



## AMERICAN HERITAGE LIFE INSURANCE COMPANY

HOME OFFICE:  
1776 AMERICAN HERITAGE LIFE DRIVE  
JACKSONVILLE, FLORIDA 32224-6687  
(904) 992-1776

A Stock Company

### GROUP ACCIDENT INSURANCE POLICY INCLUDES ACCIDENTAL DEATH AND DISMEMBERMENT NON-PARTICIPATING

American Heritage Life Insurance Company (referred to as we, us, or our) will provide benefits under this policy. We make this promise subject to all of the provisions of this policy.

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

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

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

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

A handwritten signature in black ink, appearing to read "Kurt Helms".

Secretary

A handwritten signature in black ink, consisting of a stylized, horizontal line with a long, sweeping tail.

President

**THIS IS A GROUP ACCIDENT ONLY POLICY WHICH PROVIDES BENEFITS FOR OFF THE JOB ACCIDENTS AS DEFINED WITHIN THIS POLICY OR OTHER BENEFITS THAT MAY BE ADDED. THIS POLICY DOES NOT PROVIDE BENEFITS FOR ANY OTHER CONDITIONS.**

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## POLICY SPECIFICATIONS

POLICYHOLDER: MEMPHIS FURNITURE GROUP LLC DBA OFFICE INTERIORS

POLICY NUMBER: 51733

POLICY EFFECTIVE DATE: January 1, 2021

POLICY ANNIVERSARY DATE: January 1, 2022 and the first day of January each calendar year thereafter.

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

### ELIGIBLE CLASS(ES):

All full-time active employees working at least 30 hours per week excluding those who are insured under any other accident policy issued by American Heritage Life Insurance Company

### ELIGIBILITY WAITING PERIOD:

First of the month following 60 days

### PLAN I - BENEFITS:

See page 3B

Benefit Enhancements (2.00 units) – See page 3C

### RIDER(S):

Outpatient Physician's Treatment for Accident and Preventative Care Benefit Rider (1.00 unit) - \$25.00/visit

### INITIAL RATE:

The following are the initial rates for all available coverage types:

Monthly rate of \$12.67 per insured employee for Individual Coverage; or

\$20.37 per insured employee for Individual and Spouse Coverage; or

\$29.23 per insured employee for Individual and Child(ren) Coverage; or

\$37.38 per insured employee for Family Coverage

### PLAN II - BENEFITS:

See page 3B

Benefit Enhancements (3.00 units) – See page 3D

### RIDER(S):

Outpatient Physician's Treatment for Accident and Preventative Care Benefit Rider (1.00 unit) - \$25.00/visit

### INITIAL RATE:

The following are the initial rates for all available coverage types:

Monthly rate of \$18.31 per insured employee for Individual Coverage; or

\$29.36 per insured employee for Individual and Spouse Coverage; or

\$42.48 per insured employee for Individual and Child(ren) Coverage; or

\$53.98 per insured employee for Family Coverage

## POLICY SPECIFICATIONS (Continued)

**RATE GUARANTEE DATE:**

January 1, 2023

**PREMIUM DUE**

January 1, 2021 and the first day of each calendar month thereafter.

The policyholder must send all premiums on or before the premium due date to us. All premiums must be sent to us on or before the premium due date. The premium must be paid in United States dollars.

**COST OF COVERAGE:**

The insured employee pays the cost of coverage.

**DIVISIONS, SUBSIDIARIES OR AFFILIATED COMPANIES:**

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

**Name**

None

**Location (City and State)**

**ACCIDENT POLICY**  
**SEE BENEFITS SECTION OF CERTIFICATE FOR DETAILS OF BENEFITS**

| <b>PLAN I - BENEFITS</b>          |                  | <b>AMOUNT</b>       |           |            |
|-----------------------------------|------------------|---------------------|-----------|------------|
|                                   |                  | INSURED<br>EMPLOYEE | SPOUSE    | CHILD(REN) |
| ACCIDENTAL DEATH                  | PRINCIPAL AMOUNT | \$40,000            | \$20,000  | \$10,000   |
| COMMON CARRIER ACCIDENTAL DEATH   | PRINCIPAL AMOUNT | \$200,000           | \$100,000 | \$50,000   |
| DISMEMBERMENT                     | PRINCIPAL AMOUNT | \$40,000*           | \$20,000* | \$10,000*  |
| DISLOCATION/FRACTURE              | PRINCIPAL AMOUNT | \$4,000*            | \$4,000*  | \$4,000*   |
| HOSPITALIZATION CONFINEMENT       |                  | \$1,000             | \$1,000   | \$1,000    |
| DAILY HOSPITALIZATION CONFINEMENT | DAILY BENEFIT    | \$200               | \$200     | \$200      |
| INTENSIVE CARE                    | DAILY BENEFIT    | \$400               | \$400     | \$400      |
| AMBULANCE SERVICES                |                  |                     |           |            |
| A. GROUND AMBULANCE               |                  | \$200               | \$200     | \$200      |
| B. AIR AMBULANCE                  |                  | \$600               | \$600     | \$600      |
| ACCIDENT PHYSICIAN TREATMENT      |                  | \$100               | \$100     | \$100      |
| X-RAY                             |                  | \$200               | \$200     | \$200      |
| EMERGENCY ROOM SERVICES           |                  | \$200               | \$200     | \$200      |

| <b>PLAN II - BENEFITS</b>            |                  | <b>AMOUNT</b>       |           |            |
|--------------------------------------|------------------|---------------------|-----------|------------|
|                                      |                  | INSURED<br>EMPLOYEE | SPOUSE    | CHILD(REN) |
| 1. ACCIDENTAL DEATH                  | PRINCIPAL AMOUNT | \$60,000            | \$30,000  | \$15,000   |
| 2. COMMON CARRIER ACCIDENTAL DEATH   | PRINCIPAL AMOUNT | \$300,000           | \$150,000 | \$75,000   |
| 3. DISMEMBERMENT                     | PRINCIPAL AMOUNT | \$60,000*           | \$30,000* | \$15,000*  |
| 4. DISLOCATION/FRACTURE              | PRINCIPAL AMOUNT | \$6,000*            | \$6,000*  | \$6,000*   |
| 5. HOSPITALIZATION CONFINEMENT       | PRINCIPAL AMOUNT | \$1,500             | \$1,500   | \$1,500    |
| 6. DAILY HOSPITALIZATION CONFINEMENT | DAILY BENEFIT    | \$300               | \$300     | \$300      |
| 7. INTENSIVE CARE                    | DAILY BENEFIT    | \$600               | \$600     | \$600      |
| 8. AMBULANCE SERVICES                |                  |                     |           |            |
| A. GROUND AMBULANCE                  |                  | \$300               | \$300     | \$300      |
| B. AIR AMBULANCE                     |                  | \$900               | \$900     | \$900      |
| 9. ACCIDENT PHYSICIAN TREATMENT      |                  | \$150               | \$150     | \$150      |
| 10. X-RAY                            |                  | \$300               | \$300     | \$300      |
| 11. EMERGENCY ROOM SERVICES          |                  | \$300               | \$300     | \$300      |

