums does not reflect any values provided by riders or any certificate loans.

TABLE OF REDUCED PAID-UP NET SINGLE PREMIUMS
NON-TOBACCO USER

ATTAINED AGE	NET SINGLE PREMIUM	ATTAINED AGE	NET SINGLE PREMIUM	ATTAINED AGE	NET SINGLE PREMIUM	ATTAINED AGE	NET SINGLE PREMIUM
0	$0.10004	24	$0.19424	48	$0.36930	72	$0.66449
1	$0.10282	25	$0.19941	49	$0.37908	73	$0.67871
2	$0.10578	26	$0.20476	50	$0.38911	74	$0.69288
3	$0.10883	27	$0.21037	51	$0.39938	75	$0.70698
4	$0.11199	28	$0.21619	52	$0.40988	76	$0.72101
5	$0.11525	29	$0.22221	53	$0.42057	77	$0.73495
6	$0.11862	30	$0.22845	54	$0.43148	78	$0.74882
7	$0.12209	31	$0.23489	55	$0.44260	79	$0.76261
8	$0.12568	32	$0.24149	56	$0.45396	80	$0.77627
9	$0.12937	33	$0.24827	57	$0.46557	81	$0.78979
10	$0.13317	34	$0.25521	58	$0.47745	82	$0.80312
11	$0.13708	35	$0.26229	59	$0.48961	83	$0.81627
12	$0.14110	36	$0.26948	60	$0.50202	84	$0.82919
13	$0.14521	37	$0.27680	61	$0.51467	85	$0.84188
14	$0.14940	38	$0.28425	62	$0.52751	86	$0.85432
15	$0.15364	39	$0.29185	63	$0.54053	87	$0.86654
16	$0.15789	40	$0.29963	64	$0.55370	88	$0.87859
17	$0.16213	41	$0.30761	65	$0.56704	89	$0.89067
18	$0.16635	42	$0.31577	66	$0.58053	90	$0.90307
19	$0.17067	43	$0.32413	67	$0.59419	91	$0.91632
20	$0.17511	44	$0.33269	68	$0.60801	92	$0.93117
21	$0.17967	45	$0.34148	69	$0.62198	93	$0.94879
22	$0.18436	46	$0.35051	70	$0.63608	94	$0.97087
23	$0.18922	47	$0.35978	71	$0.65027		

The Table of Reduced Paid-Up Net Single Premiums is based on the 2017 Commissioners Standard Ordinary (CSO) mortality table, age last birthday, male, nonsmoker, as applicable, using an interest rate of 3.00%. The Table of Reduced Paid-Up Net Single Premiums does not reflect any values provided by riders or any certificate loans.

DEFINITIONS

(May contain definitions that are not included in the coverage selected)

Active employment or **actively employed** means the employee or member is working for his or her 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 coverage, the employee or member:

1. must be working at least the minimum number of hours as described under Eligible Class(es) in the policy; and
2. will be deemed to be in active employment on weekends or employer approved vacations, holidays, or business closures if the employee or member was actively employed on the last scheduled work day preceding such time off.

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

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

Normal vacation is considered active employment. However, if vacation days are used to cover disability, sickness, or injury, those days are not considered active employment.

Attained age means the insured's age on his or her last birthday as of the most recent certificate anniversary date (or the certificate effective date if this certificate has been in force less than 1 year).

Beneficiary means any person or entity named by you in our records or under the terms of this certificate to receive the benefits payable under this certificate and any attached rider(s).

Certificate means a document that describes the terms of the coverage made available to the eligible employees or members of the policyholder and their eligible dependents, as defined in the policy. It provides evidence of the coverage provided to the insured under the policy.

Certificate anniversary date means the same day and month each year as the certificate effective date for each succeeding year the certificate remains in force.

Certificate effective date means the effective date of coverage under this certificate and is the date upon which certificate years, certificate anniversary dates, and premium due dates are based. The certificate effective date is shown in the Certificate Specifications.

Certificate debt means the sum of all unpaid certificate loans plus unpaid accrued certificate loan interest.

Certificate grace period means the period where this certificate remains in force, but where the certificate may terminate as described in the End of a Certificate Grace Period provision, if timely premium payments and/or loan repayments are not received by us. During the certificate grace period, the death benefit and all certificate provisions remain in effect.

Certificate holder means the employee or member to whom all rights and privileges under this certificate and any attached rider(s) belong during the lifetime of the insured. The certificate holder may be someone other than the insured. The certificate holder is designated on the enrollment form and/or evidence of insurability form as the owner.

Certificate month means a one month period which begins on a monthly date and ends the day before the next monthly date. The first certificate month begins on the certificate effective date.

Certificate year means the period from the certificate effective date to the first certificate anniversary date or from one certificate anniversary date to the next. A certificate year does not include the certificate anniversary date at the end of the certificate year.

DEFINITIONS (Continued)

Child means an unmarried person under age 19, or under age 25 if a full-time student, who is a citizen or resident alien of the United States or one of its territories, and who is the employee's or member's:

1. natural child;
2. stepchild, which means a child of the employee's or member's spouse by a past marriage or relationship;
3. legally dependent grandchild; or
4. adopted child.

He or she cannot be covered as a child or a rider insured child if he or she is an insured under a certificate.

Death benefit means the amount payable to the beneficiary. The death benefit is equal to the death benefit amount minus certificate debt.

Death benefit amount means the amount described in this certificate, which depends on the death benefit option selected.

Employee means a person who is a citizen or resident alien of the United States or one of its territories and in active employment with the policyholder. The employee may exercise all applicable rights provided by this certificate and any attached rider(s).

Enrollment form means any form or electronic process acceptable to us that is used to enroll for benefits under the policy.

Evidence of insurability means a statement or proof of a person's medical history on a form or electronic process approved by us that will be used to determine whether the person is approved for the coverage requested.

Fund value means the current accumulation of value as described in this certificate.

In force means coverage that remains in effect and has not terminated.

Insured means the person accepted for coverage by us and whose name is shown in the Certificate Specifications.

Issue age means the insured's age on the date this certificate was issued as shown in the Certificate Specifications.

Loan value means the maximum amount you may borrow according to the provisions of the policy and this certificate.

Material and substantial duties means duties that:

1. are normally required for the performance of the employee's or member's regular occupation; and
2. cannot be reasonably omitted or modified. 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 satisfy that requirement if he or she is working or has the capacity to work 40 hours per week.

Maturity date means the certificate anniversary date on or immediately following the insured's 95th birthday and is shown in the Certificate Specifications. It is possible that coverage may not continue to the maturity date, even if scheduled premiums are paid in a timely manner.

Member means an actively employed member in good standing in the labor union or association named as the policyholder and who is a citizen or resident alien of the United States or one of its territories.

Minimum monthly premium means the amount which, if received by us on or before the first day of each certificate month, during the first five certificate years, will guarantee that this certificate will not enter a grace period during the first five certificate years. The initial minimum monthly premium is shown in the Certificate Specifications. Changes to this certificate may change the minimum monthly premium. The Beginning of a Certificate Grace Period provision and the End of a Certificate Grace Period provision describe in more detail how the minimum monthly premium affects this certificate.

Monthly date means the same day of each month as the certificate anniversary date. If this date is not a day in the calendar, the monthly date is the first day of the next month.

Monthly deduction means the monthly expense charge plus the monthly cost of insurance for this certificate and any attached rider(s).

DEFINITIONS (Continued)

Net surrender value means the surrender value minus any certificate debt.

Physician means a person who is licensed to practice medicine or treat illness in the state or territory in which treatment is received. The physician cannot be the employee or member or a member of his or her family by blood, marriage, or adoption.

Planned periodic premium means the amount and frequency of the premium issued and as shown in the Certificate Specifications.

Policy means the group contract, which governs the coverage made available to eligible employees or members of the policyholder and their eligible dependents, as defined in the policy.

Policyholder means the entity through which we make this group coverage available.

Proof of loss means written evidence satisfactory to us that a person has satisfied the conditions and requirements for a benefit described in this certificate and any attached rider(s). The proof of loss must establish:

1. the nature and extent of the loss or condition;
2. our obligation to pay the claim; and
3. the claimant's right to receive payment.

Proof of death means a certified copy of the death certificate or other lawful evidence providing equivalent information.

Rider means additional or optional benefit(s) elected by the policyholder and attached to this certificate. No coverage is available under a rider unless elected and attached as an additional or optional benefit to this certificate.

Rider effective date means the effective date of coverage under a rider. The rider effective date is the certificate effective date, unless the rider is applied for at a later date. If that rider is applied for at a later date, the rider effective date is the effective date assigned by our home office.

Rider insured means the person whose life is insured under a rider.

Spouse means the person who is a citizen or resident alien of the United States or one of its territories and to whom the employee or member is legally married or who is required to be covered as the employee's or member's spouse under the civil union, domestic partnership, or other family or domestic relations laws of the employee's or member's state of residence.

Domestic partnership means a relationship where both the employee or member and his or her same-sex or opposite-sex partner are considered domestic partners according to the law of the employee's or member's state of residence. If the employee's or member's state of residence has no domestic partnership law, the relationship must satisfy the definition of domestic partnership as defined by the policyholder.

A spouse must be at least age 18, but not older than age 80 to be eligible for coverage.

He or she cannot be covered as a spouse or a rider insured if he or she is an insured under the policy.

Specified amount means the amount shown in the Certificate Specifications, adjusted by any increase or decrease in specified amount since the certificate effective date.

Surrender value means the fund value less the surrender charge.

We, **us**, or **our** mean American Heritage Life Insurance Company.

Written or **writing** means a record which is on or transmitted by paper, electronic or telephonic media, and which is consistent with applicable law and acceptable by us.

You or **your** means the certificate holder as shown on the enrollment form and/or evidence of insurability form as the owner.

CERTIFICATE HOLDER AND BENEFICIARY

CERTIFICATE HOLDER

All certificate rights and privileges belong to you and may be exercised by you during the lifetime of the insured. If you die before the insured, the insured (or a minor insured's legal guardian) becomes the certificate holder with limited rights and privileges for a period of 31 days from the date we receive notification of your death. During that time, the insured (or a minor insured's legal guardian) may exercise the Continuation of Coverage or Conversion. In the event the insured (or a minor insured's legal guardian) does not exercise the Continuation of Coverage or Conversion, this certificate will terminate and any net surrender value will be paid to the insured.

BENEFICIARY

Subject to the terms and conditions of the policy, this certificate, and any attached rider(s), the beneficiary receives the death benefit when the insured dies. You may name a beneficiary on the beneficiary designation form, enrollment form, and/or evidence of insurability form. The beneficiary may be changed by you, as explained in the Change of Beneficiary provision.

"Beneficiary" as used in this certificate refers to two classes of beneficiaries: primary and contingent beneficiaries. We will pay the death benefit to the beneficiary in the following order:

1. to the primary beneficiary, if living; otherwise,
2. to the contingent beneficiary.

If there is more than one beneficiary in a class and one of the beneficiaries dies before the insured, the remaining beneficiaries in that class will divide the deceased beneficiary's share equally.

If two or more beneficiaries are designated and their shares are not specified, we will pay the designated beneficiaries in equal shares.

If there is no named beneficiary, or if the named beneficiary does not survive the insured, we will pay any benefits due at the insured's death in the following order:

1. to the living certificate holder; otherwise,
2. to the insured's living spouse; otherwise,
3. to the insured's living natural or legally adopted child(ren) in equal shares; otherwise,
4. to the insured's living parents in equal shares; otherwise,
5. to the insured's living natural or legally adopted siblings in equal shares; otherwise,
6. to the insured's estate.

CHANGE OF BENEFICIARY

Any change of beneficiary must be filed at our home office in a form acceptable to us. It will not take effect unless so filed, but if so filed and accepted by us, will take effect on the date signed by you. This will be true whether or not the insured is living on the date it is filed. There will be no prejudice to us on account of any payment we make prior to its receipt by us at our home office.

The right to change a beneficiary is reserved to you. The consent of the beneficiary or beneficiaries will not be required to assign benefits or to change a beneficiary or beneficiaries, or to make any other changes, unless the designation of the beneficiary is irrevocable.

ASSIGNMENT OF BENEFITS

An assignment of benefit is not binding on us unless:

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

An assignment will take effect when recorded at our home office. We are not responsible for the validity of any assignment.

PREMIUMS AND GRACE PERIOD

PAYMENT OF PREMIUMS
Premiums are payable to our Home Office. The first premium due date is the certificate effective date.

FLEXIBILITY
Premium payments are flexible. This means you may choose the amount and frequency of payments. The amount of premium payments that you may pay is limited by the Internal Revenue Service (IRS). We have the right to:

1. limit the number and the amount of premiums in accordance with IRS requirements. We will conduct a test no less frequently than annually, and return any excess premium payments, with interest, within 60 days of the end of the certificate year in which the excess premium payments were paid; and
2. require evidence of insurability if the death benefit amount must be increased due to IRS requirements.

The actual amount and frequency of premium payments affects the fund value and the amount and duration of insurance. Refer to the Certificate Fund Value provision for a detailed explanation.

PLANNED PERIODIC PREMIUM
The amount and frequency of the planned periodic premium is as issued. You may make a written request to change the amount and frequency. No premium may be paid after the maturity date.

BEGINNING OF A CERTIFICATE GRACE PERIOD
When this certificate has been in force for less than five years, a certificate grace period will begin when all of the following conditions occur:

1. this certificate is in force and not in a grace period;
2. the net surrender value is zero or less; and
3. the sum of the minimum monthly premiums for each of the certificate months that this certificate has been in force for at least a portion of the certificate month is greater than:
   a. the sum of all premium payments received by us; minus
   b. the sum of all loans taken by you, including the sum of all loan repayments received by us; minus
   c. the sum of all partial surrenders taken by you, including the sum of all partial surrender service charges.

When this certificate has been in force for five or more years, a certificate grace period will begin when all of the following conditions occur:

1. the certificate is in force and not in a grace period; and
2. the net surrender value is zero or less.

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PREMIUMS AND GRACE PERIOD (Continued)

END OF A CERTIFICATE GRACE PERIOD

A certificate grace period will end at any time any of the following conditions occur:

1. it has been at least 61 days since the certificate grace period began, and it has been at least 31 days since we mailed you a notice that this certificate is in the certificate grace period. If a certificate grace period ends as a result of this condition becoming true, this certificate and any attached rider(s) terminate;
2. we received a premium payment or loan repayment equal to or exceeding the amount stated in a notice we mailed you as necessary to end the certificate grace period with this certificate still in force;
3. we received a premium payment or loan repayment after the certificate grace period began but before we mailed you notice of what premium payment or loan repayment would be necessary to end the certificate grace period with this certificate still in force; and this certificate has been in force for less than 5 years; and the sum of the minimum monthly premiums for each of the certificate months that this certificate has been in force for at least a portion of the certificate month is less than or equal to:
   a. the sum of all premium payments received by us; minus
   b. the sum of all loans taken by you minus the sum of all loan repayments received by us; minus
   c. the sum of all partial surrenders taken by you, including the sum of all partial surrender service charges;
4. we received a premium payment or loan repayment after the certificate grace period began but before we mailed you notice of what premium payment or loan repayment would be necessary to end the certificate grace period with this certificate still in force, and the net surrender value is greater than zero; or
5. this certificate terminates for a reason not directly caused by the certificate grace period. If the certificate grace period ends as a result of this condition occurring, the amount payable, if any, will be based on this certificate's values as of the date of termination.

