

# GROUP TERM LIFE INSURANCE WITH ACCELERATED BENEFITS

*Your Group Insurance Certificate  
Provided by Your Employer and*



A subsidiary of Blue Cross and Blue Shield of Louisiana,  
independent licensees of the Blue Cross and Blue Shield Association.

5525 Reitz Avenue • Baton Rouge, Louisiana • 70809-3802  
[www.bcbsla.com](http://www.bcbsla.com)

Signed for The Company

A handwritten signature in black ink, appearing to read "I. Steven Udvarhelyi".

I. Steven Udvarhelyi, M. D.,  
President and Chief Executive Officer



**GROUP TERM LIFE INSURANCE WITH ACCELERATED BENEFITS CERTIFICATE  
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## ARTICLE I      GROUP AND VOLUNTARY TERM LIFE GENERAL PROVISIONS

The Schedules of Benefits are controlling in regards to which of all the benefits described in this Certificate apply to You (or Your Dependents, if Dependent coverage is available). There are two possible Schedules of Benefits that could be attached to this Certificate:

- a **Group Term Life Schedule of Benefits**, which describes the non-voluntary coverages that the Employer has provided for You, and
- a **Voluntary Group Term Life Schedule of Benefits**, which describes the voluntary coverages that You may have chosen to participate in, if the Employer provides You options of voluntary coverage.

Each Schedule of Benefits shows the date on which this Certificate becomes effective for the coverages shown in it. We will issue a new Certificate with changed Schedules of Benefits, or the absence of a particular Schedule of Benefits, to reflect any future changes in coverage. The absence of a particular Schedule of Benefits in a Certificate issued at a later date will mean that, as of the effective date shown on the Schedule of Benefits attached to that Certificate, the coverages that belonged to the omitted Schedule of Benefits are no longer available. The effective date on any newly issued Schedule of Benefits will indicate the date on which any changes are effective, and will render any previous Certificate and its attached Schedules of Benefits void on that date.

This Article I applies generally to all of Your coverages under this Certificate.

### DEFINITIONS

**Active Employee** means an employee who works for the Employer on a regular basis in the usual course of the Employer's business. This must be at least the number of hours designated by the Employer in the application for group insurance.

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

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

We will also consider You to be Actively At Work on any regularly scheduled vacation day, paid time off day, personal day or holiday, only if You were Actively At Work on the preceding scheduled work day.

Paid time off and personal days do not include days off taken for Sickness or Injury.

**Amount of Life Insurance** means the total amount of benefits that would be available because of Your death or the death of any of Your Dependents, whether under this Certificate, a Prior Policy or any other life insurance policy. In relation to this Certificate when it regards to You, it includes any applicable Basic Life Benefit, Basic Accidental Death and Dismemberment Benefit, Voluntary Life Benefit, and/or Voluntary Accidental Death and Dismemberment Benefit for which You are covered, according to the Schedule of Benefits. When it regards to Dependents under this Certificate (if Dependent coverage is available), it includes any applicable Dependent Life Benefit and/or Spouse AD&D Benefit for which they are covered, according to the Schedule of Benefits.

**Basic Life Benefit** means the benefit amount that appears in the Schedule of Benefits that represents the benefit that would be available under the Group Term Life coverage in the event of Your death.

<b>Basic Accidental Death and Dismemberment Benefit or Basic AD&amp;D Benefit</b>	means the benefit amount, as it appears of the Schedule of Benefits, which represents the benefit that would be available under the Group Term Life coverage in the event that You die because of an accident or suffer an accidental injury that results in dismemberment, as established in the Accidental Death and Dismemberment provision.
<b>Certificate</b>	means this certificate of Group Term Life Insurance with Accelerated Benefits, which is part of The Policy, and in regards to the specific coverage's and benefits that apply to You and Your Dependents (if Dependent coverage is available) as stated in each of Your Schedules of Benefits for this Certificate.
<b>Commissions</b>	means the monthly average of monetary commissions You received from the Employer over: <ol style="list-style-type: none"> <li>1) the 24 month period immediately prior to this Certificate Anniversary Date; or</li> <li>2) the period of time You worked for the Employer, if less than 24 months.</li> </ol>
<b>Contributory Coverage</b>	means coverage for which You are required to contribute toward the cost. Your employer will let you know if you are required to contribute towards the cost.
<b>Dependent</b>	means Your legal Spouse. means Your child who depends upon You for support and is: born to You, legally placed for adoption with You, legally adopted by You, a child for whom You or Your legal spouse is a court appointed tutor/tutrix, or for whom a qualified medical child support order has been issued or a stepchild of Yours; or any unmarried grandchild in the legal custody of and residing with You; and who is also: <ul style="list-style-type: none"> <li>- under twenty-six (26) years old; or</li> <li>- mentally or physically disabled prior to attaining age 26 and incapable of self-support. (Periodic proof of the child's continuing incapacity may be required.)</li> </ul> Anyone who is eligible as an Employee will not be considered as a Dependent. No one may be considered as Dependent of more than one Employee.
<b>Dependent Life Benefit</b>	means the amount of benefit established in the Schedule of Benefits for each type of Dependent
<b>Disability or Disabled</b>	means You are prevented by injury or sickness from doing any work for which You are, or could become, qualified by: <ol style="list-style-type: none"> <li>a) education;</li> <li>b) training; or</li> <li>c) experience.</li> </ol>
<b>Eligible Class</b>	means a class of persons eligible for insurance under this Certificate. This class is based on employment with the Policyholder.
<b>Evidence of Insurability</b>	means any kind of evidence that We may request to evaluate Your (or Your Dependent's) insurability. All Evidence of Insurability must be satisfactory to Us, and may include, but is not limited to, health and medical history forms, a medical examination, attending physician statements, medical and hospital records, or any other evidence.
<b>Employer</b>	means the Policyholder.
<b>Guaranteed Issue Amount</b>	means the amount that appears on the Schedule of Benefits and which represents the maximum to which You could increase a Basic Life Benefit or Voluntary Life Benefit without providing Evidence of Insurability.
<b>Hospital</b>	means an institution which: <ol style="list-style-type: none"> <li>1) operates pursuant to law;</li> <li>2) primarily and continuously provides medical care and treatment to sick and injured persons on an inpatient basis;</li> <li>3) operates facilities for medical and surgical diagnosis and treatment by or under the supervision of Physicians; and</li> </ol>

4) provides 24-hour nursing service by or under the supervision of registered graduate nurses (R.N.).

Hospital does not mean any institution or part thereof which is used primarily as:

- 1) a nursing home, convalescent home, or skilled nursing facility;
- 2) a place for rest, custodial care, or for the aged;
- 3) a clinic; or
- 4) a place for the treatment of mental illness, alcoholism, or substance abuse.

However, a place for the treatment of mental illness, alcoholism or substance abuse will be regarded as a Hospital if it is:

- 1) part of an institution that meets the above requirements; and
- 2) listed in the American Hospital Association Guide as a general Hospital.

**Intoxicated**

means:

- 1) the blood alcohol content;
- 2) the results of other means of testing blood alcohol level; or
- 3) the results of other means of testing other substances;

that meet or exceed the legal presumption of intoxication, or under the influence, under the law of the state where an accident occurred.

**Injury**

means bodily injury resulting:

- 1) directly from an accident; and
- 2) independently of all other causes;

which occurs while You are covered under this Certificate.

Loss resulting from:

- 1) sickness or disease, except an infection which occurs through an accidental wound; or
- 2) medical or surgical treatment of a sickness or disease;

is not considered as resulting from Injury.

**Maximum Benefit Amount**

means the amount that appears on the Schedule of Benefits and which represents the maximum amount of Basic Life Benefit, Basic AD&D Benefit, Voluntary Life Benefit, and/or Voluntary AD&D Benefit that you could possibly have under this Certificate, through approved increases by Us or otherwise. The Maximum Benefit Amount does not represent an amount for which you are actually covered.

**Motor Vehicle**

means a self-propelled, four or more wheeled:

- 1) private passenger: car, station wagon, van or sport utility vehicle;
- 2) motor home or camper; or
- 3) pick-up truck;

not being used as a common carrier.

A Motor Vehicle does not include farm equipment, snowmobiles, all-terrain vehicles, lawnmowers or any other type of equipment vehicles.

**Non-Contributory Coverage**

means coverage for which You are not required to contribute toward the cost. Your Employer will let you know if you are not required to contribute towards the cost of coverage.

**Normal Retirement Age**

means the Social Security Normal Retirement Age under the most recent amendments to the United States Social Security Act. It is determined by Your date of birth, as follows:

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

**Physician**

means a legally qualified physician or surgeon other than a physician or surgeon who is Related to You by blood

or marriage.

<b>Prior Policy</b>	means the group life insurance policy carried by the Employer on the day before this Certificate Effective Date.
<b>Related</b>	means Your spouse or other adult living with You, sibling, parent, step-parent, grandparent, aunt, uncle, niece, nephew, son, daughter, or grandchild or similar relationship in law.
<b>Retirement, Retire or Retired</b>	means that a person terminates employment with the Employer with the purpose of receiving retirement benefits from either a retirement plan sponsored by the Employer, an associated company that provides retirement services, or a government plan.
<b>Retiree</b>	means a former employee of the Employer who Retired.
<b>Salary</b>	means Your regular annual rate of pay, not counting commissions, bonuses, tips and tokens, overtime pay or any other fringe benefits or extra compensation, in effect on the most recent date immediately prior to the last Policy Anniversary Date.
<b>Sickness</b>	means sickness or disease which is: <ol style="list-style-type: none"><li>1) caused or contributed to by:<ol style="list-style-type: none"><li>a) any condition, illness, disease or disorder of the body;</li><li>b) any infection, except an infection which occurs through an accidental cut or wound or bacterial infection resulting from an accidental ingestion of a contaminated substance;</li><li>c) hernia of any type unless it is the immediate result of an accidental Injury; or</li><li>d) pregnancy.</li></ol></li><li>2) caused or contributed to by any medical or surgical treatment for a condition shown in item 1 above.</li></ol>
<b>Spouse</b>	means Your spouse who is not legally separated or divorced from You.  Spouse will include Your domestic partner or party to a civil union, if allowed by Your employer provided You have registered as domestic partners or parties to a civil union with a government agency or office where such registration is available and provide proof of such registration unless requiring proof is prohibited by law. You will continue to be considered domestic partners or parties to a civil union provided You continue to meet the requirements described in the domestic partner affidavit or required by law.
<b>Spouse Accidental Death and Dismemberment or Spouse AD&amp;D</b>	means a maximum amount, as it appears of the Schedule of Benefits that represents the maximum benefit that would be available under the Voluntary Group Term Life coverage in the event that Your Spouse dies because of an accident or suffers an accidental injury that results in dismemberment, as established in the Accidental Death and Dismemberment provision.
<b>Terminal Illness or Terminally Ill</b>	means a medically determined life expectancy of 12 months or less.
<b>The Policy</b>	means the policy which We issued to the Policyholder under the Policy Number shown on the face page.
<b>Voluntary Life Benefit</b>	means the amount that appears in the Schedule of Benefits that represents the benefit that would be available under the Voluntary Group Term Life coverage in the event of Your death.
<b>Voluntary Accidental Death and Dismemberment Benefit or Voluntary AD&amp;D Benefit</b>	means a maximum amount, as it appears of the Schedule of Benefits that represents the maximum benefit that would be available under the Voluntary Group Term Life coverage in the event that You die because of an accident or suffer an accidental injury that results in dismemberment, as established in the Accidental Death and Dismemberment provision.



<b>We, Us or Our</b>	means the insurance company named on the face page of This Certificate.
<b>Waiting Period</b>	The period of time that You must be Actively at Work as a member of an Eligible Class before You (and Your dependents, if dependent coverage is available) become covered under this Certificate.
<b>You or Your</b>	means the person to whom this certificate is issued.

## ELIGIBILITY AND ENROLLMENT

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

**Eligibility for Coverage:** You will become eligible for coverage on the latest of:  
*When will I become eligible?*

- 1) this Certificate Effective Date;
- 2) the date on which You complete the Eligibility Waiting Period for Coverage as designated by the Employer ; or
- 3) the date you become a member of an Eligible Class.

If Retiree coverage is shown as included in the Schedule of Benefits; You are eligible for Retiree coverage on the later of:

- 1) the date You become a member of an Eligible Class as noted on the Schedule of Benefits;
- 2) the date You meet the definition of Retiree; or
- 3) this Certificate Effective Date.

**Eligibility for Dependent Coverage:** If Dependent coverage is shown as included in the Schedule of Benefits, You will become eligible to purchase Dependent coverage on the later of:  
*When will I become eligible to purchase Dependent Coverage?*

- 1) the date You become insured for employee coverage; or
- 2) the date You acquire Your first Dependent.

You may not elect coverage for Your Dependent if such Dependent is covered as an employee under this Certificate. No person can be insured as a Dependent of more than one employee under This Certificate.