**\* MULTIPLIED BY THE APPLICABLE FACTOR LISTED IN THE SCHEDULE OF BENEFITS AND FACTORS IN THE CERTIFICATE.**

**ACCIDENT POLICY  
GROUP ACCIDENT BENEFIT ENHANCEMENTS  
SEE BENEFITS SECTION OF CERTIFICATE FOR DETAILS OF BENEFITS**

| <b>PLAN I - BENEFITS</b>   | <b>AMOUNT</b>       |
|--|---------------------|
| 1. LACERATIONS   | \$100               |
| 2. BURNS   |                     |
| A. SECOND AND THIRD DEGREE BURNS COVERING LESS THAN<br>15% OF THE TOTAL BODY SURFACE | \$200               |
| B. SECOND AND THIRD DEGREE BURNS COVERING 15% OR MORE<br>OF THE TOTAL BODY SURFACE   | \$1,000             |
| 3. SKIN GRAFT  | 50% OF BURN BENEFIT |
| 4. BRAIN INJURY DIAGNOSIS  | \$300               |
| 5. COMPUTED TOMOGRAPHY SCAN OR MAGNETIC RESONANCE<br>IMAGING                         | \$100               |
| 6. PARALYSIS   |                     |
| A. PARAPLEGIA (PARALYSIS OF 2 OR 3 LIMBS)  | \$15,000            |
| B. QUADRIPLEGIA (PARALYSIS OF 4 LIMBS)   | \$30,000            |
| 7. COMA WITH RESPIRATORY ASSISTANCE  | \$20,000            |
| 8. OPEN ABDOMINAL OR THORACIC SURGERY  | \$2,000             |
| 9. TENDON, LIGAMENT, ROTATOR CUFF OR KNEE CARTILAGE<br>SURGERY                       |                     |
| A. WITH REPAIR   | \$1,000             |
| B. WITHOUT REPAIR  | \$300               |
| 10. RUPTURED DISC SURGERY  | \$1,000             |
| 11. EYE SURGERY  | \$200               |
| 12. GENERAL ANESTHESIA   | \$200               |
| 13. BLOOD AND PLASMA   | \$600               |
| 14. APPLIANCE  | \$250               |
| 15. MEDICAL SUPPLIES   | \$10                |
| 16. MEDICINE   | \$10                |
| 17. PROSTHESIS   |                     |
| A. 1 DEVICE  | \$1,000             |
| B. 2 OR MORE DEVICES   | \$2,000             |
| 18. PHYSICAL THERAPY   | DAILY BENEFIT \$60  |
| 19. REHABILITATION UNIT  | DAILY BENEFIT \$200 |
| 20. NON-LOCAL TRANSPORTATION   | PER TRIP \$800      |
| 21. FAMILY MEMBER LODGING  | DAILY BENEFIT \$200 |
| 22. POST-ACCIDENT TRANSPORTATION   | \$400               |
| 23. ACCIDENT FOLLOW-UP TREATMENT   | DAILY BENEFIT \$100 |

**ACCIDENT POLICY  
GROUP ACCIDENT BENEFIT ENHANCEMENTS**

**SEE BENEFITS SECTION OF CERTIFICATE FOR DETAILS OF BENEFITS**

| <b>PLAN II - BENEFITS</b>  | <b>AMOUNT</b>       |
|--|---------------------|
| 1. LACERATIONS   | \$150               |
| 2. BURNS   |                     |
| A. SECOND AND THIRD DEGREE BURNS COVERING LESS THAN<br>15% OF THE TOTAL BODY SURFACE | \$300               |
| B. SECOND AND THIRD DEGREE BURNS COVERING 15% OR MORE<br>OF THE TOTAL BODY SURFACE   | \$1,500             |
| 3. SKIN GRAFT  | 50% OF BURN BENEFIT |
| 4. BRAIN INJURY DIAGNOSIS  | \$450               |
| 5. COMPUTED TOMOGRAPHY SCAN OR MAGNETIC RESONANCE<br>IMAGING                         | \$150               |
| 6. PARALYSIS   |                     |
| A. PARAPLEGIA (PARALYSIS OF 2 OR 3 LIMBS)  | \$22,500            |
| B. QUADRIPLEGIA (PARALYSIS OF 4 LIMBS)   | \$45,000            |
| 7. COMA WITH RESPIRATORY ASSISTANCE  | \$30,000            |
| 8. OPEN ABDOMINAL OR THORACIC SURGERY  | \$3,000             |
| 9. TENDON, LIGAMENT, ROTATOR CUFF OR KNEE CARTILAGE<br>SURGERY                       |                     |
| A. WITH REPAIR   | \$1,500             |
| B. WITHOUT REPAIR  | \$450               |
| 10. RUPTURED DISC SURGERY  | \$1,500             |
| 11. EYE SURGERY  | \$300               |
| 12. GENERAL ANESTHESIA   | \$300               |
| 13. BLOOD AND PLASMA   | \$900               |
| 14. APPLIANCE  | \$375               |
| 15. MEDICAL SUPPLIES   | \$15                |
| 16. MEDICINE   | \$15                |
| 17. PROSTHESIS   |                     |
| A. 1 DEVICE  | \$1,500             |
| B. 2 OR MORE DEVICES   | \$3,000             |
| 18. PHYSICAL THERAPY   | DAILY BENEFIT \$90  |
| 19. REHABILITATION UNIT  | DAILY BENEFIT \$300 |
| 20. NON-LOCAL TRANSPORTATION   | PER TRIP \$1,200    |
| 21. FAMILY MEMBER LODGING  | DAILY BENEFIT \$300 |
| 22. POST-ACCIDENT TRANSPORTATION   | \$600               |
| 23. ACCIDENT FOLLOW-UP TREATMENT   | DAILY BENEFIT \$150 |

## **POLICYHOLDER PROVISIONS**

### **RATE GUARANTEE**

A change in premium rate will not take effect before the Rate Guarantee Date but in no event will the rate change more frequently than annually, except for reasons which affect the risk assumed, including those reasons shown below:

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

We will notify the policyholder in writing at least 31 days before a premium rate is changed. A change may take effect on an earlier date when both we and the policyholder agree in writing.

### **PREMIUM INCREASES OR DECREASES**

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

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

### **INFORMATION REQUIRED FROM THE POLICYHOLDER**

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

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

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

### **INCONTESTABILITY**

After 2 years from the effective date of this policy, no misstatement of the policyholder, made in any applications, can be used to void this policy.

### **CLERICAL ERROR**

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



## **POLICYHOLDER PROVISIONS (Continued)**

### **CANCELING POLICY**

This policy can be canceled:

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

We may cancel or offer to modify this policy, with at least 31 days written notice to the policyholder, if:

1. less than 25% of those eligible for coverage are participating; or
2. this policy has been in effect more than 12 months; or
3. the policyholder does not promptly provide us with information that is reasonably required; or
4. the policyholder fails to perform any of its obligations that relate to this policy; or
5. fewer than 5 employees or members are insured; or
6. premiums are not received within the 31 day grace period.

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

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

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

### **ENTIRE CONTRACT**

The contract consists of the following items:

1. the group policy; and
2. any amendments and endorsements; and
3. the applications and other written statements of the policyholder; and
4. any individual applications, enrollments, evidence of insurability or other statements of the insured employee or member.

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

### **CERTIFICATES OF INSURANCE**

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

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

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

## GLOSSARY

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

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

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

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

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

**Calendar Year** means a consecutive 12 month period beginning on January 1<sup>st</sup> of each year and ending on December 31<sup>st</sup> of the same year.

**Covered Person** means any of the following:

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

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

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

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

**Family Coverage** means coverage that includes the insured employee as defined, his or her eligible spouse or Domestic Partner and children as described in the certificate.

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

**Individual and Child(ren) Coverage** means coverage that includes only the insured employee or member, as defined and eligible children as described in the certificate.

**Individual and Spouse Coverage** means coverage that includes only the insured employee or member, as defined, and his or her eligible spouse or Domestic Partner as described in the certificate.

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

**Initial Enrollment Period** means one of the following periods during which the employee may first apply in writing for coverage under this policy:

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

## **GLOSSARY (Continued)**

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

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

**Plan** means a line of coverage under the policy.

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

**We, Us** and **Our** means American Heritage Life Insurance Company.

## **CERTIFICATE PROVISIONS MADE PART OF THIS GROUP POLICY**

The remainder of this group policy consists of the provisions that will appear in the group certificate, including any optional riders or endorsements or amendments. The group certificate describes the insurance made available under this group policy to insured employees or members and their dependents, if applicable.

**(This space intentionally left blank)**



**AMERICAN HERITAGE LIFE INSURANCE COMPANY**

HOME OFFICE:  
1776 AMERICAN HERITAGE LIFE DRIVE  
JACKSONVILLE, FLORIDA 32224-6687  
(904) 992-1776

A Stock Company

**THIS IS A GROUP ACCIDENT ONLY POLICY WHICH PROVIDES BENEFITS FOR OFF THE JOB ACCIDENTS AS DEFINED WITHIN THIS POLICY OR OTHER BENEFITS THAT MAY BE ADDED. THIS POLICY DOES NOT PROVIDE BENEFITS FOR ANY OTHER CONDITIONS.**



## AMERICAN HERITAGE LIFE INSURANCE COMPANY

HOME OFFICE:  
1776 AMERICAN HERITAGE LIFE DRIVE  
JACKSONVILLE, FLORIDA 32224-6687  
(904) 992-1776

A Stock Company

### CERTIFICATE OF INSURANCE

This certificate of insurance ("certificate") describes your insurance coverage under the policy.

In this certificate, the words:

"You" and "your" mean the named insured employee or member shown on page 3 who is a member of an eligible class as described in the policy and for whom premiums are remitted.

"We", "us" and "our" mean American Heritage Life Insurance Company.