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BENEFITS

DEATH BENEFIT
If the insured dies prior to the maturity date and while this certificate is in force, we will pay the death benefit amount in a lump sum to the beneficiary upon our receipt of proof of death. We may also require submission of this certificate with the proof of death.

In no event will the amount payable upon death of the insured be less than the minimum amount required to permit this certificate to qualify as life insurance under the Federal Income Tax Rules applicable to this certificate.

The death benefit will not include a refund of any planned periodic premium waived under the Payor Waiver of Premium for Total Disability Rider.

Interest on the death benefit will begin to accrue 20 days from the day we receive due proof of death of the insured. The rate of interest will be the same rate paid on deposits with us.

DEATH BENEFIT OPTIONS
The death benefit amount depends on the death benefit option in effect on the date of the insured's death. The death benefit option and the initial specified amount in effect on the certificate effective date are shown in the Certificate Specifications:

1. under Death Benefit Option 1, the death benefit amount is the specified amount on the date of death;
2. under Death Benefit Option 2, the death benefit amount is the specified amount, plus the fund value on the date of death.

The above options are subject to IRS requirements.

The death benefit amount in any certificate year is not less than the minimum death benefit amount. The minimum death benefit amount equals a percent of the fund value on the date of death, based on the following table:

Attained Age	Fund Value %	Attained Age	Fund Value %	Attained Age	Fund Value %	Attained Age	Fund Value %
40 and Under	250	54	157	68	117	82	105
41	243	55	150	69	116	83	105
42	236	56	146	70	115	84	105
43	229	57	142	71	113	85	105
44	222	58	138	72	111	86	105
45	215	59	134	73	109	87	105
46	209	60	130	74	107	88	105
47	203	61	128	75	105	89	105
48	197	62	126	76	105	90	105
49	191	63	124	77	105	91	104
50	185	64	122	78	105	92	103
51	178	65	120	79	105	93	102
52	171	66	119	80	105	94	101
53	164	67	118	81	105	95	100

MATURITY BENEFIT
If the insured is living on the maturity date and while this certificate is in force, we will pay the net surrender value in a lump sum to you.

CHANGING THE DEATH BENEFIT

RIGHT TO CHANGE AMOUNT OR DEATH BENEFIT OPTION
After the first certificate anniversary date, you may make a written request to change the specified amount or the death benefit option. We may limit the number of each such type of change to one per 12-month period. A change approved by us goes into effect on the monthly date after the date we receive the written request at our Home Office.

INCREASING THE SPECIFIED AMOUNT
A request for an increase must include the following:
1. an evidence of insurability form; and
2. the first monthly deduction for the increase.

Increases in the specified amount are subject to our underwriting rules, issue limit amounts, and age limits.

DECREASING THE SPECIFIED AMOUNT
Any decrease is applied in the following order:
1. against the specified amount of the most recent increase; then
2. against the next most recent increases, in order; then
3. against the initial specified amount.

The specified amount remaining in force after a decrease cannot be less than the minimum specified amount shown in the Certificate Specifications. We reserve the right to refuse a decrease which causes a certificate not to qualify as life insurance under IRS requirements.

CHANGING THE DEATH BENEFIT OPTION
If you request a change from Death Benefit Option 1 to Death Benefit Option 2, the specified amount is decreased by the amount of the fund value, but not below the minimum specified amount shown in the Certificate Specifications. Evidence of insurability may be required.

If you request a change from Death Benefit Option 2 to Death Benefit Option 1, the specified amount is increased by the amount of the fund value. No evidence of insurability is required.

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CERTIFICATE FUND VALUE

FUND VALUE ON THE CERTIFICATE EFFECTIVE DATE

The fund value on the certificate effective date is:

1. 92.5%* of any premiums received on or before the certificate effective date; minus
2. the monthly expense charge for the first certificate month; minus
3. the monthly cost of insurance for this certificate for the first certificate month.

FUND VALUE ON EACH MONTHLY DATE

On any monthly date after the certificate effective date, the fund value is:

1. the fund value on the last monthly date; plus
2. one month's interest on item 1 above; plus
3. 92.5%* of any premiums received since the last monthly date; minus
4. any partial surrender of fund value and any partial surrender service charge since the last monthly date; minus
5. the monthly expense charge for the month following the monthly date; minus
6. the monthly cost of insurance for this certificate for the month following the monthly date.

* At our option, we may credit more than 92.5% of any premiums received. The amount we credit will always be at least 92.5% and will never be greater than 100%.

On any day other than the monthly date, the fund value will be calculated in a like manner.

INTEREST RATE

The guaranteed rate used in calculating fund values is the monthly rate shown in the Certificate Specifications, compounded monthly. This is equivalent to the annual rate shown in the Certificate Specifications, compounded annually. We may use rates greater than guaranteed rates to calculate fund values. We may use a different rate for the portion of the fund value which equals the amount of certificate debt, but never less than the monthly rate shown in the Certificate Specifications.

HOW WE CALCULATE THE MONTHLY EXPENSE CHARGE

The monthly expense charge for a certificate month equals:

1. the monthly cost of insurance for benefits provided by any rider(s) attached to this certificate; plus
2. a monthly fee of $2.00 in all certificate years; plus
3. the monthly per thousand charge, if any.

HOW WE CALCULATE THE MONTHLY COST OF INSURANCE

We calculate the cost of insurance on each monthly date. The monthly cost of insurance is determined as follows:

1. divide the death benefit amount on the monthly date (prior to the deduction of the cost of insurance for this certificate) by the death benefit discount factor amount shown in the Certificate Specifications (this discounts the death benefit amount to the beginning of the month at the guaranteed interest rate); then
2. determine the fund value on the monthly date (prior to the deduction of the cost of insurance for this certificate); and
3. subtract item 2 from item 1 above, divide by 1,000 (this is the number of $1,000's of net amount at risk), then multiply by the cost of insurance rate per $1,000.

COST OF INSURANCE RATES

The cost of insurance rates are based on many factors, including, but not limited to, the insured's age, certificate year, premium class, and specified amount. We may change the cost of insurance rates for any reason at any time, but they will never be more than the guaranteed maximum rates shown in the Certificate Specifications. For the specified amount at issue, the premium class on the certificate effective date applies. For increases in the specified amount, the premium class applicable to the increase applies. When the death benefit amount is increased due to the minimum death benefit, the premium class for the most recent increase applies to the amount of increase. When the specified amount is decreased, the order of decreases is explained in the Decreasing the Specified Amount provision. Each time there is an increase or decrease, an average premium class weighted by specified amount is computed. The same weighting is used to determine an average cost of insurance rate to apply to the total specified amount.

CERTIFICATE FUND VALUE (Continued)

HOW WE CALCULATE THE MONTHLY PER THOUSAND CHARGE

The monthly per thousand charge is a charge for each $1,000 of initial specified amount to be deducted at the beginning of each certificate month. The monthly per thousand charge will also be deducted for each $1,000 of increased specified amount at the beginning of each certificate month beginning on the effective date of such increase. Maximum annual charges per $1,000 are shown below. At our option, we may determine a lower annual charge. The monthly charges per $1,000 are the annual per $1,000 charges divided by 12.

MAXIMUM ANNUAL EXPENSE CHARGES PER $1,000 OF INITIAL SPECIFIED AMOUNT OR INCREASED SPECIFIED AMOUNT

Age at issue or increase	Non-Tobacco User Duration since Issue or Increase (Year)		Age at issue or increase	Tobacco User Duration since Issue or Increase (Year)	
	1-14	15+		1-14	15+
0-20	1.92	0.00	0-20	2.52	0.48
21-25	1.92	0.00	21-25	3.00	0.96
26-30	1.92	1.08	26-30	3.60	0.96
31-35	2.16	1.08	31-35	4.08	1.44
36-40	3.12	2.40	36-40	5.16	1.44
41-45	3.12	3.12	41-45	6.48	2.28
46-50	5.12	5.12	46-50	9.24	3.24
51-55	6.68	6.68	51-55	11.76	11.76
56-60	10.00	10.00	56-60	15.84	15.84
61-65	15.00	15.00	61-65	23.88	23.88
66-67	23.00	23.00	66-67	37.44	37.44
68	24.00	24.00	68	37.44	37.44
69	27.00	27.00	69	37.44	37.44
70	30.00	30.00	70	37.44	37.44
71	35.00	35.00	71	61.68	61.68
72	40.00	40.00	72	61.68	61.68
73-75	45.00	45.00	73-75	61.68	61.68
76-80	48.00	48.00	76-80	100.56	100.56

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CERTIFICATE LOAN, PARTIAL SURRENDER, AND NON-FORFEITURE OPTIONS

CERTIFICATE LOANS

You may take a loan under this certificate if:

1. this certificate is in force; and
2. the loan is not more than the loan value.

The loan value is the surrender value minus:

1. the existing certificate debt;
2. the interest on the existing certificate debt and the amount to be borrowed to the next certificate anniversary date;
3. any unpaid monthly deductions; and
4. an amount equal to 2 monthly deductions.

Loans are evidenced by our check payable to and endorsed by you, or electronic versions of the same.

The minimum certificate loan amount is $100, unless it is used to pay premiums on this certificate.

LOAN INTEREST

The interest we will charge on certificate debt is shown in the Certificate Specifications. Interest on certificate debt is due and payable in arrears at the end of each certificate anniversary date. Interest not paid when due will be added to the existing certificate debt and bear interest at the same rate.

LOAN REPAYMENT

You may repay certificate debt at any time, except that:

1. repayment must be made while this certificate is in force and while the insured is living; and
2. a partial repayment must be at least $25.

A loan that exists at the end of the grace period cannot be repaid.

If at any time the certificate debt exceeds the surrender value, this certificate terminates. At least a 31-day prior notice will be sent to you.

PARTIAL SURRENDER

After the first certificate anniversary date, you may request a partial surrender any time during the insured's lifetime and before the maturity date. The partial surrender is effective on the date we receive and accept your written request. A $25 service charge is deducted from the fund value for each partial surrender. The amount surrendered plus the service charge cannot exceed the net surrender value, but must be at least $250.

Under Death Benefit Option 1, the specified amount is reduced by the amount of the partial surrender. A partial surrender is not allowed if it would reduce the specified amount below the minimum specified amount shown in the Certificate Specifications.

A partial surrender cannot be repaid, but you can make unscheduled premium payments.

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CERTIFICATE LOAN, PARTIAL SURRENDER, AND NON-FORFEITURE OPTIONS (Continued)

NON-FORFEITURE
If this certificate is in force and has a net surrender value greater than zero, then you may select one of the following non-forfeiture options by written request:

1. **Cash Surrender.** You may return this certificate to us and request its net surrender value. A surrender is effective on the date we receive your written request at our Home Office. The fund value used to calculate the surrender value is the value as of the day we receive your request at our Home Office.

   How to Calculate the Cash Surrender Value

   For renewal years, multiply the maximum surrender charge by the percentages shown in the Percent of Maximum Surrender Charge table on the next page. Years and months are measured from the certificate effective date or date of increase, respectively.

   The surrender charge for this certificate equals the sum of the surrender charge on the initial specified amount, plus the surrender charge on any increase in specified amount. The surrender charge on the initial specified amount equals the rate per $1,000 shown in the Percent of Maximum Surrender Charge table on the next page, times the number of $1,000s of initial specified amount.

   The surrender charge on any increased specified amount equals the rate per $1,000 shown in the Percent of Maximum Surrender Charge table on the next page, based on the attained age at increase, times the number of $1,000's of increased specified amount.

   If the specified amount is decreased for any reason, the surrender charge is not affected. There is no reduction in the surrender charge due to such decrease.

TABLE OF MAXIMUM SURRENDER CHARGES
(Per $1,000 of Initial Specified Amount or Increased Specified Amount)

Age at Issue or Increase	Maximum Surrender Charge	Age at Issue or Increase	Maximum Surrender Charge	Age at Issue or Increase	Maximum Surrender Charge	Age at Issue or Increase	Maximum Surrender Charge
0	5.00	21	6.50	42	15.50	63	40.00
1	5.00	22	7.00	43	16.00	64	40.00
2	5.00	23	7.00	44	17.00	65	40.00
3	5.00	24	8.00	45	18.00	66	48.00
4	5.00	25	8.00	46	18.00	67	48.00
5	5.00	26	8.00	47	18.00	68	48.00
6	5.00	27	8.00	48	18.50	69	48.00
7	5.00	28	9.00	49	19.00	70	51.00
8	5.00	29	9.00	50	19.50	71	55.00
9	5.00	30	9.00	51	20.00	72	55.00
10	5.00	31	10.00	52	21.00	73	55.00
11	5.00	32	10.00	53	22.00	74	55.00
12	5.00	33	11.00	54	23.00	75	55.00
13	5.00	34	11.00	55	25.00	76	55.00
14	6.00	35	12.00	56	33.00	77	55.00
15	6.00	36	12.00	57	33.00	78	55.00
16	6.00	37	13.00	58	33.00	79	55.00
17	6.00	38	13.50	59	33.00	80	55.00
18	6.00	39	14.00	60	40.00		
19	6.00	40	14.50	61	40.00		
20	6.50	41	15.00	62	40.00		

CERTIFICATE LOAN, PARTIAL SURRENDER, AND NON-FORFEITURE OPTIONS (Continued)

NON-FORFEITURE (Continued)

PERCENT OF MAXIMUM SURRENDER CHARGE

During Year	Age at Issue or Increase				
	0-30	31-45	46-54	55-70	71+
1	100%	100%	100%	100%	100%
2	100%	100%	100%	100%	90%
3	100%	100%	100%	100%	80%
4	80%	80%	60%	60%	60%
5	60%	60%	25%	50%	50%
6	50%	50%	25%	40%	40%
7	50%	50%	25%	30%	30%
8	50%	50%	25%	20%	20%
9	50%	50%	25%	10%	10%
10	50%	50%	25%	0%	0%
11	50%	50%	25%		
12	50%	50%	25%		
13	50%	45%	25%		
14	50%	40%	25%		
15	50%	35%	0%		
16	50%	30%			
17	50%	25%			
18	50%	20%			
19	50%	10%			
20	0%	0%			

2. **Reduced Paid-Up Insurance.** You may, at any time, elect to surrender this certificate and use the net surrender value to purchase reduced paid-up insurance. This reduced paid-up insurance will be in force until the maturity date unless it is surrendered. If the insured is living on the maturity date, we will pay the reduced paid-up insurance amount to you.

   The reduced paid-up amount is calculated by dividing the net surrender value by the net single premium. The net single premium is calculated using the guaranteed maximum cost of insurance rates and the guaranteed interest rate. See the Table of Reduced Paid-Up Net Single Premiums on pages 5A and 5B.

   We reserve the right to refuse to provide this option if the reduced paid-up insurance amount would be less than $1,000.

   Once elected, the reduced paid-up insurance option can be surrendered at any time. The surrender is effective on the date we receive your written request. Once the reduced paid-up insurance is surrendered, it cannot be reversed.

   The value provided on surrender is calculated by multiplying the reduced paid-up insurance amount by the net single premium calculated at the time this option is surrendered.

When a non-forfeiture option is elected, any rider(s) attached to this certificate will terminate.