As a Retiree, You are not eligible for Dependent coverage.

**Enrollment:** *How do I enroll for coverage for myself and my Dependents?* For Non-contributory Coverage, all eligible Active Employees will be enrolled automatically by the Policyholder. For Contributory Coverage, either the Policyholder may enroll You, or You must enroll, depending on the Policyholder's enrollment practices. You must obtain information from the Policyholder on what its enrollment practices are.

If the Policyholder enrolls You:

- 1) the Policyholder may have elected to provide US with a previous carrier election form in which your Policyholder considered that election form and all of its data valid for this Policy; or
- 2) the Policyholder may have elected to provide US with Your enrollment data via a spreadsheet in which the Policyholder received Your coverage elections through some other method approved by the Policyholder.

If, on the contrary, under the Policyholder's practices you have to enroll, You must:

- 1) complete and sign a group insurance enrollment form, satisfactory to Us, for Your coverage and, if Dependent Coverage is shown as included in the Schedule of Benefits, for Your Dependent's coverage; and
- 2) deliver it to the Policyholder.

If You do not enroll for Your coverage and/or Your Dependent's coverage within 31 days after becoming eligible under this Certificate, or if You were eligible to enroll under the Prior Policy and did not do so, and later choose to enroll:

- 1) You must give Us Evidence of Insurability satisfactory to Us; and

- 2) You may only enroll for Your coverage and/or Your Dependent's coverage:
  - a) during an Annual Enrollment Period designated by the Policyholder (You should contact The Policyholder for dates of open enrollment, if any, if allowed by The Policyholder); or
  - b) within 31 days of the date You have a Change in Family Status.

If Retiree Coverage is shown as included in the Schedule of Benefits, You must enroll for Retiree coverage within 31 days of the date You Retire.

Any Enrollment may be subject to the Evidence of Insurability Requirements provision.

**Evidence of Insurability Requirements:**  
*When will I first be required to provide Evidence of Insurability?*

We require Evidence of Insurability, satisfactory to Us, for initial coverage, if You:

- 1) enroll more than 31 days after the date You are first eligible to enroll, including electing initial coverage after a Change in Family Status
- 2) enroll for an Amount of Life Insurance greater than the Guaranteed Issue Amount, regardless of when You enroll for coverage; or
- 3) were eligible for any coverage under the Prior Policy, but did not enroll during the eligibility period and later choose to enroll for coverage under this Certificate.

If Your Evidence of Insurability is not satisfactory to Us:

- 1) Your Amount of Life Insurance will equal the amount for which You were eligible without providing Evidence of Insurability, provided You enrolled within 31 days of the date You were first eligible to enroll; and
- 2) You will not be covered under this Certificate if You enrolled more than 31 days after the date You were first eligible to enroll.

**Dependent Evidence of Insurability Requirements:**  
*When will my Dependents first be required to provide Evidence of Insurability?*

If Dependent coverage is shown as included in the Schedule of Benefits, We require Evidence of Insurability, satisfactory to Us, for initial coverage, if You:

- 1) enroll for Your Dependents' coverage more than 31 days after the date You are first eligible to enroll, including electing initial coverage after a Change in Family Status
- 2) enroll for an amount of Dependent Life Benefit that exceeds our underwriting guidelines for Dependent coverage, regardless of when You enroll for coverage; or
- 3) were eligible for any coverage under the Prior Policy, but did not enroll and later choose to enroll for that coverage under this Certificate

If Your Dependents' Evidence of Insurability is not satisfactory to Us:

- 1) Your Dependents' Amount of Life Insurance will equal the amount for which Your Dependents were eligible without providing Evidence of Insurability, provided You enrolled within 31 days of the date You were first eligible to enroll; or
- 2) Your Dependents will not be covered under this Certificate if You enrolled more than 31 days after the date You were first eligible to enroll.

**Evidence of Insurability:**  
*What is Evidence of Insurability?*

Evidence of Insurability must be satisfactory to Us and may include, but will not be limited to:

- 1) a completed and signed application approved by Us; and
- 2) a medical examination
- 3) attending Physician's statement
- 4) any additional information We may require

All Evidence of Insurability will be furnished at Your expense. We will then determine if You or Your Dependents are insurable for initial coverage or an increase in coverage under this Certificate.

You will be notified in writing of Our determination of any Evidence of Insurability submission.

**Change in Family Status:**  
*What constitutes a Change in Family Status?*

A Change in Family Status occurs when:

- 1) You get married or You execute a domestic partner affidavit;
- 2) You and Your Spouse divorce or terminate a domestic partnership;
- 3) Your child is born or You adopt or become the legal guardian of a child;
- 4) Your Spouse or domestic partner dies;
- 5) Your child is no longer financially dependent on You or dies;
- 6) Your Spouse is no longer employed, which results in a loss of group insurance; or
- 7) You have a change in classification from part-time to full-time or from full-time to part-time.

## PERIOD OF COVERAGE

**Effective Date:**  
*When does my coverage start?*

If You are not required to contribute toward this Certificate's cost, Your coverage will start:

- 1) for benefit amounts not requiring Evidence of Insurability, on the first of the month coincident with or immediately following the date You become eligible; or
- 2) for benefit amounts requiring Evidence of Insurability, on first of the month coincident with or immediately following the date We approve it.

If You must contribute toward this Certificate's cost, Your coverage will start on the earliest of:

- 1) the date You become eligible, for benefit amounts not requiring Evidence of Insurability, if You enroll or have enrolled by then;
- 2) the date on which You enroll, for benefit amounts not requiring Evidence of Insurability, if You do so within 31 days after the date You are eligible;
- 3) the first day of the month on or immediately following the last day of the Annual Enrollment Period, if You enroll during an Annual Enrollment Period, for benefit amounts not requiring Evidence of Insurability;
- 4) the date We approve Your Evidence of Insurability, for benefit amounts requiring Evidence of Insurability, if You are then eligible for coverage; or
- 5) the date You become eligible, if We have approved Your Evidence of Insurability, for benefit amounts requiring Evidence of Insurability.

**Deferred Effective Date:** *Will my coverage start or an increase in my coverage take effect if I am not Actively at Work on the date my coverage is to start or increase?*

If You are absent from work due to:

- 1) accidental bodily injury;
- 2) Sickness;
- 3) Mental Illness;
- 4) Substance Abuse; or
- 5) pregnancy;

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

If Retiree coverage is shown as included in the Schedule of Benefits; and if, on the date You are to become covered through an eligible class shown on the Schedule of Benefits;

- 1) for increased benefits; or
- 2) for a new benefit;

You are:

- 1) confined in a hospital; or
- 2) Confined Elsewhere;

such coverage will not start until You

- 1) are discharged from the hospital; or
- 2) are no longer confined elsewhere;

and have engaged in all the normal and customary activities of a person of like age and gender, in good health for at least 15 consecutive days.

**Confined Elsewhere** means You are unable to perform, unaided, the normal functions of daily living, or leave

home or other place of residence without assistance.

**Continuity from a Prior Policy:**

*Is there continuity of coverage from a Prior Policy?*

*(If Retiree coverage is shown as included in the Schedule of Benefits, this provision is Not Applicable To Retirees)*

Your initial coverage under this Certificate will begin, and will not be deferred, if on the day before this Certificate Effective Date, You were insured under the Prior Policy, but on this Certificate Effective Date You were not Actively at Work, and would otherwise meet the Eligibility requirements of this Certificate. However, Your benefits under this Certificate will be the lesser of the Amount of Life Insurance, including accidental death and dismemberment benefits:

- 1) You had under the Prior Policy; or
- 2) shown in the Schedule of Benefits;

reduced by any coverage amount:

- 1) that is in force, paid or payable under the Prior Policy; or
- 2) that would have been so payable under the Prior Policy had timely election been made.

Such amount of insurance under this provision is subject to any reductions in this Certificate and will not increase.

Coverage provided through this provision ends on the first to occur of:

- 1) the last day of a period of 12 consecutive months after this Certificate Effective Date;
- 2) the date Your insurance terminates for any reason shown under the Termination provision;
- 3) the last day You would have been covered under the Prior Policy, had the Prior Policy not terminated;
- 4) the date You are Actively at Work.

However, if the coverage provided through this provision ends because You are Actively at Work, You may be covered as an Active Employee under this Certificate.

**Dependent Effective Date:**

*When does Dependent coverage start?*

Non-Contributory Coverage for Dependents, for which Evidence of Insurability is not required, will start on the date You become eligible for Dependent coverage.

Contributory Coverage, for which Evidence of Insurability is not required will start on the latest to occur of:

- 1) the first day of the month coincident with or immediately following the date You become eligible for Dependent coverage, if You have enrolled on or before that date; or
- 2) the first day of the month on or immediately following the last day of the Annual Enrollment Period, if You enroll during an Annual Enrollment Period; or
- 3) the date You enroll, if You do so within 31 days from the date You are eligible for Dependent coverage.

Coverage for which Evidence of Insurability is required, will become effective on the later of:

- 1) the first day of the month coincident with or immediately following the date You become eligible for Dependent coverage; or
- 2) the date We approve Your Dependents' Evidence of Insurability

In no event will Dependent coverage become effective before You become insured.

**Dependent Deferred Effective Date:**

*When will the effective date for Dependent Coverage or a change in coverage be deferred?*

If Dependent coverage is shown as included in the Schedule of Benefits, and if on the date Your Dependent is to become covered:

- 1) under this Certificate;
- 2) for increased benefits; or
- 3) for a new benefit;

he or she is:

- 1) confined in a hospital; or
- 2) Confined Elsewhere;

such coverage will not start until he or she:

- 1) is discharged from the hospital; or
- 2) is no longer Confined Elsewhere;

and has engaged in all the normal and customary activities of a person of like age and gender, in good health, for at least 15 consecutive days.

This Deferred Effective Date provision will not apply to disabled children who qualify under the definition of Dependent Children.

**Confined Elsewhere** means Your Dependent is unable to perform, unaided, the normal functions of daily living, or leave home or other place of residence without assistance.

**Dependent  
Continuity from a  
Prior Policy:**

*Is there continuity  
of coverage from  
a Prior Policy for  
my Dependents?*

If Dependent coverage is shown as included in the Schedule of Benefits, and if on the day before this Certificate Effective Date, You were covered with respect to Your Dependents under the Prior Policy, the Deferred Effective Date provision will not apply to initial coverage under this Certificate for such Dependents. However, the Dependent Amount of Insurance will be the lesser of the amount of life insurance:

- 1) they had under the Prior Policy; or
- 2) shown in the Schedule of Benefits;

reduced by any coverage amount:

- 1) that is in force, paid or payable under the Prior Policy; or
- 2) that would have been so payable under the Prior Policy had timely election been made.

## CHANGES IN COVERAGE

**Change in  
Coverage:**

*When may I  
change my  
coverage or  
coverage for my  
Dependents?*

After Your initial enrollment You may increase or decrease coverage for You or Your Dependents or add a new Dependent to Your existing Dependent coverage:

- 1) during any annual enrollment period designated by the Policyholder; or
- 2) within 31 days of the date of a Change in Family Status.

**Effective Date for  
Changes in  
Coverage:**

*When will changes  
in coverage  
become effective?*

Any decrease in coverage will take effect on the first day of the month coincident with or immediately following the date the change is requested.

Any increase in coverage will take effect on the latest of:

- 1) the first day of the month coincident with or immediately following the date a change is requested;
- 2) the date requirements of the Deferred Effective Date provision are met; and
- 3) the date Evidence of Insurability is approved, if required.

**Evidence of  
Insurability due  
to Increases in  
Salary:**

*If any of my  
coverage's is a  
multiple of my  
Salary, and the  
coverage  
increases because  
my Salary  
increases, must I  
provide Evidence  
of Insurability?*

If the Basic Life Benefit and/or Voluntary Life Benefit are based on a multiple of Your Salary, You must provide Evidence of Insurability if Your Salary increases such that Your benefit would be greater than the Guaranteed Issue Amount.

Additionally, once approved, We require Evidence of Insurability again if Your Voluntary Life Benefit:

- 1) is greater than the Guaranteed Issue Amount; and
- 2) would increase solely because Your Salary increased more than \$25,000
  - a) during the last 12 consecutive month period: or
  - b) since Your Evidence of Insurability was last approved:

whichever occurs most recently

In any case, if:

- 1) You do not submit Evidence of Insurability; or
- 2) Your Evidence of Insurability is not satisfactory to Us,

Your Basic Life Benefit and/or Voluntary Life Benefit:

- 1) will increase, but only up to the amount for which You were eligible without having to provide Evidence of Insurability; and
- 2) will not increase again, or beyond that amount, until Your Evidence of Insurability is approved.