"This policy" and "the policy" mean the policy of insurance issued by us to the policyholder.

The policy alone makes up the agreement under which insurance coverage is provided and benefits are determined. If the terms of your certificate and the policy differ, the policy will govern. The policy may be inspected at the office of the policyholder during normal business hours.

Coverage under the policy is issued in consideration of your enrollment or other form of application and the payment of the first premium.

We certify that coverage under the policy is in effect for persons who have satisfied all eligibility requirements and for whom the required premium has been paid when due.

The policy is delivered in and is governed by the laws of the governing jurisdiction and, to the extent applicable, by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments.

The policy and this certificate may be changed in whole or in part or cancelled by agreement between us and the policyholder. Such an action may be taken without the consent or notice to you or anyone covered under the policy. Only an authorized officer at our home office can approve a change. The approval must be in writing and endorsed on or attached to the policy. No other person, including an agent, may change the policy or certificate or waive any of its provisions. Premiums are subject to periodic changes.

This certificate supersedes and replaces any certificate previously issued to you under the policy.

A handwritten signature in black ink, appearing to read "Kurt Helms".

Secretary

A handwritten signature in black ink, consisting of a stylized, elongated mark.

President

**THIS IS GROUP ACCIDENT ONLY COVERAGE WHICH PROVIDES BENEFITS FOR OFF THE JOB ACCIDENTS AS DEFINED WITHIN THIS CERTIFICATE OR OTHER BENEFITS THAT MAY BE ADDED. THIS COVERAGE DOES NOT PROVIDE BENEFITS FOR ANY OTHER CONDITIONS.**

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**AMERICAN HERITAGE LIFE INSURANCE COMPANY**  
1776 American Heritage Life Drive, Jacksonville, Florida 32224

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**CERTIFICATE SPECIFICATIONS**

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| FORM NO. | DESCRIPTION OF BENEFITS   | NUMBER OF YEARS PAYABLE* |
|----------|---|--------------------------|
| GVAC2TN  | ACCIDENT COVERAGE (3.00 UNITS)<br>*** SEE PAGE 3A FOR BENEFIT AMOUNTS ***                 | LIFE                     |
|          | BENEFIT ENHANCEMENTS (3.00 UNITS)<br>*** SEE PAGE 3B FOR BENEFIT AMOUNTS ***              | LIFE                     |
| GC6OPHTN | OUTPATIENT PHYSICIAN'S TREATMENT FOR ACCIDENT AND<br>PREVENTIVE CARE BENEFIT RIDER - \$25 | LIFE                     |

\* SUBJECT TO TERMINATION OF COVERAGE PROVISION  
FAMILY COVERAGE

BILLABLE PREMIUM      \$XX.XX

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PREMIUM PAYMENT METHOD      PAYROLL MONTHLY

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INSURED:                      JOHN DOE                                      ISSUE AGE:                      35  
EFFECTIVE DATE:              JANUARY 01, 2021                              CERTIFICATE NUMBER:              123456  
GROUP POLICY NUMBER:      51733  
BENEFICIARY:                      AS NAMED ON ENROLLMENT FORM

ACCIDENT COVERAGE

GVAC2TN

**ACCIDENT CERTIFICATE**  
**SEE BENEFITS SECTION OF CERTIFICATE FOR DETAILS OF BENEFITS**

| <b>BENEFITS</b> |                                   | <b>AMOUNT</b>       |           |            |           |
|-----------------|-----------------------------------|---------------------|-----------|------------|-----------|
|                 |                                   | INSURED<br>EMPLOYEE | SPOUSE    | CHILD(REN) |           |
| 1.              | ACCIDENTAL DEATH                  | PRINCIPAL AMOUNT    | \$60,000  | \$30,000   | \$15,000  |
| 2.              | COMMON CARRIER ACCIDENTAL DEATH   | PRINCIPAL AMOUNT    | \$300,000 | \$150,000  | \$75,000  |
| 3.              | DISMEMBERMENT                     | PRINCIPAL AMOUNT    | \$60,000* | \$30,000*  | \$15,000* |
| 4.              | DISLOCATION/FRACTURE              | PRINCIPAL AMOUNT    | \$6,000*  | \$6,000*   | \$6,000*  |
| 5.              | HOSPITALIZATION CONFINEMENT       | PRINCIPAL AMOUNT    | \$1,500   | \$1,500    | \$1,500   |
| 6.              | DAILY HOSPITALIZATION CONFINEMENT | DAILY BENEFIT       | \$300     | \$300      | \$300     |
| 7.              | INTENSIVE CARE                    | DAILY BENEFIT       | \$600     | \$600      | \$600     |
| 8.              | AMBULANCE SERVICES                |                     |           |            |           |
|                 | A. GROUND AMBULANCE               |                     | \$300     | \$300      | \$300     |
|                 | B. AIR AMBULANCE                  |                     | \$900     | \$900      | \$900     |
| 9.              | ACCIDENT PHYSICIAN TREATMENT      |                     | \$150     | \$150      | \$150     |
| 10.             | X-RAY                             |                     | \$300     | \$300      | \$300     |
| 11.             | EMERGENCY ROOM SERVICES           |                     | \$300     | \$300      | \$300     |

\* MULTIPLIED BY THE APPLICABLE FACTOR LISTED IN THE SCHEDULE OF BENEFITS AND FACTORS.



**ACCIDENT CERTIFICATE  
GROUP ACCIDENT BENEFIT ENHANCEMENTS  
SEE BENEFITS SECTION OF CERTIFICATE FOR DETAILS OF BENEFITS**

| <b>BENEFITS</b>  | <b>AMOUNT</b>       |
|--|---------------------|
| 1. LACERATIONS   | \$150               |
| 2. BURNS   |                     |
| A. SECOND AND THIRD DEGREE BURNS COVERING LESS THAN<br>15% OF THE TOTAL BODY SURFACE | \$300               |
| B. SECOND AND THIRD DEGREE BURNS COVERING 15% OR MORE<br>OF THE TOTAL BODY SURFACE   | \$1,500             |
| 3. SKIN GRAFT  | 50% OF BURN BENEFIT |
| 4. BRAIN INJURY DIAGNOSIS  | \$450               |
| 5. COMPUTED TOMOGRAPHY SCAN OR MAGNETIC RESONANCE<br>IMAGING                         | \$150               |
| 6. PARALYSIS   |                     |
| A. PARAPLEGIA (PARALYSIS OF 2 OR 3 LIMBS)  | \$22,500            |
| B. QUADRIPLEGIA (PARALYSIS OF 4 LIMBS)   | \$45,000            |
| 7. COMA WITH RESPIRATORY ASSISTANCE  | \$30,000            |
| 8. OPEN ABDOMINAL OR THORACIC SURGERY  | \$3,000             |
| 9. TENDON, LIGAMENT, ROTATOR CUFF OR KNEE CARTILAGE<br>SURGERY                       |                     |
| A. WITH REPAIR   | \$1,500             |
| B. WITHOUT REPAIR  | \$450               |
| 10. RUPTURED DISC SURGERY  | \$1,500             |
| 11. EYE SURGERY  | \$300               |
| 12. GENERAL ANESTHESIA   | \$300               |
| 13. BLOOD AND PLASMA   | \$900               |
| 14. APPLIANCE  | \$375               |
| 15. MEDICAL SUPPLIES   | \$15                |
| 16. MEDICINE   | \$15                |
| 17. PROSTHESIS   |                     |
| A. 1 DEVICE  | \$1,500             |
| B. 2 OR MORE DEVICES   | \$3,000             |
| 18. PHYSICAL THERAPY   | DAILY BENEFIT \$90  |
| 19. REHABILITATION UNIT  | DAILY BENEFIT \$300 |
| 20. NON-LOCAL TRANSPORTATION   | PER TRIP \$1,200    |
| 21. FAMILY MEMBER LODGING  | DAILY BENEFIT \$300 |
| 22. POST-ACCIDENT TRANSPORTATION   | \$600               |
| 23. ACCIDENT FOLLOW-UP TREATMENT   | DAILY BENEFIT \$150 |

## GENERAL PROVISIONS

### EFFECTIVE DATE OF COVERAGE

Your coverage will be effective at 12:01 a.m. on the effective date shown on page 3 provided you are actively employed on that date.

If you are not actively employed on that date due to disability, injury, sickness, temporary layoff, leave of absence or Family and Medical Leave of Absence, coverage begins on the date you return to active employment. This applies to your initial coverage, as well as any increase or addition to coverage that occurs after your initial coverage is effective.