If the insured dies before a non-forfeiture request becomes effective, we will void your request for that non-forfeiture option and pay the death benefit pursuant to this certificate.

PAYMENTS BY US AND RIGHT TO DEFER PAYMENT

We have the right to wait up to 6 months after written notice to us before we:

1. pay the net surrender value; or
2. make a certificate loan, unless it is used to pay premiums on this certificate.

GENERAL PROVISIONS

TERMINATION OF COVERAGE
Subject to the Continuation of Coverage provision, this certificate terminates on the earliest of:
1. the end of the certificate grace period when premiums remain unpaid;
2. the date of the insured's death;
3. the maturity date of this certificate;
4. the date you surrender this certificate for its net surrender value;
5. the date the policy is terminated;
6. the last day the employee or member is in active employment with his or her employer and/or a member in good standing in the labor union or association that is the policyholder;
7. the date the employee or member is no longer in an eligible class; or
8. the date the employee's or member's class is no longer eligible.

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 may construe disputed or seemingly inconsistent provisions of the policy, this certificate, and any attached rider(s), and make decisions regarding eligibility and/or entitlement to coverage or benefits.

INCONTESTABILITY
Any statement made by you will be considered a representation and not a warranty. No statements will be used to void coverage, reduce benefits, or deny a claim unless it is included in the enrollment form and/or evidence of insurability form for this certificate, which has been signed by you and a copy of such statement has been given to you or your beneficiary. No such statement will be used to contest this coverage after it has been in force for 2 years from its effective date.

No such statement will be used to contest any increased coverage after it has been in force for 2 years from its effective date.

SUICIDE EXCLUSION
If the insured or a rider insured commits suicide, while sane or insane, within 2 years after the effective date of coverage for that person, the death benefit is limited to the premiums paid for that person's coverage.

If there are any increases to the specified amount, a new 2-year suicide exclusion period applies to each increase starting on the date of increase. The death benefit for the new increase is the monthly deductions due to the increase during such period.

MISSTATEMENT OF AGE, SEX, OR TOBACCO USE STATUS
If the insured's age, sex, or tobacco use status is misstated and this misstatement impacts the rate calculation, the death benefit amount will be adjusted using the correct age, sex, or tobacco use status in accordance with any applicable Internal Revenue Code requirements. In the event this certificate would not have been issued using the correct age, this certificate is void and we will refund any premiums paid for this certificate. No adjustments to the fund value will be made as a result of the insured's age, sex, or tobacco use status being misstated.

NON-PARTICIPATING
This certificate does not share in surplus distribution.

GENERAL PROVISIONS (Continued)

BASIS OF CERTIFICATE VALUES
The basis for the minimum surrender values and guaranteed maximum cost of insurance rates is shown in the Certificate Specifications. All of the values are the same or more than the minimums set by the laws of the state where the policy is issued. If required, we have filed a detailed statement about this with the state insurance department. Reserves will always be at least as great as the minimum required by law.

ANNUAL REPORT
We will send you a report at least once a year without charge. It shows since the last report:
1. current fund value;
2. current certificate debt;
3. premiums paid;
4. expenses;
5. cost of insurance deducted for this certificate and any attached rider(s);
6. interest credited to the fund value;
7. partial surrenders (including service charges); and
8. current death benefit amount.

PROJECTION OF VALUES AND BENEFITS
At your written request, we will provide a report which shows projected future results. The report is based on assumptions in regard to:
1. the death benefits and planned periodic premium payments you specify; and
2. such other assumptions needed as specified by you or us.

A fee of up to $25.00 may be charged as determined by us. The report is based on assumptions, and is not a guarantee of results or performance.

COMPLIANCE WITH FEDERAL LAWS
We reserve the right to amend the policy and this certificate to comply with:
1. requirements of the Internal Revenue Code (IRC);
2. any regulations or rulings issued by the Internal Revenue Service (IRS); and
3. any other requirements imposed by the IRS.

We will give you a copy of any such amendment(s).

The policy and this certificate are intended to qualify as life insurance under the IRC. Accordingly, the provisions of the policy and this certificate are to be interpreted, and will be administered by us, to ensure tax qualification.

RECEIPT OF PREMIUMS
You will be given credit for premiums under this certificate and any attached rider(s) at the time the premiums are actually received by us or our authorized agent. The policyholder and financial institutions (such as banks and credit unions) who send the premiums to us directly at the employee's or member's request are not our agents, and premiums paid by those parties are not credited until actually received by us.

COOPERATION OF BENEFICIARY
The beneficiary must reasonably cooperate during any investigation and/or adjudication of a claim. This includes the authorization for the release of medical records and other information.

GENERAL PROVISIONS (Continued)

APPEALS PROCEDURE
You, or your beneficiary, have the right to appeal any denial of benefits under this certificate, or any attached rider(s), up to two times. A written request for review must be submitted to us at 1776 American Heritage Life Drive, Jacksonville, Florida 32224-6687 within 60 days of the denial of benefits.

LEGAL ACTION
Prior to filing any legal action for benefits under this certificate or any attached rider(s), you or your beneficiary must appeal the denial of such benefit.

The time limit on legal actions for loss covered by this certificate is subject to applicable law in the state where the policy was issued.

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CONTINUATION OF COVERAGE

If your coverage ends pursuant to items 5, 6, 7 or 8 of the Termination of Coverage provision, you may elect to continue your coverage, including any rider(s) attached to this certificate, by paying the premiums directly to us at our Home Office. We will bill you for these premiums. If you stop paying premiums under this option, your coverage may enter its certificate grace period.

Continuation of Coverage and Conversion are mutually exclusive. You may not elect both Continuation of Coverage and Conversion.

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CONVERSION

While this coverage is in force, you may convert all or part of this life insurance to an individual non-term life insurance policy without submitting evidence of insurability, subject to the terms below, by applying for an individual policy and paying the first premium within 31 days after the earliest date one of the following events occurs:

1. the insured ceases to be in an eligible class or is in a class for which coverage under the policy ends; or
2. the policy terminates.

The conversion amount is limited by the minimums and maximums of the individual product we offer at the time of conversion.

The new policy will be an individual non-term life insurance policy then being offered by us or another insurance company chosen by us for conversions from this certificate. The mortality and interest basis for the new policy may be different than for this certificate. Any rider(s) attached to the certificate will terminate upon conversion. The new policy will not include any additional benefits or riders unless agreed to by us.

You will be given written notice of the right to convert coverage within 15 days of the date coverage ends. The right to convert will expire on the later of 16 days after you are given such notice or the end of the conversion period, but in no event will the right to convert extend beyond 60 days after the expiration of the conversion period. Written notice will be given to you, which will constitute notice of the right to convert.

If the insured dies within the 31 day conversion period, and before the individual policy would become effective, the amount of insurance which you would have been entitled to have issued under the individual policy will be payable as a claim under the group policy, whether or not application for the individual policy or payment of the first premium has been made.

Conversion and Continuation of Coverage are mutually exclusive. You may not elect both Continuation of Coverage and Conversion.

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AMERICAN HERITAGE LIFE INSURANCE COMPANY

EXTENSION OF BENEFITS RIDER

This rider is issued in consideration of the enrollment form for this rider and payment of the first premium. Benefits are subject to all of the terms, conditions and provisions of this rider and the certificate. All terms defined in the certificate and used in this rider apply to this rider, unless otherwise defined in this rider.

This rider extends the benefits provided by the certificate and Accelerated Death Benefit for Long Term Care Rider by increasing the certificate's specified amount, subject to the terms and conditions defined herein.

DEFINITIONS

Certificate. The certificate to which this rider is attached.

Death Benefit Amount Increase. The death benefit amount of the certificate on the monthly date immediately following the date the insured first becomes eligible for long term care benefits times the confinement percentage shown on the certificate specifications page.

INCREASE IN DEATH BENEFIT AMOUNT

We will increase the death benefit amount of the certificate by the death benefit amount increase subject to our determination that all the following terms and conditions have been satisfied:

1. this rider remains in force; and
2. we have received proof satisfactory to us that the insured is alive and continues to meet all conditions of the Accelerated Death Benefit for Long Term Care Rider under the Eligibility for the Payment of Benefits provision; and
3. the remaining death benefit available for the Long Term Care Benefit Rider has been exhausted; and
4. the certificate will not be eligible for any additional death benefit amount increase until the previous death benefit amount increase has been paid under the terms of this Extension of Benefits Rider; and
5. the cumulative death benefit amount increases under this rider will not exceed the death benefit amount of the certificate, determined as of the monthly date immediately following the date the insured first became eligible for payment of long term care benefits.

The effective date of each death benefit amount increase will be the monthly date preceding the monthly date that the entire death benefit amount of the certificate was paid.

PREMIUMS

The annual premium for this rider is shown on the certificate specifications page. The monthly cost of insurance for this rider is deducted from the certificate's fund value on each monthly date and is based on the certificate's specified amount on each monthly date.

TERMINATION

This rider terminates and is no longer in force on the earliest of:

1. the date the certificate terminates; or
2. the date the entire death benefit amount of the certificate minus any death benefit advance and certificate debt has been paid under the Accelerated Death Benefit for Long Term Care Rider and the insured no longer continues to meet all conditions of the Accelerated Death Benefit for Long Term Care Rider under the Eligibility for the Payment of Benefits provision; or
3. the date the cumulative death benefit amount increases have been increased up to the total amount allowed under this rider; or
4. by written request of the certificateholder; or
5. the date the Accelerated Death Benefit for Long Term Care Rider terminates.

GENERAL

This rider is a part of the certificate to which it is attached. This rider has no cash or loan value. It does not affect any net single premium referred to in the certificate.

Signed for American Heritage Life Insurance Company at its Home Office in Jacksonville, Florida.

Secretary

President

Home Office
American Heritage Life Insurance Company
1776 American Heritage Life Drive
Jacksonville, Florida 32224

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AMERICAN HERITAGE LIFE INSURANCE COMPANY

CHILDREN'S TERM RIDER

This rider is issued in consideration of the rider premium and the enrollment form for this rider. Benefits are paid in addition to the life insurance benefits of the certificate. Benefits are subject to the provisions of this rider and the certificate. All terms defined in the certificate and used in this rider apply to this rider, unless otherwise defined in this rider.

DEFINITIONS

Age. Issue age is each insured child's age on his or her last birthday as of the rider date. Attained age is each insured child's age on his or her last birthday as of the most recent rider anniversary (or the rider date if this rider has been in force less than one year).

Conversion Date. The next monthly date after we receive a request for conversion.

Insured Child. An insured child under this rider is any natural child or legally adopted child of the insured who is unmarried and financially dependent on the certificate insured for support and is:

1. more than 24 hours and less than 25 years of age on the rider date; or
2. born after the date of enrollment for this rider, is more than 24 hours and less than 25 years of age, and the certificate insured is named as parent on the child's birth certificate; or
3. legally adopted by the certificate insured after the rider date for this rider and is more than 24 hours and less than 25 years of age.

Certificate. The certificate to which this rider is attached.

Certificate Insured. The person named as the insured in the certificate.

Rider Beneficiary. Any person and/or entity named in our records to receive the death benefit of this rider when an insured child dies.

Rider Date. The effective date of this rider. The rider date is the certificate date, unless this rider is applied for at a later date. If this rider is applied for at a later date, the rider date is the effective date assigned by our Home Office in accordance with our dating rules in effect at the time this rider is issued.

DEATH BENEFIT ON INSURED CHILDREN

We pay the benefit amount shown for this rider on the certificate specification page(s) of the certificate to the rider beneficiary after we receive written proof that the death of an insured child occurred:

1. while this rider and the certificate are in force; and
2. before the insured child's 25th birthday.

SUICIDE

Insured Child. If an insured child dies by suicide, whether sane or insane, within 2 years from the date he or she is insured, our liability for that insured child is limited to a return of all premiums paid for this rider.

Certificate Insured. In the event of suicide of the certificate insured within 2 years from the date of the enrollment for this rider, coverage for any insured children may be converted as explained in the Conversion Option for Insured Child provision of this rider.

PREMIUMS

The annual premium for this rider is shown on the certificate specification page(s) of the certificate. The monthly cost of insurance for this rider is deducted from the certificate's fund value on each monthly date.

REINSTATEMENT

This rider may be reinstated upon reinstatement of the certificate if satisfactory evidence of insurability is furnished to us with respect to each insured child and for each insured within 15 days of the reinstatement of the certificate. The death of an insured child before the date of the reinstatement or evidence of insurability unsatisfactory to us with respect to an insured child shall not preclude the reinstatement of the certificate and this rider on the lives of those for whom the evidence of insurability is satisfactory to us.

MISSTATEMENT OF AGE

If the age of any insured child is misstated, any benefit payable with respect to such insured child is determined by the correct age.

CONVERSION OPTION FOR INSURED CHILD

We provide a conversion option to an individual policy for each insured child when that insured child's coverage ends:

1. at his or her 25th birthday. We must receive a written request for this conversion option within 30 days of the insured child's 25th birthday and while this rider is in force; or
2. due to the certificate insured reaching age 70. We must receive a written request for this conversion option within 30 days of the certificate insured's attained age 70; or
3. due to the death of the certificate insured, including death by suicide. We must receive a written request for this conversion option within 30 days of the certificate insured's death.

Upon receipt of such request, we will send a questionnaire to determine the tobacco use status of the insured child. Other than this requirement, no additional evidence of insurability is required. The new policy will have a standard premium class.

The insured child may select the plan and amount of insurance for the new policy. The plan may be any other non-term life policy currently being offered:

1. at the insured child's attained age; and
2. for the amount of insurance selected; and
3. for an amount of insurance not more than 5 times the death benefit of this rider; and
4. for an amount of insurance not less than the minimum benefit amount available for that plan on the conversion date.

Premiums for the new policy are:

1. at the rate in effect for the insured child's attained age and premium class on the conversion date; and
2. subject to our rules on frequency of premium payments in effect on the conversion date.

Coverage under this rider ends for that insured child when coverage under the new policy begins.

The new policy will not include any additional benefits or riders unless agreed to by us.

RIDER BENEFICIARY

If not otherwise named in the enrollment form for this rider, the certificateholder is the rider beneficiary.

The certificateholder may change the rider beneficiary by a written request to us:

1. while the insured child is alive; and
2. if the prior designation does not prohibit such a change.

A change revokes any prior designation.

If not provided otherwise:

1. The interest of any named rider beneficiary who dies before the insured child, passes to the remaining named rider beneficiaries in equal shares, if any.
2. If no named rider beneficiary survives the insured child, the death benefit of the rider is paid to the certificateholder, if living, otherwise to the certificateholder's estate.

INCONTESTABILITY

We cannot contest payment of this rider once this rider has been in force while each insured child is alive for 2 years from the rider date except for:

1. nonpayment of premiums; and
2. the coverage on any insured child who is added subsequent to the rider date. This 2 year period begins on the date he or she becomes an insured child.

TERMINATION

Coverage for each insured child automatically terminates on the earlier of his or her 25th birthday or the date this rider terminates.

This rider terminates and is no longer in force on the earliest of:

1. the death of the certificate insured (see Conversion Option for Insured Child); or
2. the date any premium for this rider or the certificate remains unpaid, subject to the Grace Period provision of the certificate; or
3. the date the certificate insured turns age 70; or
4. the date the certificate matures, expires, or otherwise terminates; or
5. the monthly date on or next following the date we receive your written request to terminate.