## TERMINATION OF COVERAGE

**Termination:**  
*When will my  
coverage end?*

Your coverage and that of any Dependents will end on the earliest of the following:

- 1) the date this Certificate terminates;
- 2) the date You are no longer in a class eligible for coverage, or the class is cancelled;

- 3) the date the required premium is due but not paid, subject to the grace period;
- 4) the date You or Your Employer terminates Your employment;
- 5) the date You are no longer Actively at Work;

unless continued in accordance with the Continuation Provisions or Waiver of Premium provision.

**Reinstatement:**

*Can my coverage be reinstated after it ends?*

If:

- 1) Your coverage ends because You are no longer employed by the Employer or no longer in an Eligible Class; and
- 2) You are rehired or return to an Eligible Class within 12 months of the date Your coverage ended;

then coverage for You and Your previously covered Dependents may be reinstated, provided You request such reinstatement within 31 days of the date You return to work or to an Eligible Class.

The reinstated coverage will:

- 1) be the same coverage amounts in force on the date coverage terminated; and
- 2) not be subject to any Waiting Period for Coverage, Evidence of Insurability or Pre-existing Conditions Limitations; and
- 3) be subject to all the terms and provisions of this Certificate.

We will not reinstate any amount of coverage which You or Your Dependent:

- 1) converted in accordance with the Conversion clause; or
- 2) continued under the Portability Provision;

unless You cancel such coverage.

**Reinstatement after Military Service:**

*Can my coverage be reinstated after return from active military service?*

If:

- 1) Your coverage terminates because You enter active military service; and
- 2) You are rehired within 12 months of the date Your coverage terminated;

then coverage for You and Your previously covered Dependents (if Dependent coverage is shown in the Schedule of Benefits) may be reinstated, provided you request such reinstatement within 31 days of the date You return to work.

The reinstated coverage will:

- 1) be the same coverage amounts in force on the date coverage terminated; and
- 2) not be subject to any Waiting Period for Coverage, Evidence of Insurability or Pre-existing Conditions Limitations; and
- 3) be subject to all the terms and provisions of this Certificate.

**Dependents Termination:**

*When does coverage for my Dependents end?*

If Dependent coverage is shown as included in the Schedule of Benefits, Coverage for Your Dependents will end on the earliest to occur of the following, unless continued in accordance with the Continuation provision:

- 1) the date Your coverage ends;
- 2) the date the required premium is due but not paid subject to the grace period;
- 3) the date You are no longer eligible for Dependent's coverage;
- 4) the date We or the Employer terminate Dependent's coverage;
- 5) the date the Dependent no longer meets the definition of Dependent.

**Retiree Coverage Termination:**

*When will my Retiree Coverage end?*

If Retiree coverage is shown as included in the Schedule of Benefits, Your coverage will end on the earliest of the following:

- 1) the date this Certificate terminates;
- 2) the date You are no longer in a class eligible for coverage, or the class is cancelled; or
- 3) the date the required premium is due but not paid.

## CONTINUATION PROVISIONS

**Continuation:**  
*Can my coverage and my Dependent's coverage be continued beyond the date it would otherwise terminate?*

Coverage under this Certificate may be continued in the events described below, or any other events which might be included through Amendatory Endorsements attached to this Certificate. Such continuation is at Your Employer's option, beyond a date shown in the Termination provision, and provided Your Employer offers a plan of continuation which applies to all employees the same way. The amount of continued coverage applicable to You or Your Dependents will be the amount of coverage in effect on the date immediately before coverage would otherwise have ended. Continued coverage:

- 1) is subject to any reductions in this Certificate;
- 2) is subject to payment of premium;
- 3) may be continued up to the maximum time shown in the provisions; and
- 4) terminates if this Certificate terminates.

In no event will the amount of insurance increase while coverage is continued in accordance with these provisions.

In all other respects, the terms of Your and Your Dependents' coverage remain unchanged.

Sickness or Injury: If You are not Actively at Work due to sickness or injury, all of Your coverage including Dependent Life coverage may be continued:

- 1) for a period of twelve consecutive months from the date You were last Actively at Work; or
- 2) if such absence results in a leave of absence in accordance with state and/or federal family and medical leave laws, then the combined continuation period will not exceed twelve consecutive months.

Family and Medical Leave (applies to employers with 50+ employees): If You are granted a leave of absence, in writing, according to the Family and Medical Leave Act of 1993, or other applicable state or local law, Your coverage may be continued for up to 12 weeks if required by other applicable law, following the date Your leave commenced. If the leave of absence ends prior to the agreed upon date, this continuation will cease immediately.

**Continuation for Dependent Child(ren) with Disabilities:**  
*Will coverage for Dependent Children with Disabilities be continued?*

If Dependent coverage is shown as included in the Schedule of Benefits, and if Your Dependent child(ren) reach the age at which they would otherwise cease to be a Dependent as defined, and they are:

- 1) age 26 or older; and
- 2) disabled; and
- 3) primarily dependent upon You for financial support;

then dependent child(ren) coverage will not terminate solely due to age. However:

- 1) You must submit proof satisfactory to Us of such dependent child(ren) 's disability within 31 days of the date he or she reaches such age; and
- 2) such dependent child(ren) must have become disabled before attaining age 26.

Coverage under this Certificate will continue as long as:

- 1) You remain insured;
- 2) the child continues to meet the required conditions; and
- 3) any required premium is paid when due.

However, no increase in coverage for such dependent children will be available.

We have the right to require proof, satisfactory to Us, as often as necessary during the first two years of continuation, that the child continues to meet these conditions. We will not require proof more often than once a year after that.

## WAIVER OF PREMIUM

**Waiver of Premium:**

*Does coverage continue if I am Disabled?*

Waiver of Premium is a provision which allows You to continue Your (and Your Dependent's Life Insurance coverage, if included) without paying premium, while You are Disabled and qualify for Waiver of Premium.

To qualify for Waiver of Premium, You must be Disabled prior to age 60. If You qualify for Waiver of Premium, Your coverage will be continued while You are Disabled without payment of premium until You reach Your Normal Retirement Age.

If You qualify for Waiver of Premium, the amount of continued coverage:

- 1) will be the amount in force on the date You cease to be an Active Employee;
- 2) will be subject to any reductions provided by this Certificate; and
- 3) will not increase.

**Eligible Benefits for Waiver of Premium:**

*What benefits are eligible under Waiver of Premium??*

The Waiver of Premium provision applies only to:

- 1) Your Basic Life Benefit
- 2) Your Voluntary Life Benefit
- 3) Dependent Life Benefit (If included in Schedule of Benefits.)
- 4) Voluntary Dependent Life Benefit (If included in the Schedule of Benefits.)

This provision does not apply to:

- 1) Retirees; (Even if included in Schedule of Benefits.)
- 2) Any Accidental Death and Dismemberment benefits.

You may not apply for both Portability and this Waiver of Premium provision for the same Voluntary Life Benefit.

**Conditions for Qualification for Waiver of Premium:**

*What conditions must I satisfy before I qualify for Waiver of Premium?*

To qualify for Waiver of Premium You must:

- 1) be covered under this Certificate and be under age 60;
- 2) be Disabled and provide Proof of Loss that You have been Disabled for 9 consecutive months, starting on the date You were last Actively at Work; and
- 3) provide such proof within one year of Your last day of work as an Active Employee.

In any event, You must have been Actively at Work under this Certificate to qualify for Waiver of Premium.

**When Premiums are Waived:**

*When will premiums be waived?*

If We approve Waiver of Premium, We will notify You of the date We will begin to waive premium. In any case, We will not waive premiums for the first 9 months You are Disabled. We have the right to:

- 1) require Proof of Loss that You are Disabled; and
- 2) have You examined at reasonable intervals during the first 2 years after receiving initial Proof of Loss, but not more than once a year after that.

If You fail to submit any required Proof of Loss or refuse to be examined as required by Us, then Waiver of Premium will cease, and you will have to continue to pay premiums.

However, if We deny Waiver of Premium, You may be eligible to:

- 1) continue coverage under the Portability Benefit if available according to the Schedule of Benefits; or
- 2) convert coverage in accordance with the Conversion clause;

for You and Your Dependents, if Dependent coverage is included in the Schedule of Benefits.

If You return to work for a total of 5 days or less during the first 9 months that You are Disabled, the 9 month waiting period will not be interrupted. Except for the 5 days or less that You worked, You must be Disabled by the same condition for the total 9 month period. If You return to work for more than 5 days, You will have to satisfy a new 9 months waiting period to qualify for a Waiver of Premium.

**Benefit Payable before Approval of Waiver of Premium:**

If You or Your Dependent (if included in the Schedule of Benefits) die within one year of Your last day of work as an Active Employee, but before You qualify for the Waiver of Premium, We will pay the Life Insurance Benefit which is in force for the deceased person provided:

- 1) You were continuously Disabled;



*What if I die or my Dependent dies before I qualify for Waiver of Premium?*

- 2) the Disability lasted or would have lasted 9 months or more; and
- 3) premiums had been paid for coverage.

**Waiver Ceases:**  
*When will Waiver of Premium cease?*

We will waive premium payments and continue Your coverage, while You remain Disabled, until the earliest of:

- 1) the date You attain age "Normal Retirement Age" if Disabled prior to age 60; or
- 2) the date you cease to be totally disabled.

We will waive premium payments for Your Dependent Life Insurance (if included in Schedule of Benefits) and continue such coverage, while You remain Disabled, until the earliest of the date:

- 1) You die;
- 2) You no longer qualify for Waiver of Premium;
- 3) this Certificate or any benefit of this Certificate subject to a Waiver of Premium terminates;
- 4) Your Dependents are no longer in an Eligible Class; or Dependent coverage is no longer offered; or
- 5) Your Dependents no longer meets the definition of Dependent.

*What happens when Waiver of Premium ceases?*

When the Waiver of Premium ceases:

- 1) if You return to work in an Eligible Class, as an Active Employee, then You may again be eligible for coverage for Yourself and Your Dependents as long as premiums are paid when due; or
- 2) if You do not return to work in an Eligible Class, coverage will end and You may be eligible to exercise the Conversion right for You and Your Dependents, if You do so within the time limits described in such provision. The amount of coverage that may be converted will be subject to the terms and conditions of the Conversion clause. Portability coverage will not be available.

**Effect of Certificate Termination:**  
*What happens to the Waiver of Premium if This Certificate terminates?*

If this Certificate terminates while You are in the process of applying for Waiver of Premium:

- 1) You may be eligible to exercise the Conversion Right, provided You do so within the time limits described in such provision; or
- 2) You may still be approved for Waiver of Premium if You qualify.

If this Certificate terminates after You qualify for Waiver of Premium:

- 1) Your Dependent coverage will terminate; and
- 2) Your coverage under the terms of this provision will not be affected.

## LIFE INSURANCE BENEFIT

**Life Insurance Benefit:**  
*When is the Life Insurance Benefit payable?*

If You (or Your Dependents, if Dependent coverage is included in the Schedule of Benefits) die while covered under this Certificate, We will pay all of the deceased person's coverages that are applicable according to the corresponding Schedule(s) of Benefits (together referred to as "Life Insurance Benefit") in a lump sum, after We receive Proof of Loss in accordance with the Proof of Loss provision.

The applicable Life Insurance Benefit will be paid according to the general provisions of this Certificate that apply to each individual coverage, and will be subject to any reductions applicable because of age.

**Suicide:**  
*What benefit is payable if death is a result of suicide?*

If You (or Your Dependent, if Dependent coverage is included in the Schedule of Benefits) commit suicide while sane or insane within the first 2 years from the effective date of this Certificate, We will not pay any Life Insurance Benefit for the deceased person. This applies to initial coverage and elected increases in coverage. If after the first 2 years from the effective date of this Certificate, You (or Your Dependent) commit suicide while sane or insane within 2 years after You elected an increase in coverage, we will pay the Life Insurance Benefit that applied before the increase became effective. This will not apply to benefit increases that resulted solely due to an increase in Salary.

This 2 year period includes the time group life insurance coverage was in force under the Prior Policy, if any.

## ACCELERATED BENEFIT

**Any accelerated benefit received under this section may be taxable. You should consult a personal Tax Advisor for further information.**

**Accelerated Benefit:**

*What is the benefit?  
(This benefit is not available for Retirees.)*

In the event that You are diagnosed as Terminally Ill while covered under this Certificate for a Basic Life Benefit or Voluntary Life Benefit of at least \$10,000, We will pay an Accelerated Benefit amount under this clause, provided We receive proof of such Terminal Illness. The Accelerated Benefit will be a portion of Your Basic Life Benefit or Your Voluntary Life Benefit, according to Your Schedule of Benefits for each coverage. This Accelerated Benefit is not available for Retirees.

The Accelerated Benefit will be effective for claims related to accidents on the day You become covered under this Certificate, and for claims related to injury, 30 days after the date You become covered under this Certificate.