For any change in coverage, the change in coverage is effective on the date we approve such change.

### CERTIFICATE OF INSURANCE

This certificate of insurance provides a description of the insurance provided by the policy issued to the policyholder. It describes the essential features of the insurance coverage and to whom benefits are payable.

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

### WHEN YOU CAN ENROLL, CHANGE OR DISCONTINUE COVERAGE

1. You may apply for coverage during:
  - a. the initial enrollment period; or
  - b. at any other time.
2. You may increase coverage at any time.
3. You may decrease coverage at any time.
4. You may discontinue coverage at any time.

### ELIGIBILITY OF DEPENDENTS

Eligible dependents are:

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

A child is a person under age 26 who is:

1. your or your domestic partner's natural or adopted son or daughter, stepson or stepdaughter; or
2. a foster child who is placed with you or your domestic partner by an authorized placement agency or by judgment, decree or other order of any court of competent jurisdiction.

A child born to you or your spouse or domestic partner, will be eligible for coverage. This coverage begins at the moment of birth of such child and benefits will be the same as provided for any other child insured under the certificate. No additional premium will be required for newborns added if you already have children coverage in force at the time the newborn is added.

If you do not already have children coverage in force, or do not have coverage in force that covers more than one child, newborn children are automatically covered from the moment of birth for a period of 31 days. If you desire uninterrupted coverage for a newborn child, you must notify the policyholder within 31 days of that child's birth. Upon notification to us, we will convert your coverage to include the additional child and provide notification of the additional premium due. If you do not notify the policyholder within 31 days of the birth of the child, the temporary automatic coverage ends.

If you marry and desire coverage for your spouse, you must notify the policyholder of the marriage within 31 days of the marriage. We will change your coverage to include your spouse and provide notification of the additional premium due.

## **GENERAL PROVISIONS (Continued)**

### **ELIGIBILITY OF DEPENDENTS (Continued)**

If you enter into a domestic partnership and desire coverage for your domestic partner, you must notify the policyholder of the domestic partnership within 31 days of the date the domestic partnership was formed. We will change your coverage to include your domestic partner and provide notification of the additional premium due.

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

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

Coverage must be provided as long as you have custody of the child pursuant to decree of the court and required premiums are paid.

If you do not already have child coverage in force, or do not have coverage in force that covers more than one child, we will convert your coverage to include the additional adopted child or child pending adoption and provide notification of the additional premium due.

### **TERMINATION OF COVERAGE**

Your coverage under the policy ends on the earliest of:

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

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

If your spouse is a covered person, your spouse's coverage ends upon valid decree of divorce or your death.

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

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

Coverage does not end for an incapacitated dependent child who:

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

Coverage for an incapacitated dependent child continues as long as the certificate remains in force and the child remains in such condition. Proof of the incapacity and dependency of the child must be furnished, in writing, to us when the child reaches the limiting age of eligibility. Thereafter, such proof must be furnished as often as may be required, but no more often than annually after the 2 year period following the child's attainment of the limiting age for eligibility.

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

Coverage may be eligible for continuation as outlined in the CONTINUATION OF INSURANCE provision.

## **GENERAL PROVISIONS (Continued)**

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

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

If your coverage ends while on a Family and Medical Leave of Absence, your coverage will be reinstated when you return to active status.

### **LEGAL ACTION**

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

1. for at least 60 days after proof of loss has been furnished; or
2. after the expiration of 6 years from the time written proof of loss is required to have been furnished.

### **INCONTESTABILITY**

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

### **CLERICAL ERROR**

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

### **AGENCY**

For purposes of the policy, the policyholder acts on its own behalf or as your agent. Under no circumstances will the policyholder be deemed the agent of American Heritage Life Insurance Company.

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## EXCLUSIONS AND LIMITATIONS

We will not pay any benefits for any loss that is caused by, contributed to by or results from:

1. Injury incurred prior to the covered person's effective date of coverage subject to the incontestability provision.
2. An injury that occurred as a result of an on the job accident.
3. Any act of war whether or not declared, participation in a riot, insurrection or rebellion.
4. Suicide, or any attempt at suicide, whether sane or insane.
5. Intentionally self-inflicted injury or action.
6. Any injury sustained while the covered person is under the influence of alcohol or any narcotic, unless administered upon the advice of a physician.
7. Any bacterial infection (except pyogenic infections which shall occur with and through an accidental cut or wound).
8. Participation in any form of aeronautics except as a fare-paying passenger in a licensed aircraft provided by a common carrier and operating between definitely established airports.
9. Engaging in an illegal occupation or committing or attempting to commit an assault or felony.
10. Driving in any organized or scheduled race or speed test or while testing an automobile or any vehicle on any racetrack or speedway.
11. Hernia, including complications due to hernia.

"Under the influence" means a condition as determined by the laws of the state in which the loss occurred.

Any injury incurred while a covered person is an active member of the Military; Naval; or Air Forces of any country or combination of countries is not covered. Upon notice and proof of service in such forces, we will return the pro-rata portion of the premium paid for any period of such service.

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## BENEFIT INFORMATION

If, while this certificate is in force and as the result of an off the job accident, a covered person sustains an injury, which results, within 90 days (180 days for Accidental Death or Dismemberment) or unless otherwise stated from the date of a covered accident, in any of the losses stated in the BENEFIT INFORMATION provision, and is diagnosed by a physician, we pay the following benefits for such loss. Any loss not stated in the BENEFIT INFORMATION provision is not covered under this certificate. Treatment must be received in the United States or its territories.

- 1. Accidental Death:** We pay a benefit equal to the principal amount stated on page 3A. Benefits are subject to all of the terms, conditions and provisions of the certificate.
- 2. Common Carrier Accidental Death:** We pay a benefit equal to the principal amount stated on page 3A, if death results from an injury while riding as a fare paying passenger on a scheduled common carrier. Benefits are subject to all of the terms, conditions and provisions of the certificate.
- 3. Dismemberment:** We pay a benefit equal to the principal amount stated on page 3A, multiplied by the applicable factor in the Schedule of Benefits and Factors. If more than one dismemberment is sustained in any one injury, the total amount we will pay for the multiple dismemberments will not exceed the dismemberment principal amount stated on page 3A. Benefits are subject to all of the terms, conditions and provisions of the certificate.

Loss of hand or hands, or foot or feet, means total and permanent severance at or above the wrist or ankle joint. Loss of arm or arms or leg or legs, means severance at or above the elbow joint or knee joint. The loss of eye or eyes means the entire and irrecoverable loss of sight. The loss of finger means the severance through or above metacarpophalangeal joints.

- 4. Dislocation or Fracture:** We pay a benefit equal to the principal amount stated on page 3A, multiplied by the applicable factor in the Schedule of Benefits and Factors. If more than one dislocation or fracture is sustained in any one injury, the total amount we will pay for the multiple dislocations or fractures will not exceed the dislocation or fracture principal amount stated on page 3A. No benefit will be paid for any dislocation or fracture that is not listed in the Schedule of Benefits and Factors.
- 5. Hospitalization Confinement:** We pay the amount stated on page 3A the first time a covered person is hospital confined after that person's effective date of coverage as a result of an injury. This benefit is payable only once per covered person per calendar year.
- 6. Daily Hospital Confinement:** We pay a daily benefit of the amount stated on page 3A if a covered person is confined in a hospital, as a result of an injury. This benefit is paid for each day of hospital confinement, up to a maximum of 90 days for any one injury, starting with the first full day of confinement. A day is a 24 hour period.

"Hospital Confined or Confinement" means a confinement as an inpatient in a hospital for which a room and board charge is made by the hospital. It does not include confinement for an observation room or a fractional part of a day.

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

- 7. Intensive Care:** We pay a daily benefit of the amount stated on page 3A if a covered person is confined in a hospital intensive care unit, as a result of an injury. This benefit is paid for each day of intensive care unit confinement up to 90 days for each period of continuous hospital intensive care confinement. A day is a 24 hour period. If confinement is for only a portion of a day, then a pro-rata share of the daily benefit stated on page 3A is paid.

"Continuous Hospital Intensive Care Unit Confinement" means one continuous confinement or two or more hospital intensive care unit confinements not separated by more than 30 days. If there are more than 30 days between confinements, they are considered separate confinements.