GENERAL

This rider is a part of the certificate to which it is attached. This rider has no cash or loan value. It does not affect any net single premium referred to in the certificate.

If an insured child dies during the grace period, we deduct the unpaid premium from the benefit to be paid.

Signed for American Heritage Life Insurance Company at its Home Office in Jacksonville, Florida.

Secretary

President

Home Office
American Heritage Life Insurance Company
1776 American Heritage Life Drive
Jacksonville, Florida 32224

AMERICAN HERITAGE LIFE INSURANCE COMPANY

OTHER INSURED PERSON LEVEL TERM RIDER

This rider is issued in consideration of the rider premium and the enrollment form for this rider. Benefits are paid in addition to the life insurance benefits of the certificate. Benefits are subject to the provisions of this rider and the certificate. All terms defined in the certificate and used in this rider apply to this rider, unless otherwise defined in this rider.

DEFINITIONS

Age. Issue age is the other insured person's age last birthday on the rider date. The other insured person's issue age is shown on the certificate specifications page. The other insured person's attained age will increase by one year on each certificate anniversary.

Conversion Date. The next monthly date after we receive a request for conversion.

Other Insured Person. A person, other than the certificate insured, who is listed on the enrollment form for this rider as the person to be insured under this rider.

Certificate. The certificate to which this rider is attached.

Certificate Insured. The person named as the insured in the certificate.

Rider Anniversary. The same day and month each year as the rider date for each succeeding year this rider remains in force.

Rider Beneficiary. Any person and/or entity named in our records to receive the death benefit of this rider when the other insured person dies.

Rider Date. The effective date of this rider. The rider date is the certificate date, unless this rider is applied for at a later date. If this rider is applied for at a later date, the rider date is the effective date assigned by our Home Office in accordance with our dating rules in effect at the time this rider is issued.

DEATH BENEFIT ON OTHER INSURED PERSON

We will pay the death benefit for this rider to the rider beneficiary after we receive written proof that the death of the other insured person occurred while this rider and the certificate are in force.

This rider's death benefit is the amount shown for this rider on the certificate specification page(s) of the certificate.

Term insurance provided by this rider may not be used by any rider that provides for the acceleration of the certificate's death benefit.

CONVERSION OPTION

We provide a conversion option to an individual policy for this rider. We must receive a written request for conversion:

1. while this rider is in force; or
2. within 30 days after it terminates, if it terminates due to the death of the certificate insured.

The conversion option may be requested by either:

1. the certificateholder; or
2. the other insured person if:
   a. the certificate insured died within 30 days of the request; and
   b. the certificate insured was also the certificateholder at the time of death.

The conversion policy may be any non-term life policy currently being offered:

1. at the other insured person's age on his or her last birthday as of the conversion date; and
2. up to the death benefit amount in force for this rider on the conversion date (or the amount in force on the date of termination if conversion is due to the death of the certificate insured).

Premiums for the conversion policy will be:

1. at the rate in effect on the conversion date for the other insured person's premium class and age on his or her last birthday as of the conversion date; and
2. subject to our rules on frequency of premium payments in effect on the conversion date.

The other insured person cannot be insured under this rider and the conversion policy at the same time. The conversion policy will not include any additional benefits or riders, unless agreed to by us.

COST OF INSURANCE

The current annual premium for this rider is shown on the certificate specification page(s) of the certificate. The cost of insurance rate is based on the other insured person's attained age and premium class. The monthly cost of insurance for this rider equals:

1. this rider's death benefit;
2. divided by 1,000;
3. and then multiplied by the monthly cost of insurance rate per $1,000 for this rider.

The monthly cost of insurance rates per $1,000 of death benefit are shown in the tables in this rider. The monthly cost of insurance for this rider is deducted from the certificate's fund value on each monthly date.

SUICIDE EXCLUSION

Other Insured Person. We do not provide any benefits under this rider if the other insured person dies by suicide, while sane or insane, within 2 years from the rider date. Our liability is limited to a return of all cost of insurance charges deducted for this rider.

Certificate Insured. In the event of suicide of the certificate insured, coverage for the other insured person may be continued as explained in the conversion option provision of this rider.

MISSTATEMENT OF AGE, SEX OR TOBACCO USE STATUS

If the other insured person's age, sex or tobacco use status is misstated, this rider's death benefit will be adjusted at the time of the other insured person's death.

The adjusted death benefit equals:

1. the unadjusted death benefit, multiplied by this rider's cost of insurance rate which applies during the certificate month of the other insured person's death using the misstated age, sex or tobacco use status; divided by
2. this rider's cost of insurance rate which applies during the certificate month of the other insured person's death using the correct age, sex or tobacco use status. If there is no rider cost of insurance rate which applies during the certificate month of the other insured person's death using the correct age, sex or tobacco use status, we will extrapolate such a rate for the purpose of adjusting the death benefit.

No adjustments to the certificate fund value will be made as a result of the other insured person's age, sex or tobacco use status being misstated.

RIDER BENEFICIARY

If not otherwise named in the application for this rider, the rider beneficiary is the certificateholder.

The certificateholder may change the rider beneficiary by a written request to us:

1. while the other insured person is alive; and
2. if the prior designation does not prohibit such a change.

A change revokes any prior designation.

If not provided otherwise:

1. The interest of any named rider beneficiary who dies before the other insured person, passes to the remaining named rider beneficiaries in equal shares, if any.
2. If no named rider beneficiary survives the other insured person, the death benefit of the rider is paid to the certificateholder, if living, otherwise to the certificateholder's estate.

TERMINATION

This rider terminates and is no longer in force on the earliest of:

1. the date of the death of the certificate insured (see conversion option); or
2. the date any premium for this rider or the certificate remains unpaid, subject to the grace period provision of the certificate; or
3. the conversion date; or
4. the rider anniversary on or next following the other insured person's 65th birthday; or
5. the date the certificate matures, expires, is surrendered or otherwise terminates; or
6. the monthly date on or next following the date we receive your written request to terminate.

GENERAL

This rider is a part of the certificate to which it is attached. This rider has no cash or loan value. It does not affect any net single premium referred to in the certificate. If the other insured person dies during the grace period, we will deduct the unpaid cost of insurance from the benefit to be paid.

INCONTESTABILITY

We cannot contest payment of this rider benefit once this rider has been in force while the other insured person is alive for 2 years from the rider date, except for nonpayment of premiums.

TABLE OF MONTHLY COST OF INSURANCE RATES
TOBACCO USER RATES

Attained Age	Rate Per $1,000	Attained Age	Rate Per $1,000	Attained Age	Rate Per $1,000
0	0.2050	24	0.1650	48	0.6600
1	0.0825	25	0.1625	49	0.7150
2	0.0775	26	0.1600	50	0.7775
3	0.0775	27	0.1600	51	0.8475
4	0.0725	28	0.1600	52	0.9275
5	0.0700	29	0.1625	53	1.0150
6	0.0675	30	0.1675	54	1.1125
7	0.0625	31	0.1725	55	1.2150
8	0.0600	32	0.1800	56	1.3225
9	0.0600	33	0.1900	57	1.4350
10	0.0600	34	0.2000	58	1.5525
11	0.0650	35	0.2150	59	1.6775
12	0.0725	36	0.2300	60	1.8175
13	0.0825	37	0.2500	61	1.9750
14	0.0950	38	0.2725	62	2.1575
15	0.1075	39	0.2975	63	2.3625
16	0.1200	40	0.3275	64	2.5850
17	0.1300	41	0.3600	65	2.8200
18	0.1375	42	0.3950	66	3.0650
19	0.1700	43	0.4325	67	3.3150
20	0.1725	44	0.4725	68	3.5750
21	0.1725	45	0.5150	69	3.8550
22	0.1725	46	0.5600	70	4.1650
23	0.1700	47	0.6075		

TABLE OF MONTHLY COST OF INSURANCE RATES
NON-TOBACCO USER RATES

Attained Age	Rate Per $1,000	Attained Age	Rate Per $1,000	Attained Age	Rate Per $1,000
0	0.2050	24	0.1200	48	0.3525
1	0.0825	25	0.1175	49	0.3800
2	0.0775	26	0.1150	50	0.4125
3	0.0775	27	0.1150	51	0.4500
4	0.0725	28	0.1150	52	0.4925
5	0.0700	29	0.1150	53	0.5400
6	0.0675	30	0.1175	54	0.5950
7	0.0625	31	0.1200	55	0.6525
8	0.0600	32	0.1225	56	0.7150
9	0.0600	33	0.1275	57	0.7825
10	0.0600	34	0.1325	58	0.8575
11	0.0650	35	0.1400	59	0.9375
12	0.0725	36	0.1475	60	1.0300
13	0.0825	37	0.1575	61	1.1350
14	0.0950	38	0.1675	62	1.2550
15	0.1075	39	0.1800	63	1.3925
16	0.1200	40	0.1925	64	1.5475
17	0.1300	41	0.2075	65	1.7150
18	0.1375	42	0.2250	66	1.8950
19	0.1275	43	0.2400	67	2.0850
20	0.1275	44	0.2600	68	2.2925
21	0.1275	45	0.2800	69	2.5200
22	0.1250	46	0.3025	70	2.7975
23	0.1225	47	0.3275		

Signed for American Heritage Life Insurance Company at its Home Office in Jacksonville, Florida.

Secretary

President

Home Office
American Heritage Life Insurance Company
1776 American Heritage Life Drive
Jacksonville, Florida 32224-6687

AMERICAN HERITAGE LIFE INSURANCE COMPANY

ACCELERATED DEATH BENEFIT FOR TERMINAL ILLNESS RIDER

Provides for the Advance of a Portion of the Death Benefit due to Terminal Illness
The benefit you receive under this rider may be taxable.
Consult with your personal tax advisor.

This rider is issued in consideration of the enrollment form for this rider. Benefits are subject to the provisions of this rider and the certificate. All terms defined in the certificate and used in this rider apply to this rider, unless otherwise defined in this rider.

DEFINITIONS

Current Discount Rate. The greater of the 90 day Treasury Bill or Moody's Corporate Bond Yield Average-Monthly Average.

Death Benefit Advance. The advance, during the insured's lifetime, of a portion of the death benefit amount.

Certificate. The certificate to which this rider is attached.

Rider Date. The effective date of this rider. The rider date is the certificate date, unless this rider is applied for at a later date. If this rider is applied for at a later date, the rider date is the effective date assigned by our Home Office in accordance with our dating rules in effect at the time this rider is issued.

Terminal Illness. An illness or physical condition:

1. expected to result in the insured's death within 12 months; and
2. for which there is no reasonable prospect for recovery.

PAYMENT OF BENEFITS

If the insured incurs a terminal illness while coverage under this rider is in effect, you may request a death benefit advance. We agree to pay to you the death benefit advance amount upon our receipt of all of the following:

1. your written election of the death benefit advance; and
2. the written consent of any irrevocable beneficiary or any assignee, that you may elect the death benefit advance; and
3. a written opinion of the insured's physician that states the diagnosis of the insured's medical condition and that such medical condition is a terminal illness as defined in this rider.

If death benefit option 2 is in effect, we will change it to death benefit option 1 prior to making the death benefit advance.

The death benefit advance can only be elected once, per certificate, subject to the limits outlined in the calculation of payment provision.

Your election of the death benefit advance is automatically voided and no benefit is payable under this rider if the insured dies after the above requirements are met and before we have paid the benefit.

Any amount later payable under the certificate as a death benefit is reduced by the amount of the death benefit advance before reductions for pro-rata loans and the current discount.

Any amount later payable under the certificate from the fund value or as a surrender, or available for certificate loan, is reduced by the same proportion as the death benefit amount.

Calculation of Payment. The amount available for death benefit advance is 75% of the death benefit amount for the certificate (excluding any term riders and accidental death benefit rider) on the insured's life subject to a maximum of $100,000.

The death benefit advance amount payable to you is reduced:

1. first by any pro-rata loan; then
2. the remaining sum is discounted at the current discount rate.

The death benefit advance and any remaining death benefit amount for the certificate will be determined at the time the claim is made.

If you elect this benefit on more than one certificate that the insured has with us, we retain the right to utilize the death benefit of one certificate completely prior to using another certificate.

Waiver of Monthly Deductions Benefit. We waive monthly deductions for the certificate and any riders attached to the certificate if the death benefit advance is paid. This waiver of monthly deductions benefit is in addition to any other premium waiver benefit provided by the certificate or a rider attached to the certificate.

Waiver of monthly deductions will:

1. begin on the monthly date on or next following the date you provide us with satisfactory evidence of terminal illness as defined in this rider; and
2. continue until the certificate terminates.

CLAIMS

Notice of Claim. Written notice of claim must be given to us within 20 days after the occurrence or commencement of any loss covered by this rider, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to us at our Home Office, or to any authorized agent of ours, with information sufficient to identify the insured, shall be deemed notice to us.

Claim Forms. We, upon receipt of a notice of claim, will furnish to the certificate holder forms for filing proof of loss. If such forms are not furnished within 15 days after the giving of such notice, the certificate holder shall be deemed to have complied with the requirements of this rider as to proof of loss upon submitting, within the time frame fixed in the rider for filing proof of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

Proof of Loss. Written proof of loss must be furnished to us at our Home Office within 90 days after the date of such loss. Failure to furnish such proof within the time frame required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the insured, later than 1 year from the time proof is otherwise required.

TERMINATION

This rider terminates and is no longer in force on the earliest of:

1. the monthly date on or next following the date we receive a written termination request by the owner; or
2. the date the insured attains age 93; or
3. the date the certificate matures, expires, is surrendered or otherwise terminates.

GENERAL

This rider is a part of the certificate to which it is attached. This rider has no cash or loan value. It does not affect any net single premium that may be referred to in the certificate.

Signed for American Heritage Life Insurance Company at its Home Office in Jacksonville, Florida.

Secretary

President

Home Office
American Heritage Life Insurance Company
1776 American Heritage Life Drive
Jacksonville, Florida 32224

AMERICAN HERITAGE LIFE INSURANCE COMPANY

1776 American Heritage Life Drive, Jacksonville, Florida 32224-6687

ACCELERATED DEATH BENEFIT FOR LONG TERM CARE RIDER

TAX QUALIFICATION NOTICE: This rider is intended to provide a qualified accelerated death benefit that is excluded from gross income for federal income tax purposes under the applicable provisions of the Internal Revenue Code in existence at the time this rider is issued. To that end, the provisions of this rider and the certificate are to be interpreted to ensure or maintain such tax qualification, notwithstanding any other provision to the contrary. We reserve the right to amend this rider or the certificate to reflect any clarifications that may be needed or are appropriate to maintain such tax qualification or to conform this rider or the certificate to any applicable changes in such tax qualification requirements. We will send you a copy of any such amendment. If you refuse such an amendment, it must be by giving us written notice, and your refusal may result in adverse tax consequences. Whether any tax liability may be incurred when benefits are paid under this rider could depend on whether you are also the insured and how the Internal Revenue Service interprets applicable provisions of the Internal Revenue Code. As with any tax matter, you and any other recipient of this benefit should each consult your own tax advisor to evaluate any tax impact of this benefit.

Receipt of an accelerated death benefit MAY AFFECT MEDICAID and SUPPLEMENTAL SECURITY INCOME ("SSI") eligibility. Without exercising this option, the mere fact that this Accelerated Death Benefit for Long Term Care Rider is part of the certificate will not in and of itself affect the eligibility for these government programs. However, exercising this option before you apply for these programs, or when you are receiving government benefits, may affect your continued eligibility. Contact the Medicaid Unit of the local Department of Public Welfare and Social Security Administration Office for more information.