You must request in writing that a portion of Your Basic Life Benefit or Voluntary Life Benefit, as applicable, be paid as an Accelerated Benefit. If You are covered for both, a Basic Life Benefit and Voluntary Life Benefit, You may claim Your Accelerated Benefit against either coverage or both, but must specify against which specific coverage you are requesting the Accelerated Benefit to be paid from. If You have any Accidental Death and Dismemberment coverage, your claim for an Accelerated Benefit under this clause will not affect that coverage, as long as the corresponding premiums are paid.

The Life Insurance Benefit payable upon Your death will be reduced by any Accelerated Benefit amount paid under this clause. In addition, Your remaining Life Insurance Benefit will be subject to any reductions that would apply under this Certificate at the time of Your death. Once an Accelerated Benefit has been paid, You will not be able to increase any coverage under this Certificate.

You may request a minimum Accelerated Benefit amount of \$5,000. The Accelerated Benefit may not exceed an amount equal to 50% of Your Basic Life Benefit or Voluntary Life Benefit, as they appear on Your Schedule of Benefits, and may never be greater than \$125,000 for each coverage. You can claim an Accelerated Benefit only once during Your lifetime.

For example, if You are covered with a Basic Life Benefit of \$100,000 and are Terminally Ill, You can request any portion of the Basic Life Benefit from \$5,000 - \$50,000 to be paid now to You instead of to Your beneficiary upon death. However, if You decide to request only \$10,000 now, You cannot request the additional \$40,000 in the future. The same applies for any Accelerated Benefit over a Voluntary Life Benefit. Also, if you have both, a Basic Life Benefit and a Voluntary Life Benefit against which You can claim an Accelerated Benefit from, and you chose to claim your Accelerated Benefit against the Basic Life Benefit only, then you will not be able to claim an Accelerated Benefit against the Voluntary Life Benefit in the future, and vice versa.

In the event:

- 1) You are required by law to accelerate benefits to meet the claims of creditors; or
- 2) if a government agency requires You to apply for benefits to qualify for a government benefit or entitlement;

You will still be required to satisfy all the terms and conditions herein in order to receive an Accelerated Benefit.

If You have executed an Assignment of rights and interest with respect to Your Life Insurance Benefit or any particular coverage under this Certificate, in order to receive the Accelerated Benefit, We must receive a release from the assignee before any benefits are payable.

**Proof of Terminal Illness and Examinations:**

*Must proof of*

We reserve the right to require satisfactory Proof of Terminal Illness. Any diagnosis submitted must be provided by a Physician.

If You do not submit proof of Terminal Illness satisfactory to Us, or if You refuse to be examined by a Physician,

*Terminal Illness be submitted?* as We may require, then We will not pay an Accelerated Benefit.

**No Longer**

**Terminally Ill:**

*What happens to my coverage if I am no longer Terminally Ill [or my Dependent is no longer Terminally Ill?]*

If You are diagnosed by a Physician as no longer Terminally Ill, and an Accelerated Benefit has already been paid to You, You will not have to reimburse the paid benefit. However, once You are no longer Terminally Ill, the Life Insurance Benefit payable upon Your death will be reduced by the Accelerated Benefit paid and any applicable reductions for reasons of age.

## CONVERSION

**Conversion Right:**

*If coverage under this Certificate ends, do I have a right to convert?*

If Life Insurance coverage or any portion of it under this Certificate ends because You terminate employment with the Employer or You cease to be a member in an Eligible Class, You (and Your Dependents, if included in the Schedule of Benefits) have the right to convert the coverage that terminated to an individual conversion policy without providing Evidence of Insurability. Conversion is not available for:

- 1) any Accidental Death and Dismemberment benefit; or
- 2) any specific life benefit for which You or Your Dependents were not eligible or not covered under this Certificate.

The benefit amount of the individual policy will not be less than \$1,000 nor exceed the benefit amounts from the Certificate which existed on the date of the event.

If coverage under this Certificate ends because:

- 1) The Policy or this Certificate is terminated ; or
- 2) Coverage for an Eligible Class is terminated;

then You or Your Dependent must have been insured under this Certificate for 5 years in order to be eligible to convert coverage. The amount which may be converted under these circumstances is limited to the lesser of:

- 1) \$2,000; or
- 2) the amount of coverage convertible under this Certificate less any Amount of Life Insurance for which You or Your Dependent may become eligible under any group life insurance policy issued or reinstated within 31 days of termination of group life coverage.

If coverage under this Certificate ends for any other reason, the full amount of convertible coverage which ended may be converted.

**Electing**

**Conversion:**

*How do I convert my coverage or my Dependents' coverage?*

To convert Your coverage or coverage for Your Dependents, You must:

- 1) complete a Notice of Conversion Right form; and
- 2) We must receive the form within 31 days after this Certificate terminates.

After the Insurer verifies eligibility for coverage, the Insurer will send You a Conversion Policy application packet. You must:

- 1) complete and return the application packet; and
- 2) pay the required premium for coverage;

within the time period specified in the packet.

Any individual policy issued to You or Your Dependents under the Conversion clause:

- 1) will be effective as of the 32<sup>nd</sup> day after the date coverage ends; and
- 2) will be in lieu of coverage under this Certificate.

**Conversion Policy Provisions:**

*What will a Conversion policy be like?*

The Conversion Policy will:

- 1) be issued on one of the individual life insurance policy forms the Insurer is issuing for this purpose at the time of conversion;
- 2) base premiums on the Insurer's rates in effect for new applicants of Your class and age at the time of

conversion; and

- 3) provide whole life insurance.

The Conversion Policy will not provide:

- 1) the same terms and conditions of coverage as this Certificate;
- 2) any benefit other than life insurance benefit; and
- 3) term life insurance.

However, Conversion is not available for any amount of life benefit which was, or is being, continued:

- 1) in accordance with the Waiver of Premium provision; or
- 2) under a Portability certificate, as described in the Portability clause of this Certificate; or
- 3) in accordance with the Continuation Provisions;

until such coverage ends.

**Death within the Conversion**

*Period: What if I or my Dependents die before coverage is converted?*

We will pay the deceased person's Life Insurance Benefit You would have had the right to apply for under the Conversion provision if :

- 1) coverage under this Certificate terminates; and
- 2) You (or Your Dependent) die within 31 days of the date coverage terminates; and
- 3) We receive Proof of Loss.

If the Conversion Policy has already taken effect, no Life Insurance Benefit will be payable under this Certificate for the amount converted.

**Effect of Waiver of Premium on Conversion:**

*What happens to the Conversion Policy if Waiver of Premium is later approved?*

If You apply and are approved for a Waiver of Premium after an individual Conversion policy has been issued, any benefit payable at Your (or Your Dependent's) death under this Certificate will be paid only if the individual Conversion policy is surrendered.

## ARTICLE II VOLUNTARY GROUP TERM LIFE PROVISIONS

This Article II applies only to the coverages shown as included in the Voluntary Group Term Life Schedule of Benefits, if any such Schedule is attached to this Certificate.

### SPECIAL CONDITIONS

**Evidence of Insurability for Voluntary Coverages:**

*When will I have to provide Evidence of Insurability for coverage under the Voluntary Group Term Life benefits?*

If You do not enroll (or do not enroll a Dependent, if Dependent coverage is available) for any of the benefits available to You under the Voluntary Group Term Life coverage during the first time You become eligible to enroll ("initial enrollment"), then You and Your Dependent must provide Evidence of Insurability for any benefit for which you request enrollment at a later date.

After initial enrollment, You and Your Dependents must provide Evidence of Insurability for any increase that You request in any benefit under the Voluntary Group Term Life coverage under this Certificate.

In any event, if the amount of any benefit that You request is greater than the Guaranteed Issue Amount, You or Your Dependents, as applicable, must provide Evidence of Insurability.

If Your Evidence of Insurability is not satisfactory to Us, the coverage's that You had in effect on the date immediately prior to the date You requested the increase will not change.

If Your Dependents' Evidence of Insurability is not satisfactory to Us, the coverage's he or she had in effect on

the date immediately prior to the date You requested the increase will not change.

**Limitations in Changes in Coverage:** *Will I have any limitations when electing or changing voluntary benefits?*

Under Voluntary Group Term Life, You may have different coverage options available to You (and Your Dependents, if Dependent coverage is available), like the Voluntary Life Benefit, the Voluntary AD&D Benefit, Voluntary Dependent Life Benefit, and the Spouse AD&D Benefit. If You have more than one option, You must choose coverage for the Voluntary Life Benefit before You can choose any of the other available coverages, which will be additional to the Voluntary Life Benefit. You will not be able to choose an additional coverage to the Voluntary Life Benefit for an amount that would exceed the amount You choose for the Voluntary Life Benefit. Each option will have a minimum and a maximum limit established by the Employer and The Company.

## PORTABILITY

This Portability section only applies to You if the Portability Benefit is shown as included in the Voluntary Group Term Life Schedule of Benefits.

**Portability:** *What is Portability?*

Portability is a form of continuation of Your Voluntary Life Benefit when such benefit would otherwise terminate in connection with a Qualifying Event. The Voluntary Life Benefit that You would carry would be at a lower premium than with Conversion, because it would be a continuation of that part of Your Voluntary Group Term Life coverage.

Portability applies to Your Voluntary Life Benefit only. Portability does not apply to any of the other coverages that could be included in Your Voluntary Group Term Life Schedule of Benefits, such as the Voluntary Accidental Life and Dismemberment Benefit, nor any Voluntary Dependent Life benefit, nor the Spouse Accidental Death and Dismemberment benefit.

To carry Your Voluntary Life Benefit beyond a Qualifying Event, such event has to occur before Your Normal Retirement Age, and You have to apply for the benefit as stated in this section. If Your Portability application is approved, you will be issued a Portability Group Term Life Certificate.

The Employer must keep the Voluntary Group Term Life coverage and the Portability Benefit in force for Your Eligible Class, for You to be able to apply for Portability, or to continue to benefit from an already issued Portability certificate. If the Employer terminates the Voluntary Group Term Life coverage or the Portability Benefit for Your Eligible Class once that a Portability certificate has been issued, You will have a right to conversion according to the terms of the Portability certificate.

**Qualifying Events:** *What are Qualifying Events for Portability?*

Qualifying Events for You are:

- 1) Your employment terminates, for reasons other than retirement, sickness or injury; or
- 2) Your membership in an Eligible Class under this Certificate ends; or
- 3) You are denied Waiver of Premium solely because You do not meet the definition of Disabled, and You are not otherwise eligible to continue Voluntary Group Term Life coverage;

provided the Qualifying Event occurs prior to Your Normal Retirement Age.

**Electing Portability** *How do I elect Portability?*

You may elect Portability for Your coverage after Your Voluntary Life Benefit ends because You had a Qualifying Event.

To elect Portability, You must:

- 1) complete and sign a Portability application; and
- 2) submit the application to Us with the required premium within 31 days after this Certificate terminates.

After We verify eligibility for coverage, We will issue a Portability Group Term Life Certificate that provides insurance through the group Policy. The Portability coverage will be:

- 1) Issued without Evidence of Insurability; and
- 2) Be effective on the day following the date Your coverage ends.

The terms and conditions of coverage under the Portability certificate will not be the same terms and

conditions that are applicable to the Voluntary Life Benefit under this Certificate.

**Limitations:**

*What limitations apply to Portability?*

You may elect to carry 50%, 75% or 100% of the Voluntary Life Benefit which is ending for You because of the Qualifying Event. This amount will be rounded to the next higher multiple of \$1,000, if not already a multiple of \$1,000. However, the Voluntary Life Benefit that may be ported will not exceed \$250,000.

If You elect to continue 50% or 75% of Your Voluntary Life Benefit now, You will not be able to increase it to 100% at a later date. In no event will You be able to carry a Voluntary Life Benefit which is less than \$5,000.

Portability is not available for any Voluntary Life Benefit for which You were not eligible or covered at the date of the Qualifying Event.

In addition, Portability is not available if You are entering active military service.

Portability is not available for Retiree coverage.

**Effect of**

**Portability on**

**other Provisions:**

*How does*

*Portability affect*

*other provisions of*

*this Certificate?*

Portability is not available for any Voluntary Life Benefit which was, or is being, continued in accordance with:

- 1) The Conversion clause;
- 2) The Waiver of Premium provision; or
- 3) The Continuation Provisions;

Under this Certificate. However, if:

- 1) You elect to continue only a portion of terminated coverage under this Portability provision: or
- 2) the Voluntary Life Benefit exceeds the maximum Portability amount;

then the Conversion Right may be available for the remaining amount.

The Waiver of Premium provision will not be available if You elect to continue coverage under this Portability provision.

## **ARTICLE III ACCIDENTAL DEATH AND DISMEMBERMENT**

This Article III applies only if any Accidental Death and Dismemberment coverage is shown as included in the Group Term Life Schedule of Benefits or the Voluntary Group Term Life Schedule of Benefits. If You have a Basic Accidental Death and Dismemberment Benefit (according to Your Group Term Life Schedule of Benefits), a Voluntary Accidental Death and Dismemberment Benefit (according to Your Voluntary Group Term Life Schedule of Benefits), and/or a Spouse Accidental Death and Dismemberment Benefit (according to Your Voluntary Group Term Life Schedule of Benefits), this clause will apply to each of those coverages. The amount of each benefit, as it appears on its corresponding Schedule of Benefits, will constitute the "Principal Sum" for that benefit.