## BENEFIT INFORMATION (Continued)

### 7. Intensive Care (Continued):

“Hospital Intensive Care Unit” means a hospital area of special care, which at the time of admission is separate and apart from the surgical recovery room, other rooms, beds, or wards normally used for patient confinement. In addition, the unit must provide the following:

- a. 24 hour continuous nursing care attended by nurses assigned to the unit on a full time basis; and
- b. direction and/or supervision by a full time physician director or a standing “intensive care” committee of the medical staff; and
- c. special medical apparatus used to treat the critically ill.

“Nurse” means any one of the following who is not a member of the covered person’s immediate family or employed by the hospital where the covered person is confined:

- a. licensed practical nurse (L.P.N.); or
- b. licensed vocational nurse (L.V.N.); or
- c. graduate registered nurse (R.N.).

**8. Ambulance Services:** We pay one of the amounts stated on page 3A depending on the method of transfer, if a covered person, as a result of an injury, requires ambulance service for the transfer to or from a hospital.

**9. Accident Physician Treatment:** We pay the benefit stated on page 3A if a covered person, as a result of an injury, receives treatment by a physician. This benefit is payable only once per covered person, per accident.

**10. X-Ray:** We pay the benefit stated on page 3A if a covered person, as a result of an injury, receives x-rays. This benefit is payable only once per covered person, per accident.

**11. Emergency Room Services:** We pay the benefit stated on page 3A if a covered person, as a result of an injury, receives emergency room services. This benefit is payable only once per covered person, per accident.

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## BENEFIT INFORMATION (Continued)

### BENEFIT ENHANCEMENTS

- 1. Lacerations:** We pay the amount shown on page 3B if a covered person receives treatment for 1 or more lacerations (cuts) within 3 days after the accident. This benefit is payable only once per covered person, per calendar year.
- 2. Burns:** We pay the amount shown on page 3B if a covered person receives treatment for 1 or more burns, other than sun burns, within 3 days after the accident. This benefit is payable only once per covered person, per accident.
- 3. Skin Graft:** We pay the amount shown on page 3B if a covered person receives a skin graft for a burn for which a benefit is paid under the Burns benefit. The skin graft must be performed within 90 days after the accident. This benefit is payable only once per covered person, per accident.
- 4. Brain Injury Diagnosis:** We pay the amount shown on page 3B upon the first diagnosis of 1 of the following traumatic brain injuries by a covered person: concussion, cerebral laceration, cerebral contusion, or intracranial hemorrhage. The covered person must be first treated by a physician within 3 days after the accident.

The covered traumatic brain injury must be diagnosed within 30 days after the accident by computed tomography (CT) scan, magnetic resonance imaging (MRI), electroencephalogram (EEG), positron emission tomography (PET) scan, or X-ray. This benefit is payable only once per covered person.

- 5. Computed Tomography (CT) Scan and Magnetic Resonance Imaging (MRI):** We pay the amount shown on page 3B if a covered person receives a CT scan or MRI within 180 days after the accident. The covered person must be first treated by a physician within 30 days after the accident. This benefit is payable only once per covered person, per accident, per calendar year.
- 6. Paralysis:** We pay the amount shown on page 3B if a covered person receives a spinal cord injury resulting in the complete and permanent loss of use of 2 or more limbs as a result of an injury. Paralysis must be confirmed by the attending physician within 3 days after the accident and have a duration of at least 90 consecutive days. This benefit is payable only once per covered person.
- 7. Coma with Respiratory Assistance:** We pay the amount shown on page 3B if a covered person is in a coma. This benefit is payable only once per covered person.  
  
"Coma" means a continuous state of profound unconsciousness which lasts 7 or more consecutive days as a result of an accident. A coma is characterized by an absence of spontaneous eye movements, response to painful stimuli and vocalization. The condition must require intubation for respiratory assistance. Medically induced comas are excluded.
- 8. Open Abdominal or Thoracic Surgery:** We pay the amount shown on page 3B if a covered person undergoes open abdominal or thoracic surgery for internal injuries within 3 days of the accident. We pay this benefit even if no surgical repair is required.

If 2 or more surgical procedures are performed through the same incision or entry point, they are considered 1 operation.

- 9. Tendon, Ligament, Rotator Cuff or Knee Cartilage Surgery:** We pay the amount shown on page 3B if a covered person undergoes a surgical procedure to repair an injury to a tendon, ligament, rotator cuff or knee cartilage. The injured site must be torn, ruptured, or severed and the surgical procedure must be performed by a physician within 180 days after the accident.

If exploratory surgery using arthroscopy is performed and no surgical repair is required then we will pay the amount shown on page 3B. If 2 or more surgical procedures are performed through the same incision or entry point, they are considered 1 operation and we will pay the amount for the procedure with the largest dollar amount benefit.



## BENEFIT INFORMATION (Continued)

### BENEFIT ENHANCEMENTS (Continued)

**10. Ruptured Disc Surgery:** We pay the amount shown on page 3B if a covered person undergoes a surgical procedure to repair a ruptured disc of the spine. The ruptured disc must be diagnosed and the surgical procedure must be performed by a physician within 180 days after the accident.

If 2 or more surgical procedures are performed through the same incision or entry point, they are considered 1 operation.

**11. Eye Surgery:** We pay the amount shown on page 3B for surgery or removal of a foreign object from the eye of a covered person. The procedure must be performed by a physician within 90 days after the accident. An examination with or without anesthesia is not considered surgery. This benefit is payable only once per covered person, per accident.

**12. General Anesthesia:** We pay the amount shown on page 3B if a covered person received general anesthesia administered by a nurse anesthetist or physician for surgery required to treat an injury provided a benefit is paid for the surgery under the Surgery benefit of the policy. The surgery must be performed by a physician within 180 days after the accident.

“General Anesthesia” means a process that produces loss of consciousness, in addition to pain relief and paralysis of skeletal muscle over the entire body, by the administration of anesthetic drugs and is used during major and other invasive surgical procedures.

**13. Blood and Plasma:** We pay the amount shown on page 3B if a covered person receives a blood or plasma transfusion within 3 days after an accident. This benefit is payable only once per covered person, per accident.

**14. Appliance:** We pay the amount shown on page 3B if a covered person receives 1 of the following medical appliances prescribed by a physician as an aid in personal locomotion or mobility: wheelchair, crutches, or walker. The use of a medical appliance must begin within 90 days after the accident. This benefit is payable only once per covered person, per accident.

**15. Medical Supplies:** We pay the amount shown on page 3B for over-the-counter medical supplies purchased for a covered person provided a benefit is paid for the accident under the Accident Physician Treatment or X-Ray benefits. The supplies must be purchased within 90 days after the accident. We pay this benefit once per covered person, per accident.

**16. Medicine:** We pay the amount shown on page 3B per accident for prescription or over-the-counter medicine purchased for a covered person provided a benefit is paid for the accident under the Accident Physician Treatment or X-Ray benefits. The medicine must be purchased within 90 days after the accident. We pay this benefit once per covered person, per accident.

**17. Prosthesis:** We pay the amount shown on page 3B for a prosthetic arm, leg, hand, foot or eye prescribed by a physician to replace an arm, leg, hand, foot or eye that a covered person loses as a direct result of an accident. This benefit is paid only if a benefit is paid for the loss of an arm, leg, hand, foot or eye under the Dismemberment benefit. The prosthetic device must be received within 180 days after the accident. This benefit is payable only once per covered person, per accident.

**18. Physical Therapy:** We pay the amount shown on page 3B per day for physical therapy treatment received by a covered person when prescribed by a physician for an injury, provided a benefit is paid for the accident under the Accident Physician Treatment or X-Ray benefits. We pay for 1 physical therapy treatment per day for up to a maximum of 6 treatments per accident per covered person. Chiropractic services are excluded.

Physical therapy must be for injuries sustained in an accident and must:

- a. begin within 90 days after the accident; and
- b. take place no longer than 6 months after the accident.

This benefit is not payable for the same visit for which the Accident Follow-Up Treatment benefit is paid.

“Physical Therapist” means a licensed specialist in physical therapy. The term “Physical Therapist” does not include: a chiropractor; any covered person; or any spouse, parent, brother, sister or child of a covered person.

## BENEFIT INFORMATION (Continued)

### BENEFIT ENHANCEMENTS (Continued)

**19. Rehabilitation Unit:** We pay the amount shown on page 3B per day if a covered person is confined to a rehabilitation unit as a result of an injury, provided that the covered person has been hospital confined immediately prior to being transferred to the rehabilitation unit. This benefit is paid for each day a room charge is incurred, up to 30 days for each covered person, per continuous period of rehabilitation unit confinement, for a maximum of 60 days per calendar year. This benefit is not payable for days on which the Hospital Confinement benefit is paid.