CAUTION: The issuance of this rider is based on your responses to the questions on your enrollment form and/or evidence of insurability form. A copy of your enrollment form and/or evidence of insurability form is attached. If your answers are incorrect or untrue, then we have the right to deny benefits or to rescind your coverage under this rider. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect or untrue, please contact us at the address shown above.

NOTICE TO BUYER: This rider may not cover all of the costs associated with long term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all limitations of this rider as well as those of the certificate to which it is attached.

This rider is issued in consideration of the rider premium and the written request for this rider. This rider is a part of the certificate and is effective as of the rider effective date. Every definition, term, condition, and provision of the certificate applies to this rider, unless otherwise defined or provided in this rider.

This rider does not have a cash value or loan value. It does not affect any net single premium referred to in the certificate.

RIGHT TO EXAMINE COVERAGE

If for any reason you are not satisfied with this rider, return it to us or to our agent. If this rider is returned within 31 days after you receive it, we will refund all premiums paid for this rider and coverage under this rider will be void. If you return this rider, please note on it in writing: This rider is returned for rescission and refund of premium.

DEFINITIONS

Activities of daily living (ADLs) mean activities used to measure the insured's impairment due to being chronically ill. ADLs are any of the following:

1. Bathing – washing oneself by sponge bath; or in either a tub or shower, including the act of getting into and out of the tub or shower, with or without the aid of equipment.
2. Continence – the ability to maintain control of bowel and bladder function; or when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag), with or without the aid of equipment.
3. Dressing – putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.
4. Eating – feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.
5. Toileting – getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
6. Transferring – the ability to move into or out of a bed, chair or wheelchair.

DEFINITIONS (Continued)

Adult day care means a program for 6 or more individuals, of social and health-related services provided during the day in a community group setting for the purpose of supporting persons who are chronically ill and can benefit from care in a group setting outside the home.

Adult day care center means a facility or part of a facility that provides adult day care and is appropriately licensed or certified to provide such services (if required by the jurisdiction in which it is operating).

Assisted living facility means a facility that is primarily engaged in providing ongoing care and related services to at least 10 inpatients in one location and meets all of the following criteria:

1. it is licensed by the appropriate licensing agency, if the state in which it operates licenses such facilities;
2. it provides 24 hour a day care and services sufficient to support needs resulting from being chronically ill;
3. it has a trained and ready to respond employee on duty at all times to provide care;
4. it provides 3 meals a day and accommodates special dietary needs;
5. it has formal arrangements for the services of a physician or nurse to furnish medical care in case of an emergency; and
6. it has appropriate methods and procedures for handling and administering drugs and biologicals.

Certificate means the certificate to which this rider is attached.

Chronically ill means the insured has been certified by a licensed health care practitioner within the preceding 12 month period as:

1. being unable to perform, without substantial assistance from another individual, at least 2 ADLs for a period of at least 90 days due to a loss of functional capacity; or
2. requiring substantial supervision to protect oneself from threats to health and safety due to cognitive impairment.

Cognitive impairment means a deficiency in the insured's:

1. short or long term memory;
2. orientation as to person, place and time;
3. deductive or abstract reasoning; or
4. judgment as it relates to safety awareness.

This deficiency must be to such a degree as to require substantial supervision to maintain the safety of the insured or others. A diagnosis of cognitive impairment must be confirmed by clinical evidence and testing that reliably measures impairment.

Confined or **confinement** means admitted as an inpatient in an assisted living facility or nursing care facility for which a room and board charge is made by the facility. It does not include confinement for an observation room or a fractional part of a day.

Day means a 24-hour period which begins and ends at 12:01 a.m.

Death benefit amount means the death benefit amount of the certificate. This does not include the death benefit for any riders that may be attached to the certificate.

Elimination period means the number of days at the beginning of a period of care for which benefits are not payable under this rider. The number of days in the elimination period for this rider is 90. In order for a day to count as a day in the elimination period, the following requirements must be met:

1. the insured must be chronically ill; and
2. charges must be incurred for the qualified long term care services of the insured.

Home means:

1. the insured's private residence;
2. a residential care facility;
3. a rest home;
4. a boarding home;
5. a home for the aged;
6. a community living center; or
7. a place that provides domiciliary or retirement care.

A home does not include a nursing care facility, a hospital, or a hospice care facility.

DEFINITIONS (Continued)

Home health care means medical and non-medical services provided in the insured's home by a home health care practitioner in accordance with a plan of care.

Home health care does not include the following:
1. cooking, which means preparation of meals and nutrition;
2. shopping, which includes but is not limited to purchasing groceries, household supplies and medicine;
3. assistance with the use of the telephone, laundering clothes, correspondence, bill paying, and other housekeeping tasks;
4. any type of construction, renovation or maintenance (such as painting, etc.), lawn care, snow removal, maintenance of a vehicle and any other service performed outside of the home; or
5. any other services similar to those described above.

Home health care agency means an agency or organization which:
1. specializes in giving nursing care or therapeutic services in the home;
2. is licensed to provide such care or services by the appropriate state licensing agency or authority where the service is performed or is Medicare certified as a home health care agency;
3. maintains a complete medical record and plan of care for each patient; and
4. is operating within the scope of its license or certification.

Home health care practitioner means an individual who is qualified to provide home health care, including the following:
1. a home health aide;
2. certified nurse assistant;
3. medical social worker;
4. occupational therapist;
5. speech therapist;
6. physical therapist;
7. total parenteral nutrition specialist;
8. enterostomal specialist;
9. chemotherapy specialist;
10. licensed visiting nurse;
11. licensed vocational nurse (L.V.N.);
12. licensed practical nurse (L.P.N.); or
13. a licensed graduate nurse (R.N.).

A practitioner whose specialty is not listed above may be used if the practitioner meets the requirements below.

A home health care practitioner must:
1. be licensed in the state or recognized as such by the state in which the care is given;
2. be employed or contracted by a home health care agency; and
3. charge for the care given which the insured is legally responsible to pay.

A home health care practitioner must not:
1. be a family member by blood, marriage, or adoption; or
2. reside at the insured's address.

Inpatient means an insured who is a resident patient using the room and board facilities of an assisted living facility or nursing care facility.

Licensed health care practitioner means a physician or any registered professional nurse, licensed social worker, or other individual who meets such requirements as described by the Secretary of the Treasury. A licensed health care practitioner must not be a family member by blood, marriage, or adoption.

Maintenance or personal care services mean any care the primary purpose of which is to provide needed assistance with any of the disabilities as a result of the insured being chronically ill (including the protection from threats to health and safety due to severe cognitive impairment).

DEFINITIONS (Continued)

Monthly benefit period means the time period upon which benefit payments are based.

The first monthly benefit period during a period of care begins the day after the elimination period is satisfied and ends on the day before the next monthly date. Each subsequent monthly benefit period begins on the monthly date after the last monthly benefit period ended and ends on the day before the next monthly date. Each day in a period of care after the elimination period is satisfied applies to one monthly benefit period only.

Nursing care facility means a facility that meets all of the following standards:
1. it is licensed by the state in which it is located;
2. it is a separate facility or a distinct part of another facility physically separated from the rest of such facility;
3. it provides confined nursing care to individuals who are not able to care for themselves and who require nursing care;
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 a licensed graduate nurse (R.N.), or licensed practical nurse (L.P.N.); and
5. it is not, other than incidentally, 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.

Period of care means the period that begins on the first day the insured incurs a charge for qualified long term care services covered under this rider. It ends when, for a period of 180 consecutive days, the insured has not:
1. received qualified long term care services covered under this rider; or
2. been chronically ill.

Plan of care means a written individualized plan of care or services prepared by a licensed health care practitioner that specifies:
1. the type and frequency of all care or services required;
2. the care or service provider; and
3. the cost of care or services.

Pre-existing condition means a condition for which:
1. symptoms existed within 6 months before the rider effective date; or
2. medical advice or treatment was recommended by or received from a physician or other member of the medical profession within 6 months before the rider effective date.

Qualified confined care services mean necessary diagnostic, preventive, therapeutic, curing, treating, mitigating and rehabilitative services, and maintenance or personal care services which are required by a chronically ill individual and are provided by, and pursuant to a plan of care prescribed by, a licensed health care practitioner in an assisted living facility or nursing care facility.

Qualified long term care services mean qualified confined care services and qualified non-confined care services.

Qualified non-confined care services mean necessary diagnostic, preventive, therapeutic, curing, treating, mitigating and rehabilitative services, and maintenance or personal care services which are required by a chronically ill individual and are provided by a home health care practitioner, and pursuant to a plan of care prescribed by a licensed health care practitioner, by means of home health care or adult day care.

Rider effective date means the effective date of coverage under this rider. The rider effective date is the certificate date, unless this rider is applied for at a later day. If this rider is applied for at a later date, the rider effective date is the effective date assigned by our Home Office in accordance with our dating rules in effect at the time this rider is issued.

ELIGIBILITY FOR THE PAYMENT OF BENEFITS

Eligibility for benefits under this rider is satisfied when all of the following conditions are met:

1. the insured is chronically ill;
2. the certificate and rider are in force;
3. the insured has satisfied the elimination period;
4. the insured has used qualified long term care services and been chronically ill during the last 180 consecutive days;
5. the death benefit amount has not been totally accelerated;
6. the insured:
   a. is confined in a nursing care or assisted living facility and the confinement begins while this rider is in force;
   b. receives home health care services provided by a home health care agency for a minimum of 4 home health care visits during each monthly benefit period and while this rider is in force; or
   c. receives adult day care provided in an adult day care center for a minimum of 4 adult day care visits during each monthly benefit period and while this rider is in force;
7. the insured incurred charges for qualified long term care services which are included in the insured's plan of care; and
8. all irrevocable beneficiaries and assignees have signed the written request for this benefit.

If death benefit option 2 is in effect, we will change it to death benefit option 1 prior to paying the first monthly benefit under this rider.

We may periodically require certification that the insured is chronically ill, but not more than once every 90 days.

We will not simultaneously pay benefits under this rider for both qualified confined and non-confined services, even if the insured otherwise qualifies for both types of services during a monthly benefit period. In any given monthly benefit period that the insured qualifies for both qualified types of services, we will pay either the qualified confined or non-confined service, whichever is higher.

The accelerated death benefit is voluntary and is not intended to cause an involuntary reduction of the death benefit ultimately payable to the beneficiary. Therefore, the accelerated death benefit is not available if the insured is:

1. required by law to use this option to meet the claims of creditors, whether in bankruptcy or otherwise; or
2. required by a government agency to use this option in order to apply for, obtain, or keep a government benefit or entitlement.

PRE-EXISTING CONDITION LIMITATION

We do not pay benefits under this rider for a period of care that begins in the first 6 months after the rider effective date if a pre-existing condition causes the insured to be chronically ill. This limitation does not apply to a period of care that begins more than 6 months after the rider effective date that is caused by a pre-existing condition.

MONTHLY ACCELERATED DEATH BENEFIT FOR QUALIFIED CONFINEMENT

We will pay a monthly accelerated death benefit for each monthly benefit period or fraction thereof during which the insured is eligible for benefits. The monthly accelerated death benefit is the death benefit amount on the monthly date immediately following the date the insured first becomes eligible for benefits times the confined care percentage shown on the certificate specifications page for this rider, or the remaining death benefit if less.

If the insured is confined for only a fraction of a certificate month, we will pay a pro-rata benefit for each day of confinement.

We will require that a portion of any certificate debt be deducted from the monthly accelerated death benefit. The portion will equal the certificate debt multiplied by the ratio of the monthly accelerated death benefit to the death benefit amount prior to the monthly benefit payment.

Payment will be made not more than 30 days from the date we receive proof of loss.

MONTHLY ACCELERATED DEATH BENEFIT FOR QUALIFIED NON-CONFINED CARE

We will pay a monthly accelerated death benefit for each monthly benefit period or fraction thereof during which the insured is eligible for benefits. The monthly accelerated death benefit is the death benefit amount on the monthly date immediately following the date the insured first becomes eligible for benefits times the non-confined care percentage shown on the certificate specifications page for this rider, or the remaining death benefit if less.

If the insured receives qualified non-confined care services less than 4 times during a monthly benefit period, we will pay a pro-rata benefit for each day of the monthly benefit period that qualified non-confined care services were received.

We will require that a portion of any certificate debt be deducted from the monthly accelerated death benefit. The portion will equal the certificate debt multiplied by the ratio of the monthly accelerated death benefit to the death benefit amount prior to the monthly benefit payment.

Payment will be made not more than 30 days from the date we receive proof of loss.

EFFECT OF ACCELERATED DEATH BENEFIT PAYMENTS ON THE CERTIFICATE

At the end of each monthly benefit period for which a monthly accelerated death benefit is paid, the specified amount, fund value, surrender charge and any outstanding certificate debt will be reduced as explained below.

The specified amount will be reduced by the monthly accelerated death benefit amount. If the new specified amount is less than the minimum specified amount shown on the certificate specifications page, the minimum specified amount is amended to be the specified amount calculated according to this provision.

The fund value will be reduced by an amount equal to the reduction in specified amount multiplied by the ratio of the fund value to specified amount as of the monthly date immediately following the date the period of care begins.

The surrender charge will be reduced by an amount equal to the reduction in specified amount multiplied by the ratio of the surrender charge to specified amount as of the monthly date immediately following the date the period of care begins.

The portion of the certificate debt deducted from the monthly accelerated death benefit will reduce the certificate debt.

While the insured is eligible for monthly benefits under this rider the following conditions apply:
1. no changes may be made to the specified amount and death benefit option of the certificate;
2. no change may be made to existing riders nor may new riders be added; and
3. we will not accept any premium payments.

While the certificate is in force any accidental death benefit and level term rider will not be affected by the payment of monthly accelerated death benefits under this rider.

EFFECT ON CERTIFICATE AND RIDER(S) WHEN DEATH BENEFIT AMOUNT IS TOTALLY ACCELERATED

If the certificate's death benefit amount at the beginning of the period of care minus any advance payment of death benefits and certificate debt has been totally accelerated, then the certificate and any riders will terminate with no further benefits payable.

CONVERSION OPTION FOR OTHER RIDER(S)

If there is a rider attached to the certificate which:
1. provides term life insurance on the insured or an other insured;
2. terminates as a result of the Effect on Certificate and Rider(s) when Death Benefit Amount is Totally Accelerated provision; and
3. has a conversion option which could have been exercised on the date the rider terminates;

then the conversion option period is extended to 30 days after the date the rider terminates, except that this provision does not extend the conversion option into any time period where maximum age limitations make the conversion option inapplicable. The maximum death benefit which can be converted will be determined using the method described in the rider being converted, using the rider's death benefit on the date of termination.

DEATH BEFORE MONTHLY PAYMENT

If the insured dies before we pay an accelerated death benefit, we will void your request for that accelerated death benefit and pay the death benefit pursuant to the certificate.

ORDER IN WHICH REQUESTS ARE APPLIED

If you request payment of the accelerated death benefit under this rider and any other rider(s), we will pay the accelerated death benefit under each rider based on the order in which the requests are received.