### **BENEFITS**

**Accidental Death and Dismemberment Benefit:**

*When is the Accidental Death and Dismemberment Benefit Payable?*

If You (or Your Spouse, if Spouse Accidental Death and Dismemberment benefits are shown as included in the Schedule of Benefits) sustain an Injury which results in any of the Losses described in the table below within 365 days from the date of an accident covered under this Certificate, We will pay all or a portion of the applicable Accidental Death and Dismemberment Benefit (Principal Sum) as shown on the table, after We receive Proof of Loss in accordance with the Proof of Loss provision.

Accidental Death and Dismemberment benefits will be paid subject to all of the other applicable provisions of this Certificate.

We will not pay more than the applicable Principal Sum to any one person, for all Losses due to the same accident. The applicable Principal Sum for any Accidental Death and Dismemberment Benefit is shown in the Schedule of Benefits.

**For Loss of:****We pay:**

Life	Principal Sum
Both Hands or Both Feet or Sight of Both Eyes	Principal Sum
One Hand and One Foot	Principal Sum
Speech and Hearing in Both Ears	Principal Sum
Either Hand or Foot and Sight of One Eye	Principal Sum
Movement of Both Upper and Lower Limbs (Quadriplegia)	Principal Sum
Movement of Both Lower Limbs (Paraplegia)	Three Quarters of Principal Sum
Movement of Three Limbs (Triplegia)	Three Quarters of Principal Sum
Movement of the Upper and Lower Limbs of one Side of the Body (Hemiplegia)	One Half of Principal Sum
Either Hand or Foot	One Half of Principal Sum
Sight of One Eye	One Half of Principal Sum
Speech or Hearing in Both Ears	One Half of Principal Sum
Movement of One Limb (Uniplegia)	One-Quarter of Principal Sum
Thumb and Index Finger of Either Hand	One-Quarter of Principal Sum

**Loss:** means with regard to:

- 1) hands and feet: actual severance through or above wrist or ankle joints;
- 2) sight, speech and hearing: entire and irrecoverable loss thereof;
- 3) thumb and index finger: actual severance through or above the metacarpophalangeal joints;
- 4) movement: complete and irreversible paralysis of such limbs.

**Exposure and****Disappearance:**

*What if Loss is due to exposure or disappearance?*

Exposure to the elements will be presumed to be Injury if:

- 1) it results from the forced landing, stranding, sinking or wrecking of a conveyance in which You were an occupant at the time of the accident; and
- 2) This Certificate would have covered an Injury resulting from the accident.

We will presume that You suffered Loss of life if:

- 1) the person's body has not been found within one year after the disappearance of a conveyance in which he or she was an occupant at the time of its disappearance;
- 2) the disappearance of the conveyance was due to its accidental forced landing, stranding, sinking or wrecking; and
- 3) The Certificate would have covered the Injury resulting from the accident.

**Seat Belt and Air Bag Benefit:**

*When is the Seat Belt and Air Bag Benefit payable?*

If You sustain an Injury that results in a Loss payable under an Accidental Death and Dismemberment Benefit, We will pay an additional Seat Belt and Air Bag Benefit if the Injury occurred while the injured person was:

- 1) a passenger riding in; or
  - 2) the licensed operator of;
- a properly registered Motor Vehicle and was wearing a Seat Belt at the time of the Accident as verified on the police accident report.

This Benefit will be paid:

- 1) after We receive Proof of Loss, in accordance with the Proof of Loss provision; and
- 2) according to the General Provisions of this Certificate.

If a Seat Belt Benefit is payable, We will also pay an Air Bag Benefit if the injured person was:

- 1) positioned in a seat equipped with a factory-installed Air Bag; and
- 2) properly strapped in the Seat Belt when the Air Bag inflated.

The Seat Belt Benefit is the lesser of:

- 1) an amount resulting from multiplying Principal Sum by the Seat Belt Benefit Percentage of 10%; or
- 2) the Maximum Amount of \$10,000 for this Benefit.

The Air Bag Benefit is the lesser of;

- 1) an amount resulting from multiplying the Principal Sum by the Air Bag Benefit Percentage of 5%; or
- 2) the Maximum Amount of \$5,000 for this Benefit.

If it cannot be determined that You were wearing a Seat Belt at the time of Accident, no Seat Belt Benefit will be payable.

**Accident**, for the purpose of this Benefit only, means the unintentional collision of a Motor Vehicle during which You were wearing a Seat Belt.

**Air Bag** means an inflatable voluntary passive restraint system installed by the manufacturer of the Motor Vehicle or its proper replacement parts installed as required by the Motor Vehicle's manufacturer's specification that inflates upon collision to protect an individual from Injury and death. An Air Bag is not considered a Seat Belt.

**Seat Belt** means:

- 1) an unaltered belt, lap restraint, or lap and shoulder restraint installed by the manufacturer of the Motor Vehicle, or proper replacement parts installed as required by the Motor Vehicle's manufacturer's specifications; or

The Seat Belt and Air Bag Benefit will not be payable if You were operating the Motor Vehicle at the time of Injury while:

- 1) Intoxicated; or
- 2) under the influence of narcotics, unless administered on the advice of a physician.

## EXCLUSIONS

**AD&D Exclusions:** This Certificate does not cover any loss caused or contributed by:

*What is not covered under Accidental Death & Dismemberment?*

- 1) intentionally self-inflicted Injury;
- 2) suicide or attempted suicide, whether sane or insane;
- 3) war or act of war, whether declared or not;
- 4) Injury sustained while on full-time active duty as a member of the armed forces (land, water, air) of any country or international authority;
- 5) Injury sustained under the influence of narcotics, unless administered on the advice of a physician;
- 6) Injury Sustained while riding or driving in a scheduled race or testing any Motor Vehicle on tracks, speedways or proving grounds.
- 7) Injury sustained while committing or attempting to commit a felony;
- 8) Injury sustained while Intoxicated; or
- 9) Injury sustained while driving while Intoxicated.

## ARTICLE IV ADDITIONAL GENERAL PROVISIONS

This Article IV applies generally to all of Your coverages under this Certificate.

**Notice of Claim:** You, or the person who has the right to claim benefits, must give Us, written notice of a claim within 30 days after:

*When should I notify the Company of a claim?*

- 1) the date of death; or
- 2) the date of loss.

If notice cannot be given within that time, it must be given as soon as reasonably possible after that. Such notice must include the claimant's name, address and this Certificate Number.

**Claim Forms:**  
*Are special forms required to file a claim?*

Within 15 days of receiving a Notice of Claim, We will send forms to the claimant to provide Proof of Loss. If We do not send the forms within 15 days any other written proof which fully describes the nature and extent of the claim may be submitted.

**Proof of Loss:**  
*What is Proof of Loss?*

Proof of Loss may include, but is not limited to, the following:

- 1) a completed claim form;
- 2) a certified copy of the death certificate (if applicable);
- 3) Your Enrollment form;
- 4) Your Beneficiary Designation (if applicable);



- 5) documentation of:
  - a) the date Your Disability began;
  - b) the cause of Your Disability;
  - c) the prognosis of Your Disability;
- 6) any and all medical information, including x-ray films and photocopies of medical records, including histories, physical, mental or diagnostic examinations and treatment notes;
- 7) the names and addresses of all:
  - a) Physicians or other qualified medical professionals You have consulted;
  - b) hospitals or other medical facilities in which You have been treated; and
  - c) pharmacies which have filled Your prescriptions within the past three years;
- 8) Your (or Your beneficiary's) signed authorization for Us to obtain and release medical, employment and financial information; or
- 9) Any additional information required by Us to adjudicate the claim.

All proof submitted must be satisfactory to Us.

**Sending Proof of Loss:** *When must Proof of Loss be given?*

Written Proof of Loss should be sent to Us;

- 1) with respect to the Life Insurance Benefits, within 365 days; and
- 2) with respect to the Accidental Death and Dismemberment Benefits, within 90 days;

after the loss. However, all claims should be submitted to Us within 90 days of the date coverage ends.

If proof is not given by the time it is due, it will not affect the claim if:

- 1) it was not possible to give proof within the required time; and
- 2) proof is given as soon as possible; but not later than 1 year after it is due unless You, or the person who has the right to claim benefits, are not legally competent.

**Physical Examination and Autopsy:** *Can We have a claimant examined or request an autopsy?*

While a claim is pending We have the right at Our expense:

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

**Claim Payment:** *When are benefit payments issued?*

When We determine that benefits are payable, We will pay the benefits due in accordance with the Claims to be Paid provision, but Life benefits will be paid not more than (60) days after such Proof of Loss is received.

**Claims to be Paid:** *To whom will benefits for my claim be paid?*

Any Life Insurance Benefit payable under this Certificate while You still live will be paid to You. Any Life Insurance Benefit payable because of Your death will be paid to the beneficiaries You name according to the Beneficiary Designation clause, unless otherwise expressly stated in any particular clause of this Certificate.

If no beneficiary is named, or if no named beneficiary survives You, We may, at Our option, pay:

- 1) the executors or administrators of Your estate; or
- 2) all to Your surviving Spouse; or
- 3) if there is no surviving Spouse, in equal shares to Your surviving Children; or
- 4) if there are no surviving Children, in equal shares to Your surviving parents; or
- 5) if there are no surviving parents, in equal shares to Your surviving siblings.

In addition, We may, at Our option, pay a portion of Your Life Insurance Benefit up to \$500 to any person equitably entitled to payment because of expenses from Your funeral or other expenses incident to Your last illness or death. Payment to any person, as shown above, will release Us from liability for the amount paid.

If a beneficiary or payee is a minor or a legally incompetent person, We must receive a letter of tutorship before we pay any benefits to that person through his/her tutor. If no letter of tutorship is submitted within 60 days from the submission of Proof of Loss, we may initiate a petition to a court in the State of Louisiana to appoint a tutor to the person for the purpose of receiving the Life Insurance Benefit payable under this Certificate, and/or consign the Life Insurance Benefit payable to the registry of the court. Such consignment will release the Company from all its liability under this Certificate.

If according to the above, any payment is owed to:

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

then We may pay up to \$500 to a person who is related to You and who, at Our sole discretion, is entitled to it. Any such payment shall fulfill Our responsibility for the amount paid.

**Beneficiary**

**Designation:** *How do I designate or change my beneficiary?*

You may designate or change a beneficiary by doing so in writing on a form satisfactory to Us and filing the form with Us. Only satisfactory forms, dully signed and dated by You, and received by Us prior to Your death will be accepted. We may have an arrangement with Your Employer to receive beneficiary designation forms from You on our behalf. In that case, the submission to Your Employer will be treated as if the form was provided to Us.

Beneficiary designations will become effective as of the date that the dully executed form is received by Us (or Your Employer if such arrangement exists). We will not be liable for any amounts paid before receiving notice of a beneficiary change from the Employer.

In no event may a beneficiary be changed by a Power of Attorney.

**Claim Denial:**

*What notification will my Beneficiary or I receive if a claim is denied?*

If a claim for benefits is wholly or partly denied, You or Your beneficiary will be furnished with written or electronic notification of the decision. This written or electronic notification will:

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

**Claim Appeal:**

*What recourse do my Beneficiary or I have if a claim is denied?*

On any claim, the claimant or his or her representative may appeal to Us for a full and fair review. To do so, he or she:

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

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

**Policy**

**Interpretation:**

*Who interprets policy terms and conditions?*

We have full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of this Certificate and The Policy.

**Incontestability:**

*When can this Certificate be contested?*

Except for non-payment of premiums, Your or Your Dependents' Life Insurance Benefit cannot be contested after two years from its effective date. This provision does not apply to the Accidental Death and Dismemberment benefits.

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

No statement made relating to Your Dependents being insurable will be used to contest their insurance for which the statement was made after their insurance has been in force for two years during the Dependent's lifetime. In order to be used, the statement must be in writing and signed by You or Your representative.

**Assignment:**  
*Are there any rights of assignment?*

Except for the dismemberment benefits under the Accidental Death and Dismemberment Benefit, You have the right to assign Your rights and interest under this Certificate including:

- 1) the right to make any contributions required to keep the insurance in force; and
- 2) the right to convert.

However, you cannot assign Your right to name or change beneficiaries under this Certificate.

We will recognize any assignment made by You under this Certificate, provided:

- 1) it is duly executed; and
- 2) a copy is acknowledged and on file with Us.

We and the Policyholder assume no responsibility:

- 1) for the validity or effect of any assignment; or
- 2) to provide any assignee with notices which We may be obligated to provide to You.

You do not have the right to collaterally assign Your rights and interest under this Certificate.