**20. Non-Local Transportation:** We pay the amount shown on page 3B per trip for non-local treatment of a covered person at a hospital or other specialized freestanding treatment center prescribed by a physician when the same or similar treatment cannot be obtained locally. "Non-local" means a one-way trip of 100 miles or more from the covered person's home to the nearest treatment facility. We do not pay for visits to a physician's office or clinic or for services other than actual treatment. This benefit is payable up to 3 times per accident. Transportation by ground or air ambulance is not covered under this benefit.

**21. Family Member Lodging:** We pay the amount shown on page 3B per day for the lodging of 1 adult family member of the covered person's family to be with the covered person when a covered person is confined for treatment in a non-local hospital or other specialized freestanding treatment center. This benefit is payable for up to 30 days for each accident.

This benefit is only payable if the Non-local Transportation benefit is paid. This benefit will not be paid if the family member lives within 100 miles one-way of the treatment facility.

**22. Post-Accident Transportation:** We pay the amount shown on page 3B if a covered person is hospital confined for at least 3 consecutive days due to an injury resulting from an accident which occurs more than 250 miles from his or her place of residence and the covered person is brought home by a common carrier.

"Common carrier" means a method of transport with defined published routes, time schedules and rates approved by regulators. These include public airlines, railroads, and bus lines. Travel to the place of residence must take place within 48 hours following discharge from the hospital. This benefit is payable for the injured covered person only, and only if the Hospital Confinement benefit is paid. This benefit is payable only once per covered person, per calendar year.

**23. Accident Follow-Up Treatment:** We pay the amount shown on page 3B per day for follow-up treatment received by a covered person provided a benefit is paid for the accident under the Accident Physician Treatment or X-Ray benefits. We pay for 1 follow-up treatment per day for up to a maximum of 2 treatments per accident per covered person.

Treatments must be administered by a physician in a physician's office or in a hospital on an outpatient basis and must be for injuries sustained in an accident and must:

- a. begin within 90 days after the accident; and
- b. take place no longer than 6 months after the accident.

This benefit is not payable for the same visit for which the Physical Therapy benefit is paid.

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## SCHEDULE OF BENEFITS AND FACTORS

| <b>For the Loss of:</b>                             | <b>Factor</b> | <b>For Complete, Simple or Closed Fracture of Bone or Bones of:</b> | <b>Factor</b> |
|---|---------------|---|---------------|
| Life.....   | 1.00          | Skull (except bones of face or nose) .....                          | 0.95          |
| Both Eyes .....                                     | 1.00          | Hip, Thigh (Femur).....   | 1.00          |
| One Eye .....                                       | 0.50          | Pelvis (except Coccyx) .....  | 1.00          |
| Both Hands or Both Arms .....                       | 1.00          | Arm, between Shoulder and Elbow (shaft) .....                       | 0.55          |
| Both Feet or Both Legs .....                        | 1.00          | Shoulder Blade (Scapula) .....                                      | 0.55          |
| One Hand or Arm and One Foot or Leg.....            | 1.00          | Leg (Tibia or Fibula).....  | 0.55          |
| One Hand or One Arm .....                           | 0.50          | Ankle .....   | 0.40          |
| One Foot or One Leg .....                           | 0.50          | Knee Cap (Patella).....   | 0.40          |
| One or more entire Toes .....                       | 0.10          | Collar Bone (Clavicle) .....  | 0.40          |
| One or more entire Fingers .....                    | 0.10          | Forearm (Radius or Ulna) .....                                      | 0.40          |
|   |               | Foot (except Toes).....   | 0.35          |
| <b>For the Complete Dislocation of:</b>             | <b>Factor</b> | Hand or Wrist (except Fingers).....                                 | 0.35          |
| Hip Joint .....                                     | 1.00          | Lower Jaw (except Alveolar Process).....                            | 0.20          |
| Knee Joint (except Patella) .....                   | 0.40          | Two or More Ribs, Fingers or Toes .....                             | 0.15          |
| Bone or Bones of the Foot, other than Toes .....    | 0.40          | Bones of Face or Nose .....   | 0.15          |
| Ankle Joint.....                                    | 0.40          | One Rib, Finger or Toe .....  | 0.07          |
| Wrist Joint.....                                    | 0.35          | Coccyx .....  | 0.07          |
| Elbow Joint .....                                   | 0.30          |   |               |
| Shoulder Joint .....                                | 0.20          |   |               |
| Bone or Bones of the Hand, other than Fingers ..... | 0.15          |   |               |
| Collar Bone.....                                    | 0.15          |   |               |
| Two or more Fingers .....                           | 0.07          |   |               |
| Two or more Toes .....                              | 0.07          |   |               |
| One Finger or One Toe .....                         | 0.03          |   |               |

## CONTINUATION OF INSURANCE COVERAGE

This section provides for automatic Continuation of Insurance Coverage, hereafter referred to as Continuation Coverage. It applies if a covered person suffers the loss of this group health insurance coverage due to one of the following events:

1. Termination of your employment; or your eligibility due to reduction in your hours; or the date you are no longer in an eligible class; or the date your class is no longer eligible. Insurance may be continued for any covered person.
2. Your death. Insurance may be continued for any covered person.
3. Divorce or legal separation. Insurance may be continued for any covered person whose insurance would otherwise end.
4. Your becoming eligible for Medicare. Insurance may be continued for any covered person who is not entitled to Medicare.
5. A child ceasing to be an eligible dependent as defined in the group policy. Insurance may continue for that child.
6. The policyholder filing a Chapter 11 Bankruptcy petition. Insurance may be continued for any insured retiree and his or her covered dependents. But this only applies if the insurance ends or is substantially reduced within 1 year before or after the filing of the bankruptcy.
7. Termination of the group policy. (Benefits will be determined as if the group policy had remained in full force and effect.)
8. Strike, layoff, leave of absence for personal reasons (not Family or Medical Leave Act (FMLA)). Insurance may be continued for any covered person.
9. Military Service. Your leave of absence due to military service. Insurance may be continued for any covered person, except for the person who is in active military service.

Continuation Coverage is not available for any person if coverage under the group policy terminated due to your failure to make required premium payments.

Continuation Coverage is not available to any person who is on FMLA. Continuation Coverage is also not available if a person fails to pay premium while on FMLA.

To be eligible for Continuation Coverage, a person must be insured under the group policy on the day before the event that caused loss of coverage. In the case of bankruptcy, the person must also be: (a) an employee or member who retired on or before the date insurance ends or is substantially reduced; or (b) a dependent of the retiree on the day before the bankruptcy.

A person will not be denied Continuation Coverage solely because he or she is covered under another group health plan like this one, or eligible for Medicare on the date of the event that caused loss of coverage.

### COVERAGE CONTINUED

The Continuation Coverage may include any eligible dependents who were covered under the group policy. The coverage being continued is subject to all terms and provisions of the group policy that do not conflict with this section. The coverage will be the same as that provided under the group policy for other persons in the same insurance class in which such person would have been if the loss of coverage had not occurred. The coverage will be subject to any changes to the group policy affecting the benefits of such class. The coverage will be effective on the day after the insurance under the group policy terminates.

### NOTIFICATION AND PAYMENT REQUIREMENTS

You or other qualifying dependents have the responsibility to inform the insurer of (a) divorce; (b) legal separation; or (c) a child losing eligibility under the policy. This notice must be made within 60 days of these events. Failure to provide this notification within 60 days will result in the loss of the right to continue the insurance.

The policyholder has the responsibility of notifying the insurer of (a) an insured's death, termination of employment, or reduction in hours; or (b) the policyholder's bankruptcy. This notice must be made within 30 days of the event.

The insurer will notify the qualifying person of the right to continue within 14 days of the notice described above.

The qualifying person will be required to pay a premium for the Continuation Coverage to the insurer.

## **CONTINUATION OF INSURANCE COVERAGE (Continued)**

### **PREMIUMS**

Premiums are due and payable in advance to us at our home office. Premium due dates are the first day of each calendar month. The premium rate for the first 36 months of Continuation Coverage will not exceed 102% of the rate in effect under the group policy covering similarly situated class of employees who have not elected Continuation Coverage. After the first 36 months, the premium rate may change for the class of persons covered under Continuation Coverage. Written notice will be given at least 31 days before any change is to take effect.

### **GRACE PERIOD**

The grace period, as defined in the group policy, will apply to each certificate holder of Continuation Coverage as if such insured is the policyholder.