EXCLUSIONS

We will not pay benefits under this rider for that portion of any day of qualified long term care services that are:

1. provided as a result of mental or emotional disorder (except for Alzheimer's Disease, or similar forms of senility or senile dementia that are of organic origin);
2. provided for alcoholism or drug addiction;
3. provided as a result of illness, treatment or medical conditions arising out of:
   a. war or act of war (whether declared or undeclared);
   b. participation in a felony, riot or insurrection;
   c. service in the armed forces or units auxiliary thereto; or
   d. suicide (while sane or insane), attempted suicide or intentionally self-inflicted injury;
4. provided in a government facility (unless otherwise required by law); services for which benefits are available under Medicare (or benefits would be available under Medicare except for the applicable deductibles or co-insurance requirements) or other governmental program (except Medicaid), any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law; or
5. received outside the United States or its territories.

PREMIUMS

The annual premium for this rider is shown on the certificate specifications page. The monthly cost of insurance for this rider is deducted from the certificate's fund value on each monthly date and is based on the certificate's specified amount on each monthly date.

WAIVER OF MONTHLY DEDUCTIONS

For each certificate month you receive monthly benefits under this rider, we will waive the monthly deductions for the certificate and all riders attached to the certificate.

REINSTATEMENT

This rider will be reinstated, upon lapse, if proof is provided that you were cognitively impaired or had a loss of functional capacity before the grace period contained in the certificate expired. This request, and submission of all past due premiums, must be made within 5 months after termination. Proof of cognitive impairment or loss of functional capacity will be on the same basis as the benefit eligibility criteria for cognitive impairment or loss of functional capacity as described in this rider.

INCONTESTABILITY

If this rider has been in force for a period of less than 6 months, we may rescind this rider or deny an otherwise valid claim upon a showing of misrepresentation that is material to the acceptance of coverage.

If this rider has been in force for a period of at least 6 months, but less than 2 years, we may rescind this rider or deny an otherwise valid claim upon a showing of misrepresentation that is both material to the acceptance of coverage and which pertains to the condition for which benefits are sought.

After this rider has been in force for a period of 2 years, it becomes incontestable upon the grounds of material misrepresentation alone. This rider may be contested only upon a showing that the insured knowingly and intentionally misrepresented material facts relating to the insured's health.

NOTICE OF CLAIM

Written notice of claim must be given to us within 20 days after the occurrence or commencement of any loss covered by this rider, or as soon thereafter as is reasonably possible. Notice given by or on behalf of you or the beneficiary to us at our home office, or to any authorized agent of ours, with information sufficient to identify the insured, will be deemed notice to us. Failure to give notice within such time will not invalidate or reduce any claim if it can be shown that notice was given as soon as reasonably possible.

CLAIM FORMS

We, upon receipt of a notice of claim, will furnish to you forms for filing proof of loss. If such forms are not furnished within 15 days after the giving of such notice, you will be deemed to have complied with the requirements of this rider as to proof of loss upon submitting, within the time frame fixed in this rider for filing proof of loss, written proof covering the occurrence, the character, and the extent of the loss for which claim is made.

PROOF OF LOSS

Written proof of loss must be furnished to us at our home office within 90 days after the date of such loss. Failure to furnish such proof within the time required will not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible. In no event, except in the absence of your legal capacity, will such proof be furnished later than 1 year from the time proof is otherwise required.

TIME OF PAYMENT OF CLAIM

Benefits payable under this rider will be paid within 60 days upon receiving proof of loss.

PHYSICAL EXAMINATIONS

We have the right and the opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim and to make an autopsy in case of death where it is not forbidden by law.

LEGAL ACTIONS

No legal action may be brought to recover on this rider prior to the expiration of 60 days after proof of loss has been filed in accordance with the requirements of this rider. No legal action may be brought after the expiration of 1 year from the time proof of loss is required to be filed.

APPEALS PROCESS

If you wish to file an appeal regarding a denial of claim, you must send a written request to us within 120 days of receiving our notification of denial. You may also submit new or additional information relating to the denial of claim with the appeal request. We will complete our review of your appeal within 30 days after receiving your appeal. If the denial of claim is upheld on appeal, you may request an independent review by sending a written request to us within 120 days of receiving our notification that the denial was upheld. The cost of the independent review will be borne by us. We will refer your request for an independent review to an independent review organization within 5 business days of reviewing your written request. The independent review organization will provide written notice of its decision within 30 days from its receipt of the referral.

EXTENSION OF TIME LIMITATIONS

If any limitation of this rider with respect to giving notice of claim, furnishing proof of loss, or bringing any action on this rider is less than that permitted by the law of the state, district, or territory in which the insured resides at the time this rider is issued, such limitation is extended to agree with the minimum period permitted by such law.

TERMINATION

This rider terminates and is no longer in force on the earliest of:

1. the date any monthly deduction for the certificate remains unpaid, subject to the grace period provision of the certificate;
2. the date the policy is terminated;
3. the date this rider is terminated under the policy;
4. the date we receive the policyholder's written request to terminate this rider;
5. the date the certificate terminates;
6. the date the certificate matures;
7. the date of the insured's death;
8. the next monthly date after we receive the certificate holder's written request to terminate this rider;
9. the date the certificate holder elects a non-forfeiture option;
10. the date the insured is no longer eligible for this rider; or
11. the date the monthly accelerated death benefit has been exhausted.

Coverage will not lapse or terminate due to nonpayment of premiums unless we, at least 30 days before the effective date of the lapse or termination, give notice to you and to those persons designated by you to receive the notice of lapse or termination. Notice must be given by first class United States mail, postage prepaid, and notice may not be given until 30 days after a premium is due and unpaid. Notice is considered to have been given as of 5 days after the date of mailing.

Termination will not prejudice the payment of an accelerated death benefit if the insured was chronically ill and receiving qualified long term care services while this rider was still in force.

Signed for AMERICAN HERITAGE LIFE INSURANCE COMPANY at its Home Office.

Secretary

President

AMERICAN HERITAGE LIFE INSURANCE COMPANY

ACCIDENTAL DEATH BENEFIT RIDER

This rider is issued in consideration of the rider premium and the enrollment form for this rider. Benefits are paid in addition to the life insurance benefits of the certificate. Benefits are subject to the provisions of this rider and the certificate. All terms defined in the certificate and used in this rider apply to this rider, unless otherwise defined in this rider.

DEFINITIONS

Accidental Death. Accidental death means death that:

1. resulted directly, and independently of all other causes, from accidental bodily injury; and
2. occurred within 180 days after the injury and occurred while the certificate and this rider were in force; and
3. is not excluded from coverage by the Limitations and Exclusions provision.

Certificate. The certificate to which this rider is attached.

Rider Date. The effective date of this rider. The rider date is the certificate date, unless this rider is applied for at a later date. If this rider is applied for at a later date, the rider date is the effective date assigned by our Home Office in accordance with our dating rules in effect at the time this rider is issued.

ACCIDENTAL DEATH BENEFIT

We agree to pay to the beneficiary the rider amount shown on the certificate specifications page for accidental death after we receive due proof of the insured's accidental death.

LIMITATIONS AND EXCLUSIONS

Risks Not Covered. The death benefit provided by this rider is not payable if the insured's death results, directly or indirectly, from any of the following causes or is contributed to, wholly or in part, by any of the following causes:

1. suicide, or any attempt at suicide, while sane or insane; or
2. bodily or mental infirmity or disease of any kind, even though the proximate or precipitating cause of death is accidental bodily injury; or
3. committing or attempting to commit an assault or felony; or
4. the intentional taking of:
   a. narcotics, unless prescribed by a physician and used in the manner prescribed; or
   b. alcohol; or
   c. any poison or inhaling of gas or fumes; or
5. operating, riding in or descending from any kind of aircraft if the insured:
   a. is a pilot, officer, or member of the crew; or
   b. is being flown for the purpose of descent from such aircraft while in flight; or
   c. is giving or receiving any kind of training or instruction; or
   d. has any duties aboard such aircraft; or
6. insurrection or war, or any act attributable to war, whether or not the insured is in military service. The term "war" includes declared or undeclared war or any conflict, involving the armed forces of any country or countries.

PREMIUMS

The annual premium for this rider is shown on the certificate specifications page. The monthly cost of insurance for this rider is deducted from the certificate's fund value on each monthly date.

TERMINATION

This rider terminates and is no longer in force on the earliest of:

1. the certificate anniversary on or next following the insured's 65th birthday; or
2. the date any premium for this rider or the certificate remains unpaid, subject to the grace period provision of the certificate; or
3. the date the insurance under the certificate matures, expires or otherwise terminates.

You may terminate this rider on any premium due date by written request.

GENERAL

This rider is a part of the certificate to which it is attached. This rider has no cash or loan value. It does not affect any net single premium referred to in the certificate.

INCONTESTABILITY

We cannot contest this rider after it has been in force while the insured is alive for 2 years from the rider date except for nonpayment of premiums.

Signed for American Heritage Life Insurance Company at its Home Office in Jacksonville, Florida.

Secretary

President

Home Office
American Heritage Life Insurance Company
1776 American Heritage Life Drive
Jacksonville, Florida 32224

AMERICAN HERITAGE LIFE INSURANCE COMPANY

TOTAL DISABILITY PAYOR WAIVER OF PREMIUM RIDER

This rider is issued in consideration of the rider premium and the enrollment form for this rider. Benefits are paid in addition to the life insurance benefits of the certificate. Benefits are subject to the provisions of this rider and the certificate. All terms defined in the certificate and used in this rider apply to this rider, unless otherwise defined in this rider.

DEFINITIONS

Certificate. The certificate to which this rider is attached.

Insured. The person whose life is insured under the certificate.

Payor. The payor is the employee/member on whose total disability benefits under this rider are based.

Rider Date. The effective date of this rider. The rider date is the certificate date, unless this rider is applied for at a later date. If this rider is applied for at a later date, the rider date is the effective date assigned by our Home Office in accordance with our dating rules in effect at the time this rider is issued.

Total Disability. During the first 24 months of disability, the payor must be unable to perform the substantial and material duties of his or her principal occupation.

After the first 24 months of disability, the payor must be unable to perform the substantial and material duties of any occupation for which they are suited by education, training or experience.

The payor is not totally disabled when not under the regular care of a physician (unless the physician tells us that regular care would be of no further benefit to the payor during such continuing disability).

BENEFIT

We agree to waive the planned periodic premium (disability benefit amount) for the certificate after we receive due proof that total disability of the payor:

1. has existed continuously for at least 6 months; and
2. began before the insured's attained age 60; and
3. began while the certificate and this rider are in force; and
4. is not described in the Limitations and Exclusions provision of this rider.

We will pay the disability benefit amount shown on the certificate specifications page after total disability has existed continuously for 6 months and while total disability continues.

You may continue to make premium payments for the certificate while the disability benefit amount is being paid. The certificate can enter a grace period even though the disability benefit amount is being paid.

LIMITATIONS AND EXCLUSIONS

No benefit is provided for this rider if disability results from:

1. injuries intentionally self-inflicted; or
2. war or any act of war, whether declared or undeclared, while the payor is in the military service of any country.

WRITTEN NOTICE OF CLAIM

We must receive written notice of claim:

1. while total disability continues; and
2. while the payor is alive; and
3. within 1 year of when the payor becomes disabled.

We will not reject a claim because notice was not given within these times if you show that notice was given as soon as reasonably possible.

PROOF OF TOTAL DISABILITY

Due proof of total disability should be furnished with the written notice of claim or as soon thereafter as reasonably possible. Upon your request, we will supply forms for furnishing proof.

We can require due proof, at reasonable intervals, that total disability continues. After total disability has continued for two years, we will not require due proof more often than once a year. We can require physical examination of the payor by our medical representatives at our expense as part of any due proof of total disability. We will not pay the benefit under this rider if due proof is not furnished as required.

PREMIUMS

The annual premium for this rider is shown on the certificate specifications page. The monthly cost of insurance for this rider is deducted from the certificate's fund value on each monthly date.

CHANGES IN DISABILITY BENEFIT AMOUNT

After the first certificate year, the disability benefit amount may be changed. Any change will be subject to the following conditions:

1. a written request must be submitted to us; and
2. the disability benefit amount may not exceed the planned periodic premium; and
3. no changes are allowed during a period of total disability; and
4. an application and evidence of insurability satisfactory to us must be submitted for any increase; and
5. the first month's cost of insurance must be paid for any increase.

If the certificate's specified amount is increased due to the future purchase option rider being exercised, the disability benefit amount will automatically increase by the increase in the monthly scheduled planned periodic premium for the certificate, without evidence of insurability. This increase in the disability benefit amount only applies if the increase in planned periodic premium under the future purchase option rider is actually exercised.

TERMINATION

This rider terminates and is no longer in force on the earliest of:

1. the certificate anniversary on or next following the insured's 60th birthday; or
2. the date any premium for this rider or the certificate remains unpaid, subject to the grace period provision of the certificate; or
3. the date the insurance under the certificate matures, expires or otherwise terminates; or
4. the date the certificateholder requests a change in the payor.

You may terminate this rider on any premium due date by written request. A claim based on total disability that began before termination of this rider will not be affected by the termination.

GENERAL

This rider is a part of the certificate to which it is attached. This rider has no cash or loan value. It does not affect any net single premium referred to in the certificate.

You will remain liable for payment of interest on any certificate loan while we are providing a benefit under this rider. If the certificate loan balance exceeds the cash surrender value while we are providing a benefit under this rider, the certificate will terminate in accordance with the certificate unless a sufficient loan repayment is made. Because the benefit under this rider is a premium payment and not a loan repayment, crediting the benefit to the certificate value will not prevent termination when the loan balance exceeds the cash surrender value.

INCONTESTABILITY

We cannot contest payment of this rider after it has been in force while the payor is alive for 2 years from the rider date except for nonpayment of premiums.

We cannot contest payment of this benefit represented by increases in the disability benefit amount after an increase has been in force while the payor is alive for 2 years.

Signed for American Heritage Life Insurance Company at its Home Office in Jacksonville, Florida.

Secretary

President

Home Office
American Heritage Life Insurance Company
1776 American Heritage Life Drive
Jacksonville, Florida 32224

AMERICAN HERITAGE LIFE INSURANCE COMPANY
HOME OFFICE: 1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224-6687
(904) 992-1776

A Stock Company

ENDORSEMENT TO ADD OR CHANGE RIDERS AFTER POLICY DATE

The following provision is added to the General Provisions section of the policy to which this endorsement is attached.

Adding or Changing Riders on Your Policy. You may request the addition of any riders available at the time of request. You may also request a change to the amount or units of any rider currently attached to your policy. Any additional riders or changes to existing riders will be subject to our availability, underwriting and issue requirements at the time the request is made. Upon approval by us, the additional rider(s) or changes to existing riders will be effective on the next monthly date after the request is approved by us.

This endorsement does not change, alter or amend your policy in any way except as stated in this endorsement.

Signed for American Heritage Life Insurance Company at its home office.

Secretary

AMERICAN HERITAGE LIFE INSURANCE COMPANY

HOME OFFICE: 1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224-6687
(904) 992-1776

A Stock Company

ENDORSEMENT TO CHANGE TOBACCO STATUS

The following provision is added to the General Provisions section of the policy to which this endorsement is attached.