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

Legal action cannot be taken against Us:

- 1) sooner than 60 days after the date written Proof of Loss is furnished; or
- 1 year after the date Proof of Loss is required to be furnished according to the terms of this Certificate.

**Workers' Compensation:**  
*How does This Certificate affect Workers' Compensation coverage?*

Neither The Policy nor this Certificate replace Workers' Compensation or affect any requirement for Workers' Compensation coverage.

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

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

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Misstatements:**  
*What happens if facts are misstated?*

If material facts about You or Your Dependents were not stated accurately, including the misstatement of age:

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





A subsidiary of Blue Cross and Blue Shield of Louisiana,  
independent licensees of the Blue Cross and Blue Shield Association.

## GROUP TERM LIFE INSURANCE WITH ACCELERATED BENEFITS AMENDMENT

This amendment is issued by Southern National Life Insurance Company, Inc., a subsidiary of Blue Cross and Blue Shield of Louisiana. This amendment is effective on and after January 1, 2015.

### **Group Term Life Insurance with Accelerated Benefits Certificate 31SN0112A**

The Certificate listed above is hereby amended to replace the definition of Spouse and relocate the Portability section to the Group and Voluntary Term Life General Provisions Article as follows:

#### **DEFINITIONS**

**Spouse** means the person to whom You are legally married.

#### **PORTABILITY**

This Portability section only applies to You if the Portability Benefit is shown as included in the applicable Schedule of Benefits. Portability can apply to either Your Basic Life Benefit or Your Voluntary Life Benefit, depending on what is included according to the applicable Schedule.

**Portability:**  
*What is  
Portability?*

Portability is a form of continuation of Your Basic Life Coverage or Your Voluntary Life Benefit, as applicable, when either of such benefits would otherwise terminate in connection with a Qualifying Event. The Benefit that You would carry would be at a lower premium than with Conversion, because it would be a continuation of that part of Your Group Term Life coverage.

Portability applies to Your Basic Life Coverage or Your Voluntary Life Benefit only, as applicable. Portability does not apply to any of the other coverages that could be included in Your Group Term Life Schedule of Benefits or Your Voluntary Group Term Life Schedule of Benefits, such as the Accidental Life and Dismemberment Benefit, nor any Dependent Life benefit, nor the Spouse Accidental Death and Dismemberment benefit.

To carry Your applicable Basic Life Benefit or Voluntary Life Benefit beyond a Qualifying Event, such event has to occur before You attain age 70, and You have to apply for the benefit as stated in this section. If Your Portability application is approved, you will be issued a Portability Group Term Life Certificate.

The Employer must keep the applicable Group Term Life coverage and the Portability Benefit in force for Your Eligible Class, for You to be able to apply for Portability, or to continue to benefit from an already issued Portability Certificate. If the Employer terminates the applicable Group Term Life coverage or the Portability Benefit for Your Eligible Class once that a Portability Certificate has been issued, You will have a right to conversion according to the terms of the Portability Certificate.

**Qualifying  
Events:**  
*What are  
Qualifying  
Events for  
Portability?*

Qualifying Events for You are:

- 4) Your employment terminates; or
- 5) Your membership in an Eligible Class under this Certificate ends; or
- 6) You are denied Waiver of Premium solely because You do not meet the definition of Disabled, and You are not otherwise eligible to continue Group Term Life coverage;

provided the Qualifying Event occurs prior to You attaining age 70.

**Electing  
Portability**  
*How do I elect  
Portability?*

You may elect Portability for Your applicable coverage after Your Basic Life Benefit or Voluntary Life Benefit ends because You had a Qualifying Event. To elect Portability, You must:

- 3) complete and sign a Portability application; and
- 4) submit the application to Us with the required premium within 31 days after this
- 5) Certificate terminates.

After We verify eligibility for coverage, We will issue a Portability Group Term Life Certificate that provides insurance through the group Policy. The Portability coverage will be:

- 3) Issued without Evidence of Insurability; and
- 4) Be effective on the day following the date Your coverage ends.

The terms and conditions of coverage under the Portability Certificate will not be the same terms and conditions that are applicable under this Certificate.

**Limitations:**  
*What limitations  
apply to  
Portability?*

You may elect to carry 50%, 75% or 100% of the Basic Life Benefit or the Voluntary Life Benefit which is ending for You because of the Qualifying Event. This amount will be rounded to the next higher multiple of \$1,000, if not already a multiple of \$1,000. However, the Basic Life Benefit or Voluntary Life Benefit that may be ported will not exceed \$250,000.

If You elect to continue 50% or 75% of Your Basic Life Benefit or Voluntary Life Benefit now, You will not be able to increase it to 100% at a later date. In no event will You be able to carry a Basic Life Benefit or Voluntary Life Benefit which is less than \$5,000.

Portability is not available for any Basic Life Benefit or Voluntary Life Benefit for which You were not eligible or covered at the date of the Qualifying Event.

In addition, Portability is not available if You are entering active military service.

**Effect of  
Portability on  
other  
Provisions:**  
*How does  
Portability affect  
other provisions  
of this  
Certificate?*

Portability is not available for any Basic Life Benefit or Voluntary Life Benefit which was, or is being, continued in accordance with:

- 4) The Conversion clause;
- 5) The Waiver of Premium provision; or
- 6) The Continuation Provisions;

Under this Certificate. However, if:

- 3) You elect to continue only a portion of terminated coverage under this Portability provision; or
- 4) the Basic Life Benefit or Voluntary Life Benefit exceeds the maximum Portability amount;

then the Conversion Right may be available for the remaining amount.

The Waiver of Premium provision will not be available if You elect to continue coverage under this Portability provision.

All of the provisions of the certificate listed above are applicable to this Amendment, unless they conflict with the provisions of this Amendment. If the provision of the certificate or other amendment or endorsement heretofore issued conflict with those of this Amendment, the provisions of this Amendment will prevail. All other provisions remain unchanged.



I. Steven Udvarhelyi, M. D., President and Chief Executive Officer  
Louisiana Health Service & Indemnity Company



LIABILITY OF PLAN AFFILIATES DISCLOSURE AMENDMENT

This amendment is issued by Southern National Life Insurance Company, Inc., a subsidiary of Blue Cross and Blue Shield of Louisiana. This amendment is effective on and after January 1, 2017 on the following existing products.

31SN0111A 01/12	Group Term Life Insurance with Accelerated Benefits and Group Disability Insurance Policy
31SN0114A 01/12	Group Disability Insurance (Certificate)
31SN0112A 01/12	Group Term Life Insurance with Accelerated Benefits (Certificate)
31SN0134A 01/12	Voluntary High Limit Accidental Death and Dismemberment Insurance (Certificate)
31SN0153A 01/12	Voluntary High Limit Accidental Death and Dismemberment Insurance Policy
31SN0113A 01/12	Portable Term Life Insurance (Certificate)

The Certificates and Policies listed above are hereby amended to add the Liability of Plan Affiliates disclosure as follows:

The Policyholder, on behalf of itself and its participants, hereby expressly acknowledges its understanding that this Benefit Plan constitutes a contract solely between the Policyholder and Blue Cross and Blue Shield of Louisiana, that Blue Cross and Blue Shield of Louisiana is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the "Association"), permitting Blue Cross Blue Shield of Louisiana to use the Blue Cross and Blue Shield Service Marks in the State of Louisiana, and that Blue Cross Blue Shield of Louisiana is not contracting as the agent of the Association. The Policyholder, on behalf of itself and its participants, further acknowledges and agrees that it has not entered into this Benefit Plan based upon representations by any person other than Blue Cross Blue Shield of Louisiana and that no person, entity, or organization other than Blue Cross Blue Shield of Louisiana shall be held accountable or liable to the Policyholder, for any Blue Cross and Blue Shield of Louisiana's obligations to the Policyholder, created under this Benefit Plan. This paragraph shall not create any additional obligations whatsoever on the part Blue Cross Blue Shield of Louisiana other than those obligations created under other provisions of this agreement.

I. Steven Udvarhelyi, M.D.  
President and Chief Executive Officer

Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross and Blue Shield Association and is incorporated as Louisiana Health Service & Indemnity Company







A subsidiary of Blue Cross and Blue Shield of Louisiana,  
independent licensees of the Blue Cross and Blue Shield Association.

## BENEFICIARY DESIGNATION AMENDMENT II

This amendment is issued by Southern National Life Insurance Company, Inc., a subsidiary of Blue Cross and Blue Shield of Louisiana. This amendment is effective on and after October 1, 2017.

### **Group Term Life Insurance with Accelerated Benefits Certificate 31SN0112A**

The Certificate described above is hereby amended to replace the Beneficiary Designation clause in Article IV "Additional General Provisions" as follows:

**Beneficiary Designation:**  
*How do I designate or change my beneficiary?*

You may designate or change a beneficiary by doing so in writing on a form satisfactory to Us and filing the form with the Employer. Only satisfactory forms sent to the Employer prior to Your death will be accepted.

Beneficiary designations will become effective as of the date You submit the form to your Employer. We will not be liable for any amounts paid before receiving notice of a beneficiary designation or change from the Employer.

In no event may a beneficiary be changed by a Power of Attorney.

All of the provisions of the certificate listed above are applicable to this Amendment, unless they conflict with the provisions of this Amendment. If the provision of the certificate or other amendment or endorsement heretofore issued conflict with those of this Amendment, the provisions of this Amendment will prevail. All other provisions remain unchanged.

A handwritten signature in black ink, appearing to read "I. Steven Udvarhelyi".

I. Steven Udvarhelyi, M. D.  
President and Chief Executive Officer  
Louisiana Health Service & Indemnity Company



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## SUMMARY OF PRIVACY PRACTICES NOTICE

Blue Cross and Blue Shield of Louisiana and its affiliate, HMO Louisiana, Inc., believe that privacy and confidentiality regarding personal medical information is important to every customer. And securely protecting our customers' privacy is a responsibility we take very seriously.

We want you to know there is a federal regulation that governs the privacy of your medical information and how we use and share that information in the course of our regular business activities. This federal regulation requires us to provide you with a detailed description – or "Notice" – of how we use your medical information.

The attached Notice goes into detail on how we may use and share your medical information in the course of treatment, payment and health care (business) operations. In general, unless it is described in the accompanying Notice, we will **not** use or disclose your medical information **without** your written authorization. For example, we may use and disclose your medical information to:

- Enroll you in our plan
- Determine your eligibility for benefits
- Pay your claims
- Underwrite your contract/certificate of coverage
- Share data with your Quality Blue doctor
- Give your healthcare providers updates that help them treat you
- Connect you with Blue Cross health coaches
- Audit our business practices
- Conduct medical reviews
- Conduct quality improvement activities
- Bill you or your employer for your premiums
- Develop strategic business plans
- Remind you about important screenings, shots or tests
- Participate in research, if appropriate regulations are followed
- Improve our services

Your information may be shared with the physicians or other providers who treat you, with other insurance companies, with your employer (following specific guidelines), or with a company we hire to help us do our work. We may also disclose your medical information to your family members, friends and others you choose to involve in your health care or in the payment of your health care.

Although this occurs rarely, we may also use and disclose your medical information when required by law for various public interest activities, including regulatory oversight of our company (by the Department of Insurance, for example), law enforcement, disaster relief, and certain other public benefit functions.

The federal privacy rules also give you certain rights. Please review this entire Notice to learn about your rights and how to put them to use for you, as well as the procedure to voice complaints regarding our privacy practices.

Maintaining your trust and confidence is our highest priority, and we value your business. Thank you for being our customer.

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**BLUE CROSS AND BLUE SHIELD OF LOUISIANA & HMO LOUISIANA, INC.**  
**NOTICE OF PRIVACY PRACTICES**  
**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND**  
**DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**  
**PLEASE REVIEW IT CAREFULLY.**  
**THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.**

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**Our Legal Duty**

We are required by applicable federal and state law to maintain the privacy of your medical information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your medical information. We must follow the privacy practices that are described in this notice while it is in effect. This Notice takes effect September 23, 2013, and will remain in effect unless we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all medical information that we maintain, including medical information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and send the new Notice to our health plan subscribers at the time of the change.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information at the end of this Notice.

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**Uses and Disclosures of Medical Information**

We will refer to your "health information" throughout this Notice. When we say "health information," we mean what the federal privacy rules ("the HIPAA privacy regulations") call "Protected Health Information." This is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health plan, your employer, or a health care clearinghouse and that relates to: (i) your past, present, or future physical or mental health or condition; (ii) the provision of health care to you; (iii) the past, present, or future payment for the provision of health care to you. Any terms not defined in this Notice should have the same meaning as they have in the HIPAA Privacy Regulations as set out in 45 C.F.R. § 164.501.