### **TERMINATION OF INSURANCE**

Insurance under Continuation Coverage will automatically end on the earliest of the following dates:

1. The date the person again becomes eligible for insurance under the group policy.
2. The last day for which premiums have been paid, if the insured fails to pay premiums when due, subject to the grace period.
3. With respect to insurance for dependents:
  - a. the date your insurance terminates; or
  - b. the date the dependent ceases to be an eligible dependent under the group policy.

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

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## **CLAIM INFORMATION**

### **NOTICE OF CLAIM**

We encourage you to notify us of a claim as soon as possible so that a claim decision can be made in a timely manner. Written notice of claim must be given to us within 20 days after the occurrence or commencement of any benefit covered by the policy, or as soon as is reasonably possible. Notice given to us by, or on behalf of, you or the beneficiary at 1776 American Heritage Life Drive, Jacksonville, Florida 32224-6687, or to any authorized agent of ours, with your name and certificate number, is notice to us.

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

### **FILING A CLAIM**

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

### **PROOF OF YOUR CLAIM**

If this certificate provides for periodic payment of a continuing loss, written proof of loss must be furnished to us within 90 days after the end of each period for which we are liable. For any other loss, written proof must be given to us within 90 days after each loss. If it is not possible to give us written proof in the time required, we will not reduce or deny any claim for this reason, as long as the proof is filed as soon as reasonably possible. In any event, the proof required must be given to us no later than 1 year from the time specified unless you are legally incapacitated.

### **PHYSICAL EXAMINATION AND AUTOPSY**

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

### **PAYMENT OF CLAIMS**

After receiving written proof of claim, we will immediately pay all benefits then due under this certificate and we will make payments to you. Any amounts unpaid at your death may, at our option, be paid either to the named beneficiary or to your estate.

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

### **ASSIGNMENT**

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

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

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

## **CLAIM INFORMATION – (Continued)**

### **OVERPAID CLAIM**

We have the right to recover any overpayments due to:

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

You must reimburse us in full. We will work with you to develop a reasonable method of repayment if you are financially unable to repay us in a lump sum. In the case of an error in our processing, a recovery can only be made during the 18 months from the date the payment of claim was made. No such restriction will apply to fraudulent overpayments.

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

### **CLAIM REVIEW**

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

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

You may, upon written request, read any reports that are not confidential. For a small fee, we will make copies of those reports for your use.

### **APPEALS PROCEDURE**

Prior to filing any lawsuit and within 60 days after denial of a claim, you or your beneficiary must appeal any denial of benefits under the policy by making a written request for review of the denial.

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## GLOSSARY

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

**Active Employment** means you are working for your employer for earnings that are paid regularly and that you are performing the material and substantial duties of your own occupation. For the purposes of this coverage:

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

Your work site must be:

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

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

**Calendar Year** means a consecutive 12 month period beginning on January 1<sup>st</sup> of each year and ending on December 31<sup>st</sup> of the same year.

**Common Carrier** means only the following: commercial airlines; or passenger trains; or intercity buslines. It does not include taxis; or intracity buslines; or private charter planes.

**Covered Person** means any of the following:

1. any eligible family member (including you) named in the enrollment form or evidence of insurability form and acceptable for coverage by us; or
2. any eligible family member added by endorsement after the effective date; or
3. a newborn child.

**Day** means a 24 hour period.

**Domestic Partner** means your same-sex or opposite-sex partner who is eligible for coverage provided that:

1. both you and your same-sex or opposite-sex partner must be considered as domestic partners according to the law of your state of residence; or
2. if your state of residence has no domestic partnership laws, you must satisfy the definition of domestic partner as defined by the policyholder.

**Eligibility Waiting Period** means the continuous period of time that you must be in active employment in an eligible class before eligible for coverage under the policy.

**Employee** means a person who is a citizen or resident of the United States or Canada in active employment with his or her employer.

**Employer** means the individual, company or corporation where the covered person is in active employment, and includes any division, subsidiary, or affiliated company of the employer.

**Grace Period** means the 31 day period of time following the premium due date during which premium payment may be made.



## **GLOSSARY (Continued)**

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

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

**Initial Enrollment Period** means one of the following periods during which you may first apply in writing for coverage under the policy:

1. if you are eligible for coverage on the policy effective date, a period before the policy effective date as set by us and by the employer; or
2. if you become eligible for coverage after the policy effective date, the period ending 31 days after the date you are first eligible to apply for coverage.

**Injury** means accidental bodily injury to a covered person, as the result of an accident while coverage under this certificate is in force, and the injury is the direct cause of the loss independent of disease, bodily infirmity, or any other cause which results:

1. in a loss of life or by dismemberment within 180 days after the date the injury is sustained; or
2. in expenses incurred for medical treatment within 90 days after the injury is sustained.

All injuries sustained in any one accident and all complications and recurrences of complications are considered to be a single "injury".

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

**Insured Employee or Member** means the employee or member covered under the policy.

**Material and Substantial Duties** means duties that:

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

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

**Off The Job Accident** means any accident that is not an on the job accident.

**On The Job Accident** means an accident which occurs during the course of a covered person's working for pay or profit. If the covered person is covered by workers' compensation, the accident is an on the job accident. If the covered person is not covered by workers' compensation and the injury occurs while the covered person is working for pay or profit in the course of the covered person's regular and/or part time occupation, the accident is an on the job accident.

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

**Physician** means:

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

We will not recognize you, your spouse or Domestic Partner, children, parents, or siblings as a physician for a claim.

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

## **GLOSSARY (Continued)**

**Temporary Layoff** or **Leave of Absence** or **Family and Medical Leave of Absence** means you are absent from active employment for a period of time that has been agreed to in advance in writing by your employer.

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

**We, Us** and **Our** mean American Heritage Life Insurance Company.

**You** and **Your** mean the named insured employee or member shown on page 3 who is a member of an eligible class as described in the policy and for whom premiums are remitted.

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**AMERICAN HERITAGE LIFE INSURANCE COMPANY**

HOME OFFICE:

1776 AMERICAN HERITAGE LIFE DRIVE

JACKSONVILLE, FLORIDA 32224-6687

(904) 992-1776

A Stock Company

**THIS IS GROUP ACCIDENT ONLY COVERAGE WHICH PROVIDES BENEFITS FOR OFF THE JOB ACCIDENTS AS DEFINED WITHIN THIS CERTIFICATE OR OTHER BENEFITS THAT MAY BE ADDED. THIS COVERAGE DOES NOT PROVIDE BENEFITS FOR ANY OTHER CONDITIONS.**

# AMERICAN HERITAGE LIFE INSURANCE COMPANY

1776 American Heritage Life Drive, Jacksonville, Florida 32224-6687

## OUTPATIENT PHYSICIAN'S TREATMENT FOR ACCIDENT AND PREVENTIVE CARE BENEFIT RIDER

This rider is issued in consideration of the rider premium and the written request for the rider. Benefits are paid in addition to the benefits of the certificate to which it is attached. Benefits are subject to all of the terms, conditions and provisions of the policy. All terms defined and used in the certificate apply to this rider unless otherwise provided in this rider.

### DEFINITIONS

**Certificate** means the certificate to which this rider is attached.

**Preventive care** means services provided to prevent disease and maintain health, including early diagnosis of disease, discovery and identification of people at risk of development of specific problems, counseling and other necessary intervention to avert a health problem. These services are consistent with those considered preventive health services by group health plans or health insurers offering group or individual health coverage. Such may include screening tests, health education and immunizations. Any service intended to treat an existing illness, injury or condition is not preventive care.

**Rider date** means the effective date of coverage under this rider. The rider date is the effective date of the certificate, unless this rider is applied for at a later date. If this rider is applied for at a later date, the rider date is the effective date assigned by our home office in accordance with our coverage dating rules in effect at the time this rider is issued.

### BENEFIT

We pay the following benefit while this rider is in force. No other benefits are covered under this rider. Treatment must be received in the United States or its territories.

**Outpatient Physician Treatment:** We pay the amount shown on page 3 of the certificate for each day a covered person is treated by a physician outside of a hospital for:

1. an injury sustained as a result of an off the job accident; or
2. preventive care.

This benefit is payable only once per day per covered person, and is limited to:

1. 2 days per covered person, per calendar year; and
2. a maximum of 4 days per calendar year if coverage includes eligible dependents.