Change in Tobacco Status. If the insured is age 19 or older, you may request the insured be reassigned to the non-tobacco premium class. Upon proof satisfactory to us that the insured meets our criteria of a non-tobacco user, we will reassign the insured to the non-tobacco premium class. The change will be effective on the next monthly date after the request is approved by us.

This endorsement does not change, alter or amend your policy in any way except as stated in this endorsement.

Signed for American Heritage Life Insurance Company at its home office.

Secretary

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AMERICAN HERITAGE LIFE INSURANCE COMPANY

Jacksonville, Florida 32224-6687

AMENDMENT

The policy to which this Amendment is attached is amended as follows:

> If this policy is issued as a replacement of an existing life insurance policy or annuity of ours or a subsidiary or affiliate under common ownership or control, you are hereby given credit under this policy for the expired portion of the contestability and suicide provisions of the replaced or previously existing policy or contract. This credit shall not exceed that earned under the replaced or previously existing policy. It will not place you or the insured in a more favorable position than would have been the case had a replacement policy not been issued.

This credit shall not apply to any amount of insurance provided by the replacement policy which exceeds the amount of insurance provided by the replaced policy.

This Amendment will not change, alter, or amend the policy it is attached to, except as stated.

This Amendment becomes effective as of the policy date of the policy to which it is attached.

Secretary

AMERICAN HERITAGE LIFE INSURANCE COMPANY

Jacksonville, Florida 32224-6687

NOTICE OF RIGHT TO RETURN POLICY

If this policy is issued as a replacement of an existing life insurance policy or annuity please note that you have the right to return the policy or contract within 30 days of delivery of the contract and receive an unconditional full refund of all premium or considerations paid on it, including any policy fees or charges.

This does not change, alter, or amend the policy it is attached to, except as stated.

Secretary

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AMERICAN HERITAGE LIFE INSURANCE COMPANY
HOME OFFICE:
1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224-6687
www.allstatebenefits.com
(904) 992-1776

A Stock Company

Important Privacy Policy Notice

At Allstate Benefits ("AB"), 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 AB 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?

AB does not sell your customer or medical information to anyone. We do not share it with companies or organizations outside of AB 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.

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 AB. 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 AB 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:

AB
Policyholder Services (Privacy Section)
1776 American Heritage Life Drive
Jacksonville, FL 32224-6687

If you are an Internet user ...
Our website, www.allstatebenefits.com, provides information about AB, our products, and the agencies and brokers that represent us. You may also perform certain transactions on the website. When accessing www.allstatebenefits.com, please be sure to read the Privacy Statement that appears there. To learn more, the www.allstatebenefits.com Privacy Statement 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 us at:

AB
Policyholder Services (Privacy Section)
1776 American Heritage Life Drive
Jacksonville, FL 32224-6687

This notice is being provided on behalf of the following companies:

American Heritage Life Insurance Company
Bluegrass Life Insurance Company
Acme United Insurance Company
SMA Life Assurance Company
Holiday Life Insurance Company
Kentucky Home Mutual
Keystone State Life
National Guardian Life

AMERICAN HERITAGE LIFE INSURANCE COMPANY

1776 American Heritage Life Drive, Jacksonville, Florida 32224-6687
1-800-521-3535

ACCELERATED DEATH BENEFIT FOR LONG TERM CARE RIDER WITH EXTENSION OF BENEFITS RIDER OUTLINE OF COVERAGE

Rider Form Numbers: GULTC2LA and GULTCEXTLA

CAUTION: The issuance of the riders is based on your responses to the questions on your enrollment form and/or evidence of insurability form. A copy of your enrollment form and/or evidence of insurability form is attached. If your answers are incorrect or untrue, then we have the right to deny benefits or to rescind your coverage under the riders. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect or untrue, please contact us at the address shown above.

NOTICE TO BUYER: The riders may not cover all of the costs associated with long term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all limitations of the riders as well as those of the certificate to which the riders are attached.

1. This coverage is a rider that is issued through a group life plan in Louisiana.

2. **PURPOSE OF OUTLINE OF COVERAGE.** This outline of coverage provides you with a very brief description of the important features of the riders. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the riders and the certificate to which the riders are attached contain governing contractual provisions. This means that the certificate and the riders set forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you **READ YOUR LIFE INSURANCE CERTIFICATE AND ALL RIDERS CAREFULLY.**

3. **FEDERAL TAX CONSEQUENCES.** The riders are not intended to be a federally tax-qualified long term care insurance contract under Section 7702B(b) of the Internal Revenue Code as amended. The riders are intended to be a qualified accelerated death benefit that is excluded from gross income for federal income tax purposes under the applicable provisions of the Internal Revenue Code in existence at the time the riders are issued.

4. **TERMS UNDER WHICH THE RIDER MAY BE CONTINUED IN FORCE OR DISCONTINUED.**
   Continuation of Coverage. If the insured loses eligibility for the coverage provided under the Accelerated Death Benefit for Long Term Care Rider for any reason other than non-payment of premiums, the certificate holder will have the option to continue coverage, on the same basis as the certificate to which the rider is attached.

   Waiver of Monthly Deductions. For each certificate month you receive monthly benefits under the Accelerated Death Benefit for Long Term Care Rider, we will waive the monthly deductions for the certificate and all riders attached to the certificate.

5. **TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS.** The annual premium for the riders will be s hown on the certificate specifications page. The monthly cost of insurance will be deducted from the certificate's fund value on each monthly date and is based on the certificate's specified amount on each monthly date. **The premium quoted at issue of the rider will not be changed unless changed for all insureds in your class.**

6. **TERMS UNDER WHICH THE RIDER MAY BE RETURNED AND PREMIUM REFUNDED.** You may, within 31 days after you receive the Accelerated Death Benefit for Long Term Care Rider, return it to us or to our agent. Once returned, we will refund all premiums paid for the rider and coverage under the rider will be void. Additionally, the rider may be cancelled by a written request from you at any time. Cancellation will take effect on the date of death or the date we receive the written request for cancellation at our Home Office. We will refund a pro rata part of any premium paid for the rider beyond that date.

7. **THIS IS NOT MEDICARE SUPPLEMENT COVERAGE.** If you are eligible for Medicare, review the *Medicare Supplement Buyer's Guide* available from us. Neither American Heritage Life Insurance Company nor its agents represent Medicare, the federal government, or any state government.

8. **LONG TERM CARE COVERAGE.** Coverage in this category is designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community, or in the home. The rider provides coverage in the form of a fixed dollar indemnity benefit, by accelerating the death benefits available under your certificate, for covered long term care expenses, subject to rider limitations and requirements. After our receipt of written proof acceptable to us that the insured has satisfied the conditions stated in the Eligibility for the Payment of Benefits provision, you may choose to receive a portion of the death benefit while the insured is still alive and while the certificate and rider are in force, until the entire current death benefit provided by the certificate has been paid out.

9. **BENEFITS PROVIDED BY THE ACCELERATED DEATH BENEFIT FOR LONG TERM CARE RIDER.**
Eligibility for the Payment of Benefits. Eligibility for benefits under the rider is satisfied when all of the following conditions are met:
   a. the insured is chronically ill;
   b. the certificate and rider are in force;
   c. the insured has satisfied the elimination period;
   d. the insured has used qualified long term care services and been chronically ill during the last 180 consecutive days;
   e. the death benefit amount has not been totally accelerated;
   f. the insured:
      i. is confined in a nursing care or assisted living facility and the confinement begins while the rider is in force;
      ii. receives home health care services provided by a home health care agency for a minimum of 4 home health care visits during each monthly benefit period and while the rider is in force; or
      iii. receives adult day care provided in an adult day care center for a minimum of 4 adult day care visits during each monthly benefit period and while the rider is in force;
   g. the insured incurred charges for qualified long term care services which are included in the insured's plan of care; and
   h. all irrevocable beneficiaries and assignees have signed the written request for this benefit.

   If death benefit option 2 is in effect, we will change it to death benefit option 1 prior to paying the first monthly benefit under the rider.

   We may periodically require certification that the insured is chronically ill, but not more than once every 90 days.

   We will not simultaneously pay benefits under the rider for both qualified confined and non-confined services, even if the insured otherwise qualifies for both types of services during a monthly benefit period. In any given monthly benefit period that the insured qualifies for both qualified types of services, we will pay either the qualified confined or non-confined service, whichever is higher.

   There are two types of qualified long term care services under the rider:

   Qualified Confined Care Services. We will pay 4% of the death benefit amount at the beginning of the period of care for necessary diagnostic, preventive, therapeutic, curing, treating, mitigating and rehabilitative services, and maintenance or personal care services which are required by a chronically ill individual and are provided pursuant to a plan of care prescribed by a licensed health care practitioner in an assisted living facility or nursing care facility.

   Qualified Non-Confined Care Services. We will pay 4% of the death benefit amount at the beginning of the period of care for necessary diagnostic, preventive, therapeutic, curing, treating, mitigating and rehabilitative services, and maintenance or personal care services which are required by a chronically ill individual and are provided pursuant to a plan of care prescribed by a licensed health care practitioner by means of home health care or adult day care.
   The applicable percentage of the death benefit amount that we will pay will be based on the death benefit amount of the certificate as of the monthly date immediately following the date the insured first became eligible for payment of rider benefits. The total benefits that will be paid under the rider will not exceed this death benefit amount minus any death benefit advance and outstanding certificate debt. If the insured receives qualified long term care services for only a portion of the monthly benefit period, we will pay a pro-rata benefit for the portion of the month the benefits were received. The pro-rata benefit for confined care is $1/30^{th}$ of the full monthly benefit for Qualified Confined Care Services for each day of confinement. The pro-rata benefit for non-confined care is $1/4^{th}$ of the Qualified Non-Confined Care Services for each day of non-confined care up to 3 days. We will deduct a proportional repayment of any outstanding certificate debt from the monthly accelerated death benefit amount.

Definitions. These are some of the important definitions that will help you understand the Eligibility for the Payment of Benefits provision. Please review the rider for further information.

a. **Activities of daily living (ADLs)** mean activities used to measure the insured's impairment due to being chronically ill. ADLs are any of the following:
   i. Bathing – washing oneself by sponge bath; or in either a tub or shower, including the act of getting into and out of the tub or shower, with or without the aid of equipment.
   ii. Continence – the ability to maintain control of bowel and bladder function; or when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag), with or without the aid of equipment.
   iii. Dressing – putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.
   iv. Eating – feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.
   v. Toileting – getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
   vi. Transferring – the ability to move into or out of a bed, chair or wheelchair.

b. **Chronically ill** means the insured has been certified by a licensed health care practitioner within the preceding 12-month period as:
   i. being unable to perform, without substantial assistance from another individual, at least 2 ADLs for a period of at least 90 days due to a loss of functional capacity; or
   ii. requiring substantial supervision to protect oneself from threats to health and safety due to cognitive impairment.

c. **Cognitive impairment** means a deficiency in the insured's:
   i. short or long term memory;
   ii. orientation as to person, place and time;
   iii. deductive or abstract reasoning; or
   iv. judgment as it relates to safety awareness.

   This deficiency must be to such a degree as to require substantial supervision to maintain the safety of the insured or others. A diagnosis of cognitive impairment must be confirmed by clinical evidence and testing that reliably measures impairment.

d. **Elimination period** means the number of days at the beginning of a period of care for which benefits are not payable under the rider. The number of days in the elimination period for the rider is 90. In order for a day to count as a day in the elimination period, the following requirements must be met:
   i. the insured is chronically ill; and
   ii. charges must be incurred for the qualified long term care services of the insured.

BENEFITS PROVIDED BY THE EXTENSION OF BENEFITS RIDER. If the rider is in force, after we have paid out the entire certificate death benefit amount, as of the beginning of the period of claim, we will increase the death benefit amount of the certificate by the death benefit amount increase subject to our determination that all the following terms and conditions have been satisfied:

a. the rider remains in force;
b. the insured is alive and continues to satisfy all the conditions stated in the Eligibility for the Payment of Benefits provision of the Accelerated Death Benefit for Long Term Care Rider;
c. the death benefit amount of the certificate as of the monthly date immediately following the date the insured first became eligible for payment of long term care benefits minus any death benefit advance and certificate debt has been paid;
d. the certificate will not be eligible for any additional death benefit amount increase until the previous death benefit amount increase has been paid under the terms of the Extension of Benefits Rider; and
e. the cumulative death benefit amount increases will not exceed the death benefit amount of certificate, determined as of the monthly date immediately following the date the insured first became eligible for payment of long term care benefits.

The effective date of each death benefit amount increase will be the monthly date preceding the monthly date that the entire death benefit amount of the certificate was paid.

The death benefit amount increase equals the death benefit amount of the certificate on the monthly date immediately following the date the insured first becomes eligible for long term care benefits times the confinement percentage shown on the certificate specifications page.

If the insured ceases to meet the Eligibility for the Payment of Benefits under the Accelerated Death Benefit for Long Term Care Rider while death benefit amount increases are being made under the Extension of Benefits Rider, the certificate and all its riders will terminate.

If 100% of the amount payable under the Extension of Benefits Rider has been paid, the certificate and all its riders will terminate.

10. **LIMITATIONS AND EXCLUSIONS.** We will not pay benefits under the Accelerated Death Benefit for Long Term Care Rider for that portion of any day of qualified long term care services that are:
    a. provided as a result of mental or emotional disorder (except for Alzheimer's Disease, or similar forms of senility or senile dementia that are of organic origin);
    b. provided for alcoholism or drug addiction;
    c. provided as a result of illness, treatment or medical conditions arising out of:
        i. war or act of war (whether declared or undeclared);
        ii. participation in a felony, riot or insurrection;
        iii. service in the armed forces or units auxiliary thereto; or
        iv. suicide (while sane or insane), attempted suicide or intentionally self-inflicted injury;
    d. provided in a government facility (unless otherwise required by law); services for which benefits are available under Medicare (or benefits would be available under Medicare except for the applicable deductibles or co-insurance requirements) or other governmental program (except Medicaid), any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law; or
    e. received outside the United States or its territories.

    Pre-existing Condition Limitation. We do not pay benefits under the rider for a period of care that begins in the first 6 months after the rider effective date if a pre-existing condition causes the insured to be chronically ill. This limitation does not apply to a period of care that begins more than 6 months after the rider effective date that is caused by a pre-existing condition.

    A pre-existing condition is a condition for which:
    a. symptoms existed within 6 months before the rider effective date; or
    b. medical advice or treatment was recommended by or received from a physician or other member of the medical profession within 6 months before the rider effective date.

    THE RIDERS MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG TERM CARE NEEDS.

11. **RELATIONSHIP OF COST OF CARE AND BENEFITS.** Because the costs of long term care services will likely increase over time, you should consider whether and how the benefits of the plan may be adjusted. The riders are level and will not increase over time. There is no inflation protection available with the riders.

12. **ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS.** The Accelerated Death Benefit for Long Term Care Rider provides coverage for insureds clinically diagnosed as having Alzheimer's Disease or related degenerative and dementing illnesses. These illnesses are covered to the same extent as long as they meet the requirements of the rider.

13. **PREMIUMS.** The monthly cost of insurance for the riders is deducted from the certificate's fund value on each monthly date and is based on the certificate's specified amount on each monthly date.