**REQUIRED DISCLOSURES OF YOUR HEALTH INFORMATION**

We **must** disclose your health information:

- To you or someone who has the legal right to act for you (your personal representative), if the information you seek is contained in a designated record set, and
  - The Secretary of the Department of Health and Human Services, if necessary, to investigate or determine our compliance with the HIPAA Privacy Regulations.
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**PERMISSIVE DISCLOSURES OF YOUR HEALTH INFORMATION**

We **have the right** to use and disclose your health information for:

**Treatment:** We may disclose your health information to a physician or other health care provider to treat you. For example, we may send a copy of a member's medical records we maintain to a physician who needs the additional information to treat the member.

**Payment:** We may use and disclose your health information to pay claims from physicians, hospitals and other health care providers for services delivered to you that are covered by your health plan, to determine your eligibility for benefits, to coordinate your benefits with other payers, to determine the medical necessity of care delivered to you, to obtain premiums for your health coverage, to issue explanations of benefits, and the like. We may disclose your health information to a health care provider or another health plan for that provider or plan to obtain payment or engage in other payment activities.

**Health Care Operations:** We may use and disclose your health information for health care operations. Health care operations include:

- reviewing and evaluating health care provider and health plan performance, health care provider and health plan accreditation, certification, licensing and credentialing activities;
- health care quality assessment and improvement activities;
- conducting or arranging for medical reviews, audits, and legal services, including fraud and abuse detection and prevention;
- underwriting and premium rating our risk for health coverage (although we are prohibited from using or disclosing any genetic information for these underwriting purposes); and
- business planning, development, management, and general administration, including customer service, grievance resolution, de-identifying health information, and creating limited data sets for health care operations, public health activities, and research;
- Sharing detailed medical claims and wellness information with your primary care physician to improve care and reduce costs.

For a full list of the activities covered by the terms in this section please consult the definitions set out in 45 C.F.R. § 164.501.

**Others Covered by the Privacy Rule:** We may disclose your health information to another health plan or to a health care provider for certain health care operations subject to federal privacy protection laws. We may do so as long as the plan or provider has or had a relationship with you and the health information is for that plan's or provider's health care quality assessment and improvement activities, evaluation, or fraud and abuse detection and prevention. For example, we may share your information with your doctors for their licensing or credentialing activities.

**Business Associates:** We hire individuals and companies to perform various functions on our behalf or to provide certain types of services for us. In order to help us, these business associates may receive, create, maintain, use, or disclose your health information. Before they may have any contact with your health information, we require them to sign a written agreement stating they will keep your health information private and secure.

Examples of our business associates include:

- Medical experts hired to review claims;
- A pharmacy benefits management company hired to assist us in managing pharmacy claims;
- A company hired to conduct data analysis to help us determine which of our programs and services are most helpful to customers, which should be changed and others that we should start.

**Your Authorization:** You may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. However, we will not be able to undo any action that was taken before that authorization was revoked. Unless you give us a written authorization, we will not use or disclose your health information for any purpose other than those described in this Notice. To the extent (if any) that we maintain or receive psychotherapy notes about you, most disclosures of these notes require your authorization. Also, to the extent (if any) that we use or disclose your information for our fundraising practices, we will provide you with the ability to opt out of future fundraising communications. In addition, most (but not all) uses and disclosures of health information for marketing purposes, and disclosures that constitute a sale of protected health information require your authorization.

**Family, Friends, and Others Involved in Your Care or Payment for Care:** Unless you object, we may disclose your health information to a family member, friend or any other person you involve in your health care or payment for your health care. We will disclose only the health information that is related to the person's involvement. We may use or disclose your name, location, and general condition to notify, or to assist an appropriate public or private agency to locate and notify, a person responsible for your health care in appropriate situations, such as medical emergency or during disaster relief efforts (for example, to Red Cross during a natural disaster).

Before we make such a disclosure, we will provide you with an opportunity to object. If you are not present or are incapacitated or it is an emergency or disaster relief situation, we will use our professional judgment to determine whether disclosing your health information is in your best interest under the circumstances.

**Your Employer:** We may disclose to your employer whether or not you are enrolled in a health plan that your employer sponsors. We may disclose summary health information to your employer to use to obtain premium bids for the health insurance coverage offered under the group health plan in which you participate or to decide whether to modify, amend or terminate that group health plan. Summary health information is information about claims history, claims expenses or types of claims experienced by the enrollees in your group health plan. Although this summary health information does not specifically identify any individual, it still may be possible to identify you or others through review of this summary health information.

We may disclose your health information and the health information of others enrolled in your group health plan to your employer to administer your group health plan. Before we may do that, your employer must meet certain requirements. This includes amending the plan document for your group health plan to establish the limited uses and disclosures it may make of your health information. Please see your group health plan document for a full explanation of the limitations placed on your employer for the use of this information and for any disclosures that may be made to the group health plan itself.

**Health-Related Products and Services:** Where permitted by law, we may use your health information to communicate with you about health-related products, benefits and services and payment for those products, benefits and services that we provide or include in our benefits plan, and about treatment alternatives that may be of interest to you. These communications may include information about the health care providers in our network, about replacement of or enhancements to your health plan, and about health-related products or services that are available only to our enrollees that add value to, although they are not part of, our benefits plan. For example, we may contact you about a Medicare Supplemental policy when you near age 65.

**Public Health and Benefit Activities:** Although this does not occur often, we may use and disclose your health information when required by law and when authorized by law for the following kinds of public interest activities:

- for public health, including to report disease and vital statistics, child abuse, and adult abuse, neglect or domestic violence;
- to avert a serious and imminent threat to health or safety;
- for health care oversight, such as activities of state insurance commissioners, licensing and peer review authorities, and fraud prevention enforcement agencies;
- for research in certain situations, such as when:
  - (1) an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the information and approved the research or
  - (2) conducting research with de-identified or limited data sets to learn more about how to help members improve their health;
- in response to court and administrative orders and other lawful process;
- to law enforcement officials with regard to crime victims, crimes on our premises, crime reporting in emergencies, and identifying or locating suspects or other persons;
- to coroners, medical examiners, funeral directors, and organ procurement organizations;
- to the military, to federal officials for lawful intelligence, counterintelligence, and national security activities, and to correctional institutions and law enforcement regarding persons in lawful custody; and
- as authorized by state worker's compensation laws.

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## Individual Rights

The following are your rights with respect to your health information. If you would like to exercise any of the following rights, please submit your request in writing, sign your request, and mail it to the Blue Cross and Blue Shield of Louisiana Privacy Office at P.O. Box 84656, Baton Rouge, LA 70884-4656. Our contact information is provided at the end of this Notice.

**Access:** You have the right to examine and to receive a copy of your health information we maintain about you in a “designated record set,” with limited exceptions. This may include an electronic copy in certain circumstances if you make this request in writing.

Generally, a “designated record set” contains:

- claims and payment information;
- enrollment and billing information;
- other records used to make decisions about your health care benefits.

We may charge you reasonable, cost-based fees for a copy of your health information, for mailing the copy to you, and for preparing any summary or explanation of your health information you may request. Contact us using the information at the end of this Notice for information about our fees. You may withdraw your request if you do not wish to pay the fees.

In certain situations we may deny your request to inspect and obtain a copy of your health information. If we deny your request, we will notify you in writing and will inform you whether or not you have the right to have the denial reviewed.

**Disclosure Accounting:** You have the right to an accounting of certain disclosures that we make of your health information, excluding disclosures for treatment, payment, health care operations, as authorized by you, and for certain other activities.

We will provide you with information about each accountable disclosure that we made during the period for which you request the accounting, except we are not obligated to account for a disclosure that occurred more than six years before the date of your request. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to your additional requests. Contact us using the information at the end of this Notice for information about our fees.

**Amendment:** You have the right to request that we amend your health information that we maintain about you in your designated record set. We may deny your request for certain reasons. For example, we may deny your request if the information you want to amend was created by your doctor. If we deny your request, we will provide you a written explanation, and explain to you how you can disagree with the denial by filing a statement of disagreement with us. If we accept your request, we will make your amendment part of your designated record set, and use reasonable efforts to inform others of the amendment who we know may have relied on the unamended information to your detriment, as well as persons you tell us you want to receive the amendment.

**Restriction:** You have the right to request that we restrict our use or disclosure of your health information for treatment, payment or health care operations, or with family, friends or others you identify. We are not required to agree to your request. If we do agree, we will honor our agreement, except in a medical emergency or as required or authorized by law. Any agreement we may make to a request for restriction must be in writing and agreed to by our Privacy Office.

**Confidential Communication:** If you believe that a disclosure of all or part of your health information may endanger you if sent to your current mailing address, you have the right to request that we communicate with you in confidence about your health information by a different means or to a different location that you specify. You must make your request in writing, and your request must represent that the information could endanger you if it is not communicated in confidence as you request.

We will accommodate your request if it is reasonable. You must specify the alternative means of contact or location for confidential communication, and continue to permit us to collect premiums and pay claims under your health plan. Please note that other information that we send to the subscriber about health care benefits received may contain sufficient information to reveal that you obtained health care for which we paid, even though you requested that we communicate with you about that health care in confidence. If you have given someone else permission to receive health information about you, a request for confidential communications will cancel this permission unless you tell us otherwise.

**Electronic Notice:** If you receive this Notice on our website or by electronic mail (e-mail), you have the right to receive this Notice in written form. Please contact us using the information at the end of this Notice to obtain this Notice in written form.



**Potential Impact of State Privacy Laws:** The federal health care Privacy Regulations generally do not "preempt" (or take precedence over) state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Regulations, might impose a privacy standard under which we will be required to operate. For example, where such laws have been enacted, we will follow more stringent state privacy laws that relate to uses and disclosures of the protected health information concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing, reproductive rights, or disclosure of health information of minors.

**Breach Notification:** In the event of a breach of your unsecured health information, we will provide you notification of such a breach as required by law or where we otherwise deem appropriate.

### Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us using the information at the end of this Notice.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information, in response to a request you made to amend, restrict the use or disclosure of, or communicate in confidence about your health information, you may complain to us using the contact information at the end of this Notice. You also may submit a written complaint to the Office for Civil Rights of the United States Department of Health and Human Services, Region VI, 1301 Young Street, Suite 1169, Dallas, TX 75202. You may contact the Office for Civil Rights' Hotline at 1-800-368-1019.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

### Contact Information

By mail:  
Privacy Office  
Blue Cross and Blue Shield of Louisiana  
P.O. Box 84656  
Baton Rouge, LA 70884-4656

Telephone: (225) 298-1751  
Fax: (225) 298-1590

E-mail: [Privacy.Office@BCBSLA.com](mailto:Privacy.Office@BCBSLA.com)  
(Individual Rights requests will not be accepted via e-mail.)





At Blue Cross and Blue Shield of Louisiana, our mission is to improve the health and lives of Louisianians – including how we store, use and protect our members' data. Blue Cross has strong processes in place, which all of our employees must follow to protect members' data in all forms (spoken, written and/or electronic).

Blue Cross approaches members' data protection from three perspectives – physical security, cybersecurity and privacy. Blue Cross recruits, hires and trains qualified staff who work together to safely store our members' information and make sure all employees are following the laws and regulations that protect it.

Blue Cross has extensive policies and procedures that outline the security and privacy standards and responsibilities for protecting members' data. Employees are trained on Blue Cross data protection protocols as soon as they start working here, and all employees have refresher training at least once a year.

Blue Cross does not give every employee access to members' information, and not all access is the same. How much member information any Blue Cross employee can access depends on his/her job and role within the company. Employees can only get to the information they need to do their jobs and not anything else. For example, a Customer Service adviser who needs member information to answer calls is able to see those records, but a business analyst working on internal projects would not need this access.

### ***Spoken Data***

Before Blue Cross employees give information over the phone or in person, they take steps to authenticate the identities of the people requesting information. This is to make sure the people calling are really who they say they are and that they have the right to request that information. Blue Cross has a process for our members to let us know whom they want to be an authorized delegate or legal representative. That means you are giving permission for them to contact Blue Cross and ask for information on your behalf.

### ***Written Data***

Blue Cross has strong privacy protection rules for paper documents. Employees are required to keep records in a safe place where they cannot be seen, for example in a locked file cabinet instead of lying on a desk. Blue Cross requires employees to go through their computers and securely destroy electronic files that are no longer needed. This prevents the information in these records from being stolen or accessed by the wrong people.

### ***Electronic Data***

Blue Cross IT staff uses the latest technology to keep electronic information secure by encrypting it within internal systems so that no one can get to it from outside the system. The IT staff members have processes in place to detect and prevent hackers from getting to our technical systems and monitor how employees access and use information within the organization.

If you have questions about how Blue Cross uses, stores or protects members' data, call our Information Governance Office at (225) 298-1751.





Blue Cross and Blue Shield of Louisiana  
HMO Louisiana  
Southern National Life

## How We Collect, Share and Protect Your Information

Effective Date: July 1, 2001

Revised Date: February 1, 2020

Blue Cross and Blue Shield of Louisiana along with HMO Louisiana, Inc. and Southern National Life Insurance Company, Inc., know that our customers expect us to keep their personal and financial information safe and private.

This notice will tell you about how we get, use, protect and share your personal information. We will share this with you when you become our customer and purchase certain insurance products. If we update this notice in the future, we will share the new version with you.

### What do we collect and how do we get it?

We collect your name, address, Social Security number, health and financial information. We get these facts from forms you fill out, phone calls or in person. We may get information from your claims, payment history and other records. We may also get information about you from your agent, companies we own and other companies.

### What do we share and whom do we share it with?

We may share your information with companies we own, your agent, and companies or financial institutions that we do business with to serve you. Examples include businesses we have hired to help us with marketing, benefit administration and claims processing. We may share your information after you are no longer our customer. We may also share your information as permitted or required by law.

### How do we keep your information safe?

Our employees who need your information to serve you are the only ones who can get to it. We keep physical, electronic and procedural safeguards in place that follow all laws to protect your information.

*We share this information with you to meet the Gramm-Leach-Bliley Act. To learn more about our privacy practices and policies, please read the "Notice of Privacy Practices Regarding Medical Information" at [www.bcbsla.com](http://www.bcbsla.com).*





## GROUP TERM LIFE INSURANCE WITH ACCELERATED BENEFITS AMENDMENT

This amendment is issued by Southern National Life Insurance Company, Inc., a subsidiary of Blue Cross and Blue Shield of Louisiana. This amendment is effective on and after January 1, 2023.

**[Any accelerated benefits received under the Group Term Life Insurance of this Policy may be taxable. Insureds should consult a personal tax advisor for further information.]**

### **Group Term Life Insurance with Accelerated Benefits Certificate 31SN0112A**

The Certificate listed above is hereby amended to add the definition of Child, Child Accidental Death and Dismemberment and Dependent Accidental Death and Dismemberment and update the Accidental Death and Dismemberment language in Article III as follows:

#### **DEFINITIONS**

**Child** means Your child who depends upon You for support and is: born to You, legally placed for adoption with You, legally adopted by You, a child for whom You or Your legal spouse is a court appointed tutor/tutrix, or for whom a qualified medical child support order has been issued or a stepchild of Yours; or any unmarried grandchild in the legal custody of and residing with You; and who is also:

- under twenty-six (26) years old; or
- mentally or physically disabled prior to attaining age 26 and incapable of self-support. (Periodic proof of the child's continuing incapacity may be required.)

**Child Accidental Death and Dismemberment (VCLA)** means a maximum amount, as it appears on the Schedule of Benefits that represents the maximum benefit that would be available under the Voluntary Group Term Life coverage in the event that Your Child dies because of an accident or suffers an accidental injury that results in dismemberment, as established in the Accidental Death and Dismemberment provision.

**Dependent Accidental Death and Dismemberment (DEPA)** means a maximum amount, as it appears on the Schedule of Benefits that represents the maximum benefit that would be available under the Group Term Life coverage in the event that Your Dependent dies because of an accident or suffers an accidental injury that results in dismemberment, as established in the Accidental Death and Dismemberment provision.

### **ARTICLE III ACCIDENTAL DEATH AND DISMEMBERMENT**

This Article III applies only if any Accidental Death and Dismemberment coverage is shown as included in the Group Term Life Schedule of Benefits or the Voluntary Group Term Life Schedule of Benefits. If You have a Basic Accidental Death and Dismemberment Benefit (according to Your Group Term Life Schedule of Benefits), a Dependent Accidental Death and Dismemberment Benefit according to Your Group Term Life Schedule of Benefits), a Voluntary Accidental Death and Dismemberment Benefit (according to Your Voluntary Group Term Life Schedule of Benefits), a Spouse Accidental Death and Dismemberment Benefit (according to Your Voluntary Group Term Life Schedule of Benefits) and/or a Child Accidental Death and Dismemberment Benefit (according to Your Voluntary Group Term Life Schedule of Benefits) this clause will apply to each of those coverages. The amount of each benefit, as it appears on its corresponding Schedule of Benefits, will constitute the "Principal Sum" for that benefit.

**Accidental Death and Dismemberment Benefit:**

*When is the Accidental Death and Dismemberment Benefit Payable?*

If You (or Your Spouse or Child, if Dependent, Spouse and/or Child Accidental Death and Dismemberment benefits are shown as included on the Schedule of Benefits) sustain an Injury which results in any of the Losses described in the table below within 365 days from the date of an accident covered under this Certificate, We will pay all or a portion of the applicable Accidental Death and Dismemberment Benefit (Principal Sum) as shown on the table, after We receive Proof of Loss in accordance with the Proof of Loss provision.

Accidental Death and Dismemberment benefits will be paid subject to all of the other applicable provisions of this Certificate.

We will not pay more than the applicable Principal Sum to any one person, for all Losses due to the same accident. The applicable Principal Sum for any Accidental Death and Dismemberment Benefit is shown in the Schedule of Benefits.

**For Loss of:**

**We pay:**

Life	Principal Sum
Both Hands or Both Feet or Sight of Both Eyes	Principal Sum
One Hand and One Foot	Principal Sum
Speech and Hearing in Both Ears	Principal Sum
Either Hand or Foot and Sight of One Eye	Principal Sum
Movement of Both Upper and Lower Limbs (Quadriplegia)	Principal Sum
Movement of Both Lower Limbs (Paraplegia)	Three Quarters of Principal Sum
Movement of Three Limbs (Triplegia)	Three Quarters of Principal Sum
Movement of the Upper and Lower Limbs of one Side of the Body (Hemiplegia)	One Half of Principal Sum
Either Hand or Foot	One Half of Principal Sum
Sight of One Eye	One Half of Principal Sum
Speech or Hearing in Both Ears	One Half of Principal Sum
Movement of One Limb (Uniplegia)	One-Quarter of Principal Sum
Thumb and Index Finger of Either Hand	One-Quarter of Principal Sum

**Loss:** means with regard to:

- 1) hands and feet: actual severance through or above wrist or ankle joints;
- 2) sight, speech and hearing: entire and irrecoverable loss thereof;
- 3) thumb and index finger: actual severance through or above the metacarpophalangeal joints;
- 4) movement: complete and irreversible paralysis of such limbs.

All of the provisions of the certificate listed above are applicable to this Amendment, unless they conflict with the provisions of this Amendment. If the provision of the certificate or other amendment or endorsement heretofore issued conflict with those of this Amendment, the provisions of this Amendment will prevail. All other provisions remain unchanged.

A handwritten signature in black ink, appearing to read "I. Steven Udvarhelyi". The signature is fluid and cursive, with a large initial "I" and "S".

I. Steven Udvarhelyi, M. D.  
President and Chief Executive Officer  
Louisiana Health Service & Indemnity Company







Blue Cross and Blue Shield of Louisiana  
HMO Louisiana  
Southern National Life

## **Nondiscrimination Notice**

Discrimination is Against the Law

Blue Cross and Blue Shield of Louisiana and its subsidiaries, HMO Louisiana, Inc. and Southern National Life Insurance Company, Inc., does not exclude people or treat them differently on the basis of race, color, national origin, age, disability or sex in its health programs or activities.

Blue Cross and Blue Shield of Louisiana and its subsidiaries:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (audio, accessible electronic formats)
- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, you can call the Customer Service number on the back of your ID card or email **MeaningfulAccessLanguageTranslation@bcbsla.com**. If you are hearing impaired call 1-800-711-5519 (TTY 711).

If you believe that Blue Cross, one of its subsidiaries or your employer-insured health plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you have the right to take the following steps;

### **1. If you are fully insured through Blue Cross, file a grievance with Blue Cross by mail, fax, or email.**

Section 1557 Coordinator  
P. O. Box 98012  
Baton Rouge, LA 70898-9012  
225-298-7238 or 1-800-711-5519 (TTY 711)  
Fax: 225-298-7240  
Email: Section1557Coordinator@bcbsla.com

### **2. If your employer owns your health plan and Blue Cross administers the plan, contact your employer or your company's Human Resources Department. To determine if your plan is fully insured by Blue Cross or owned by your employer, go to [www.bcbsla.com/checkmyplan](http://www.bcbsla.com/checkmyplan).**

Whether Blue Cross or your employer owns your plan, you can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201  
1-800-368-1019, 800-537-7697 (TDD)

Or

Electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

# NOTICE

Free language services are available. If needed, please call the Customer Service number on the back of your ID card. Hearing-impaired customers call 1-800-711-5519 (TTY 711).

Tiene a su disposición servicios lingüísticos gratuitos. De necesitarlos, por favor, llame al número del Servicio de Atención al Cliente que aparece en el reverso de su tarjeta de identificación. Clientes con dificultades auditivas, llamen al 1-800-711-5519 (TTY 711).

Des services linguistiques gratuits sont disponibles. Si nécessaire, veuillez appeler le numéro du Service clientèle figurant au verso de votre carte d'identification. Si vous souffrez d'une déficience auditive, veuillez appeler le 1-800-711-5519 (TTY 711).

Có dịch vụ thông dịch miễn phí. Nếu cần, xin vui lòng gọi cho Phục Vụ Khách Hàng theo số ở mặt sau thẻ ID của quý vị. Khách hàng nào bị suy giảm thính lực hãy gọi số 1-800-711-5519 (TTY 711).

我们为您提供免费的语言服务。如有需要，请致电您 ID 卡背面的客户服务号码。听障客户请拨打 1-800-711-5519 (TTY 711)。

الخدمات اللغوية متاحة مجاناً. يرجى، إذا اقتضى الأمر، الاتصال برقم خدمة العملاء المدون على ظهر بطاقة التعريف الخاصة بك. إذا كنت تعاني من إعاقة في السمع، فيرجى الاتصال بالرقم 1-800-711-5519 (TTY 711).

Magagamit ang mga libreng serbisyo sa wika. Kung kinakailangan, pakitawagan ang numero ng Customer Service sa likod ng iyong ID kard. Para sa mga may kapansanan sa pandinig tumawag sa 1-800-711-5519 (TTY 711).

무료 언어 서비스를 이용하실 수 있습니다. 필요한 경우 귀하의 ID 카드 뒤에 기재되어 있는 고객 서비스 번호로 연락하시기 바랍니다. 청각 장애가 있는 분은 1-800-711-5519 (TTY 711)로 연락하십시오.

Oferecemos serviços linguísticos grátis. Caso necessário, ligue para o número de Atendimento ao Cliente indicado no verso de seu cartão de identificação. Caso tenha uma deficiência auditiva, ligue para 1-800-711-5519 (TTY 711).

ພວກເຮົາມີບໍລິການແປພາສາໃຫ້ທ່ານພຣີ. ຖ້າທ່ານຕ້ອງການບໍລິການນັ້ນ, ກະລຸນາໂທຫາພະແນກບໍລິການລູກຄ້າຕາມເບີໂທທີ່ຢູ່ທາງຫຼັງຂອງບັດປະຈຳຕົວຂອງທ່ານ. ຖ້າທ່ານຫຼຸບໍ່ດີ, ຂໍໃຫ້ໂທເບີ 1-800-711-5519 (TTY 711).

無料の言語サービスをご利用頂けます。あなたのIDカードの裏面に記載されているサポートセンターの電話番号までご連絡ください。聴覚障害がある場合は、1-800-711-5519 (TTY 711)までご連絡ください。

زبان سے متعلق مفت خدمات دستیاب ہیں۔ اگر ضرورت ہو تو، براہ کرم اپنے آئی ڈی کارڈ کی پشت پر موجود کسٹمر سروس نمبر پر کال کریں۔  
سمعی نقص والے کسٹمرز 1-800-711-5519 (TTY 711) پر کال کریں۔

Kostenlose Sprachdienste stehen zur Verfügung. Falls Sie diese benötigen, rufen Sie bitte die Kundendienstnummer auf der Rückseite Ihrer ID-Karte an. Hörbehinderte Kunden rufen bitte unter der Nummer 1-800-711-5519 (TTY 711) an.

خدمات رایگان زبان در دسترس است. در صورت نیاز، لطفاً با شماره خدمات مشتریان که در پشت کارت شناسایی تان درج شده است تماس بگیرید.  
مشتریانی که مشکل شنوایی دارند با شماره 1-800-711-5519 (TTY 711) تماس بگیرید.

Предлагаются бесплатные переводческие услуги. При необходимости, пожалуйста, позвоните по номеру Отдела обслуживания клиентов, указанному на оборотной стороне Вашей идентификационной карты. Клиенты с нарушениями слуха могут позвонить по номеру 1-800-711-5519 (Телефон с текстовым выходом: 711).

มีบริการด้านภาษาให้ใช้ได้ฟรี หากต้องการ โปรดโทรศัพท์ติดต่อฝ่ายการบริการลูกค้าตามหมายเลขที่อยู่ด้านหลังบัตรประจำตัวประชาชนของท่าน  
สำหรับลูกค้าที่มีปัญหาทางการได้ยิน โปรดโทรศัพท์ไปที่หมายเลข 1-800-711-5519 (TTY 711)