14. **ADDITIONAL FEATURES.**
    a. The riders are issued or declined based on your responses to the questions on your enrollment form and/or evidence of insurability form. Issuance of the riders is contingent upon medical underwriting of the life insurance certificate to which the riders are attached.

b. **Impact on Certificate Values.** The death benefit, death benefit amount, fund value, surrender value, net surrender value, surrender charge, certificate debt and the specified amount will be reduced. If death benefit option 2 is in effect, we will change it to death benefit option 1 prior to paying the first monthly benefit under the Accelerated Death Benefit for Long Term Care Rider. The specified amount will be reduced by the monthly accelerated death benefit amount. The fund value will be reduced by an amount equal to the reduction in specified amount multiplied by the ratio of the fund value to specified amount as of the monthly date immediately following the date the period of care begins. The surrender charge will be reduced by an amount equal to the reduction in specified amount multiplied by the ratio of the surrender charge to specified amount as of the monthly date immediately following the date the period of care begins. The portion of the certificate debt deducted from the monthly accelerated death benefit will reduce the certificate debt. The portion will equal the certificate debt multiplied by the ratio of the monthly accelerated death benefit to the death benefit amount prior to the monthly benefit payment.

While the insured is eligible for monthly benefits under the rider the following conditions apply:

i. no changes may be made to the specified amount and death benefit option of the certificate; and
ii. no change may be made to existing riders nor may new riders be added; and
iii. we will not accept any premium payments.

While the certificate is in force, any accidental death benefit and level term rider will not be affected by the payment of monthly accelerated death benefits under the rider. If the certificate's the death benefit amount has been totally accelerated, then the certificate and any rider(s) will terminate with no further benefits payable.

c. **ILLUSTRATIVE EXAMPLE.** Below is a sample illustration of the effect of exercising the accelerated death benefit option for qualified confined care services:

	Specified Amount	Death Benefit Amount	Accelerated Death Benefit Amount	Fund Value	Surrender Charge	Certificate Debt
Before payment of the Accelerated Death Benefit	$50,000	$50,000	$0	$3,000	$550	$800
After payment of the Accelerated Death Benefit	$48,000	$48,000	$2,000	$2,880	$528	$768

The net monthly accelerated death benefit amount equals the monthly accelerated death benefit amount minus a pro-rata portion of the certificate debt, or $1,968 in this example.

While qualified long term care services are being paid, monthly deductions for the certificate will be waived.

15. **CONTACT THE STATE SENIOR HEALTH INSURANCE ASSISTANCE PROGRAM IF YOU HAVE GENERAL QUESTIONS REGARDING LONG TERM CARE INSURANCE. CONTACT US IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR ACCELERATED DEATH BENEFIT FOR LONG TERM CARE RIDER OR EXTENSION OF BENEFITS RIDER.**

AMERICAN HERITAGE LIFE INSURANCE COMPANY

SUMMARY OF ACCELERATED DEATH BENEFIT FOR LONG TERM CARE RIDER (FORM GULTC2LA) WITH EXTENSION OF BENEFITS RIDER (FORM GULTCEXTLA)

Explanation of Interaction of Rider Benefits with Other Components of Certificate

At the end of each monthly benefit period for which a monthly benefit is paid, the death benefit will be reduced by the amount of the monthly benefit. This will be accomplished by reducing the death benefit amount, fund value, surrender value, net surrender value, surrender charge, certificate debt, and specified amount by the same percentage the death benefit is reduced. The surrender charge will be reduced by reducing the maximum surrender charge for the initial specified amount and any increases in specified amount by the same percentage.

When the certificate's specified amount is first reduced to zero as a result of a monthly benefit being payable under the Accelerated Death Benefit for Long Term Care Rider, then the Extension of Benefits Rider will increase the certificate death benefit by the monthly long term care benefit amount each month while the insured continues to qualify for long term care benefits. The cumulative death benefit amount increases will not exceed the death benefit amount of certificate, determined as of the monthly date immediately following the date the insured first became eligible for payment of long term care benefits. When the insured no longer qualifies for long term care benefits under the Extension of Benefits Rider, then the certificate and all riders attached to the certificate terminate. The termination is effective the day after the last day of the monthly benefit period for which this monthly benefit is payable.

We waive cost of insurance charges for the certificate which become due during any monthly benefit period for which a non-zero monthly benefit is payable.

If the certificate to which the riders are attached terminates, for any reason, then the riders terminate, and no more benefits are payable from the riders. The certificate will terminate if its maturity date is reached, if it lapses, if it is surrendered, if the insured dies, if the group policy terminates (subject to the Continuation of Coverage provision), or if the death benefit is exhausted due to these riders as noted above.

Any long term care inflation protection option required by law is not available under the riders.

Illustration of Amount and Length of Rider Benefits

This is an example of the amount and length of benefits which could be received from the rider. This example assumes that the certificate's death benefit is $50,000 when the Accelerated Death Benefit for Long Term Care Rider claim begins, the certificate's death benefit does not change except as a result of benefits being paid by the rider, and the elimination period for the rider is 90 days. This example also assumes that the insured receives qualified non-confined care services every other day from March 6, 2019 through September 30, 2019, qualified non-confined care services every day from October 1, 2019 through December 31, 2019, and qualified confined care services every day of January 2020, fourteen (14) days in February 2020, and every day from March 1, 2020 through April 30, 2022. This example further assumes that the insured receives qualified non-confined care services every other day from May 1, 2022 through July 31, 2022, qualified confined care services 15 days in August 2022, qualified non-confined care services 3 days in September 2022, qualified non-confined care services every other day from October 1, 2022 and thereafter.

All of these assumptions affect the amount and length of benefits received from the rider in a very important way. If the actual situation differs from the assumptions in this example, so will the benefits received.

In this example, the 90-day elimination period is satisfied on August 31, 2019, after there are 90 days during which the insured receives qualified long-term care services. Since the elimination period is satisfied on the last day of August 2019, monthly benefit periods begin on the first day of each month and end on the last day of the same month. The maximum monthly benefit is determined on August 31, 2019 (the day the elimination period is satisfied) as 4% of the death benefit ($50,000), which is $2,000.

Assuming the insured receives qualified non-confined long-term care services every other day during September 2019, the monthly benefit for September 2019 is $2,000. This is calculated as the maximum monthly benefit of $2,000 since at least 4 days of qualified non-confined care were received during the month.

Assuming the insured receives qualified non-confined long-term care services every day during October 2019, the monthly benefit for October 2019 is $2,000. This is calculated as the maximum monthly benefit of $2,000 since at least 4 days of qualified non-confined care were received during the month.

Assuming the insured receives qualified non-confined long-term care services every day during November 2019 and December 2019, the monthly benefit for these months is $2,000 each. These calculations are identical to the calculation for October 2019.

Assuming the insured receives qualified confined long-term care services every day during January 2020, the monthly benefit for January 2020 is $2,000. This is calculated as the maximum monthly benefit of $2,000 multiplied by 1.0, the portion of the month for which qualified confined care was received.

Assuming the insured receives qualified confined long-term care services for 14 days during February 2020, the monthly benefit for February 2020 is $1,000. This is calculated as the maximum monthly benefit of $2,000 multiplied by 0.5, the portion of the month for which qualified confined care was received (14 days divided by 28 days).

The monthly benefit for March 2020 through September 2021 is $2,000 each. These calculations are identical to the calculation for January 2020.

The monthly benefit for October 2021 is $1,000. The benefit for this month is also calculated in an identical manner to January 2021, except that the benefit is limited to the death benefit of the certificate at the time, which is $1,000. (The death benefit is reduced each month a benefit is paid by the amount of the monthly benefit.)

After the October 2021 payment, $50,000 of payments have been made over a period of 26 months which began once the elimination period is satisfied. The death benefit and other values of the certificate have been reduced each month a benefit was paid and are now zero. As a result of this, the provision of the Extension of Benefits Rider begins increasing the certificate's death benefit so that monthly benefits can continue to be paid under the Accelerated Death Benefit for Long Term Care Rider. The death benefit amount increase is equal to 4% of the $50,000, the certificate's death benefit on the monthly date immediately following the date the insured first became eligible for long term care benefits.

Assuming the insured receives qualified confined long term care services every day during November 2021, the certificate's death benefit is increased by $2,000 according to the terms of the extension rider, so the monthly benefit for November 2021 can be paid as an accelerated death benefit under the long term care rider. The $2,000 accelerated death benefit for November 2021 is calculated as the maximum monthly benefit of $2,000 multiplied by 1.0, the portion of the month for which qualified confined care was received.

Assuming the insured receives qualified confined long term care services every day from December 1, 2021 to April 30, 2022, the certificate's death benefit will be increased by $2,000 each month and an accelerated death benefit of $2,000 will be paid each month, identical to the calculations for November 2021.

Assuming the insured receives qualified non-confined long term care services every other day during May, June and July 2022, the certificate's death benefit is increased by $2,000 each month according to the terms of the extension rider, so the monthly benefits can be paid as accelerated death benefits under the long term care rider. The monthly benefit for May, June and July 2022 is $2,000 each, which is calculated as the maximum monthly benefit of $2,000 multiplied by 1.0, the portion of the month for which qualified non-confined care was received.

Assuming the insured receives qualified confined long term care services 15 days during August 2022, the certificate's death benefit is increased by $2,000 according to the terms of the extension rider, so the monthly benefit for August 2022 can be paid as an accelerated death benefit under the long term care rider. The benefit for August 2022 is $1,000, which is calculated as the maximum monthly benefit of $2,000 multiplied by 0.5, the portion of the month for which qualified confined care was received (15 days divided by 30 days). Since only $1,000 is accelerated, the certificate's death benefit is $1,000 ($2,000 minus $1,000).

Assuming the insured receives qualified non-confined long term care services for 3 days during September 2022, the monthly benefit for September 2022 is $1,000, which is the certificate's remaining death benefit ($1,000). Since there is only $1,000 of death benefit left to accelerate at the beginning of September, the monthly benefit is limited to $1,000 even though the pro-rata benefit for 3 days of qualified non-confined long term care services is $1,500 (the maximum monthly benefit of $2,000 multiplied by 3 days and divided by 4 days).

Assuming the insured receives qualified non-confined long term care services every other day from October 1, 2022 through December 31, 2023, the certificate's death benefit is increased by $2,000 each month according to the terms of the extension rider, so the monthly benefit of $2,000 can be paid as an accelerated death benefit under the long term care rider each month.

After the December 2023 payment, $100,000 of payments have been made over a period of 52 months which began once the elimination period is satisfied. The death benefit and other values of the certificate have been reduced each month a benefit was paid and are now zero. As a result of this, the certificate, Accelerated Death Benefit for Long Term Care and Extension of Benefits riders, and any other riders attached to the certificate, terminate.

Exclusions, Reductions, and Limitations on Benefits

Eligibility for benefits under the Accelerated Death Benefit for Long Term Care Rider is satisfied when all of the following conditions are met:

1. the insured is chronically ill;
2. the certificate and rider are in force;
3. the insured has satisfied the elimination period;
4. the insured has used qualified long term care services and been chronically ill during the last 180 consecutive days;
5. the death benefit amount has not been totally accelerated;
6. the insured:
   a. is confined in a nursing care or assisted living facility and the confinement begins while the rider is in force;
   b. receives home health care services provided by a home health care agency for a minimum of 4 home health care visits during each monthly benefit period and while the rider is in force; or
   c. receives adult day care provided in an adult day care center for a minimum of 4 adult day care visits during each monthly benefit period and while the rider is in force;
7. the insured incurred charges for qualified long term care services which are included in the insured's plan of care; and
8. all irrevocable beneficiaries and assignees have signed the written request for this benefit.

If death benefit option 2 is in effect, we will change it to death benefit option 1 prior to paying the first monthly benefit under the rider.

We may periodically require certification that the insured is chronically ill, but not more than once every 90 days.

We will not simultaneously pay benefits under the rider for both qualified confined and non-confined services, even if the insured otherwise qualifies for both types of services during a monthly benefit period. In any given monthly benefit period that the insured qualifies for both qualified types of services, we will pay either the qualified confined or non-confined service, whichever is higher.

The accelerated death benefit is voluntary and is not intended to cause an involuntary reduction of the death benefit ultimately payable to the beneficiary. Therefore, the accelerated death benefit is not available if the insured is:

1. required by law to use this option to meet the claims of creditors, whether in bankruptcy or otherwise; or
2. required by a government agency to use this option in order to apply for, obtain, or keep a government benefit or entitlement.

We do not pay benefits under the rider for a period of care that begins in the first 6 months after the rider effective date if a pre-existing condition causes the insured to be chronically ill. This limitation does not apply to a period of care that begins more than 6 months after the rider effective date that is caused by a pre-existing condition. A pre-existing condition is a condition for which:

1. symptoms existed within 6 months before the rider effective date; or
2. medical advice or treatment was recommended by or received from a physician or other member of the medical profession within 6 months before the rider effective date.

We will not pay benefits under the rider for that portion of any day of qualified long term care services that are:

1. provided as a result of mental or emotional disorder (except for Alzheimer's Disease, or similar forms of senility or senile dementia that are of organic origin);
2. provided for alcoholism or drug addiction;
3. provided as a result of illness, treatment or medical conditions arising out of:
   a. war or act of war (whether declared or undeclared);
   b. participation in a felony, riot or insurrection;
   c. service in the armed forces or units auxiliary thereto; or
   d. suicide (while sane or insane), attempted suicide or intentionally self-inflicted injury;
4. provided in a government facility (unless otherwise required by law); services for which benefits are available under Medicare (or benefits would be available under Medicare except for the applicable deductibles or co-insurance requirements) or other governmental program (except Medicaid), any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law; or
5. received outside the United States or its territories.

Conditions for Increasing the Death Benefit Amount Under the Extension of Benefits Rider

We will increase the death benefit amount of the certificate by the death benefit amount increase if all the following terms and conditions have been satisfied:

1. the rider remains in force; and
2. we have received proof satisfactory to us that the insured is alive and continues to meet all conditions of the Accelerated Death Benefit for Long Term Care Rider under the Eligibility for the Payment of Benefits provision; and
3. the remaining death benefit available for the Accelerated Death Benefit for Long Term Care Rider has been exhausted; and
4. the certificate will not be eligible for any additional death benefit amount increase until the previous death benefit amount increase has been paid under the terms of this Extension of Benefits Rider; and
5. the cumulative death benefit amount increases under this rider will not exceed the death benefit amount of the certificate, determined as of the monthly date immediately following the date the insured became eligible for payment of long term care benefits.

Effect of Exercising Rights Under the Certificate

The certificate may provide rights which will affect the benefits available from the rider and the charges made to the certificate for the rider. Certificate loans, certificate loan repayments, partial surrenders, specified amount changes, and death benefit option changes will generally change the certificate's death benefit, the certificate's specified amount, or both. Therefore, any of these actions will affect the benefits available from the rider, the charges made to the certificate for the rider, or both.

Long Term Care and Extension of Benefits Cost of Insurance Charge Guarantee

The monthly cost of insurance for the riders are deducted from the certificate's fund value on each monthly date and is based on the certificate's specified amount on each monthly date. As long as the riders remain in force, the monthly cost of insurance rates for the riders per thousand of the certificate's specified amount are guaranteed not to change from the rates which apply when the riders are issued.

Maximum Lifetime Benefits

The maximum lifetime benefit which can be received from the combined benefits of the riders is two times the death benefit of the certificate to which the riders are attached.

SUMMARY OF THE LOUSIANA 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.

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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.

EXCLUSIONS FROM COVERAGE

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.