### EXCLUSIONS AND LIMITATIONS

We will not pay any benefits for any injury that is caused by, contributed to by or results from:

1. an injury incurred prior to the covered person's effective date of coverage subject to the INCONTESTABILITY provision; or
2. any act of war whether or not declared, participation in a riot, insurrection or rebellion; or
3. suicide, or any attempt at suicide, whether sane or insane; or
4. intentionally self-inflicted injury or action; or
5. participation in any form of aeronautics except as a fare-paying passenger in a licensed aircraft provided by a common carrier and operating between definitely established airports; or
6. engaging in an illegal occupation or committing or attempting to commit an assault or felony; or
7. driving in any organized or scheduled race or speed test or while testing an automobile or any vehicle on any racetrack or speedway; or
8. any injury sustained while the covered person is under the influence of alcohol or any drug, unless administered and taken as prescribed by a physician; or
9. an injury that occurred as a result of an on the job accident.

Any injury incurred while a covered person is an active member of the Military, Naval, or Air Forces of any country or combination of countries is not covered.

## TERMINATION

Your coverage under this rider terminates at the earliest of:

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

Signed for AMERICAN HERITAGE LIFE INSURANCE COMPANY at its Home Office.



Secretary



President



## Important Privacy Policy Notice

At Allstate Benefits ("AB"), we value you as a customer. We also share your concerns about privacy. We are sending this notice to explain how we treat personal information ("customer information") that is not public. This is information that we obtain from you or other sources when we provide you with products and services.

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

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

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

### What do we do with your information?

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

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

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

These persons or organizations may include:

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

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

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

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

**How do we protect your customer information?**

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

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

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

AB  
Policyholder Services (Privacy Section)  
1776 American Heritage Life Drive  
Jacksonville, FL 32224-6687

**If you are an Internet user ...**

Our website, [www.allstatebenefits.com](http://www.allstatebenefits.com), provides information about AB, our products, and the agencies and brokers that represent us. You may also perform certain transactions on the website. When accessing [www.allstatebenefits.com](http://www.allstatebenefits.com), please be sure to read the Privacy Statement that appears there. To learn more, the [www.allstatebenefits.com](http://www.allstatebenefits.com) Privacy Statement provides information relating to your use of the website. This includes, for example:

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

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

AB  
Policyholder Services (Privacy Section)  
1776 American Heritage Life Drive  
Jacksonville, FL 32224-6687

This notice is being provided on behalf of the following companies:

|  |                                |
|--|--------------------------------|
| American Heritage Life Insurance Company | Holiday Life Insurance Company |
| Bluegrass Life Insurance Company         | Kentucky Home Mutual           |
| Acme United Insurance Company            | Keystone State Life            |
| SMA Life Assurance Company               | National Guardian Life         |



# Allstate<sup>®</sup> BENEFITS

## NOTICE OF PRIVACY PRACTICES

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

### **EFFECTIVE APRIL 14, 2003**

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

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

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

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

Protected Health Information means information about you that is created or received by us and during the administration of coverage under the Plan, which identifies you or for which there is a reasonable basis to believe the information can be used to identify you and that relates to:

- 1) the past, present or future physical or mental health condition of the individual; or
- 2) the provision of health care to the individual; or
- 3) the past, present or future payment for the provision of health care to the individual.

### **Uses and Disclosures of Protected Health Information With Your Written Authorization**

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



## Uses and Disclosures of Protected Health Information Without Your Written Authorization

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

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

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

If you have designated a person to receive information regarding payment of the premium or pay premium via credit card, we may inform that person or credit card facility when your premium has not been paid or received by us.

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

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

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

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

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

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

- if required by law to a government authorized health oversight agency or company conducting audits, investigations, or civil or criminal proceedings.

- if required to do so by a court or administrative ordered subpoena or discovery request. In most cases you will have notice of such a release.
- for public health activities, such as required reporting of disease, injury, birth and death and for required public health investigations.
- as required by law if we suspect child abuse or neglect or if we believe you to be a victim of abuse, neglect or domestic violence.
- to the Food and Drug Administration if necessary to report adverse events, product defects or to participate in product recalls.
- to law enforcement officials as required by law to report wounds, injuries or crimes.
- to coroners, medical examiners and/or funeral directors consistent with law.
- for a national security or intelligence activity or, if you are a member of the military, as required by the armed forces.
- to workers' compensation agencies or similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

### **Your Rights**

**Right to Inspect and Copy Your Protected Health Information.** You may have access to our records that contain your Protected Health Information in order to inspect and obtain copies of the records. Under limited circumstances, we may deny you access to a portion of your records. If you desire access to your records, please obtain a record request form from our Privacy Officer and submit the completed form to our Privacy Office. If you request copies, we may charge you copying and mailing costs. If you request a copy of your Protected Health Information in electronic form, we will provide it to you electronically only if the record is readily producible in electronic form.

**Right to Amend Your Protected Health Information.** You have the right to request that we amend your Protected Health Information maintained in our enrollment, payment, claims adjudication and case or medical management records, or other records we use to make decisions about you. If you desire to amend these records, please obtain an amendment request form from our Privacy Officer and submit the completed form to our Privacy Office. We will comply with your request unless special circumstances apply. If your physician or other health care provider created the information that you desire to amend, you should contact the provider to amend the information.

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

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

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

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

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

### **Complaints**

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

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

### **Contact Information**

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

Allstate Benefits  
Attn: HIPAA Privacy Officer

1776 American Heritage Life Drive  
Jacksonville, Florida 32224

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

**NOTICE CONCERNING COVERAGE UNDER  
THE TENNESSEE LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT**

Insurance companies and health maintenance organizations (HMOs) licensed in this state to write life insurance, annuities or health insurance are members of the Tennessee Life and Health Insurance Guaranty Association. The purpose of this association is to provide a safety-net of coverage, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in the state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however. And, as noted below, this protection is not a substitute for consumers' care in selecting companies that are well managed and financially stable.

The state law that provides for this safety-net coverage is called the Tennessee Life and Health Insurance Guaranty Association Act. The following is a brief summary of this law's coverages, exclusions and limits. **This summary does not cover all provisions of the law or describe all of the conditions and limitations relating to coverage. This summary does not in any way change anyone's rights or obligations under the act or the rights or obligations of the Guaranty Association.**

**COVERAGE**

Generally, individuals will be protected by the Life and Health Insurance Guaranty Association if they live in this state and hold a life or health insurance contract, HMO contract, or an annuity, or if they are insured under a group insurance contract issued by an insurer authorized to conduct business in Tennessee. Health insurance includes disability and long term care policies. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

**EXCLUSIONS FROM COVERAGE**

However, persons holding such policies are not protected by this Guaranty Association if:

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

The Guaranty Association also does not provide coverage for:

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

## **LIMITS ON AMOUNT OF COVERAGE**

The act also limits the amount the Guaranty Association is obligated to pay out. The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. For any one insured life, the Guaranty Association guarantees payments up to a stated maximum no matter how many policies and contracts there were with the same company, even if they provided different types of coverage. These aggregate limits per life are as follows:

- \$300,000 for policies and contracts of all types, except as described in the next point
- \$500,000 for basic hospital, medical and surgical insurance and major medical insurance issued by companies that become insolvent after January 1, 2010

With these overall limits, the Guaranty Association cannot guarantee payment of benefit greater than the following:

- life insurance death benefits - \$300,000
- life insurance cash surrender value - \$100,000
- present value of annuity benefits for companies insolvent before July 1, 2009 - \$100,000
- present value of annuity benefits for companies insolvent after June 30, 2009 - \$250,000
- health insurance benefits for companies declared insolvent before January 1, 2010 - \$100,000
- health insurance benefits for companies declared insolvent on or after January 1, 2010:
  - \$100,000 for limited benefits and supplemental health coverages
  - \$300,000 for disability and long term care insurance
  - \$500,000 for basic hospital, medical and surgical insurance or major medical insurance

### **NOTE**

**The Tennessee Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Tennessee. You should not rely on coverage by the Tennessee Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.**

**Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer for which you have assumed the risk, such as a variable contract sold by prospectus.**

**Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.**

**Tennessee Life and Health Guaranty Association  
P.O. Box 190434  
Nashville, TN 37219  
Website: [www.tnlifeqa.org](http://www.tnlifeqa.org)**

**Tennessee Department of Commerce and Insurance  
500 James Robertson Parkway  
Nashville, TN 37243**

**AMERICAN HERITAGE LIFE INSURANCE COMPANY**  
Jacksonville, Florida

**NOTICE TO TENNESSEE POLICYHOLDERS / CERTIFICATEHOLDERS**

If you have any questions concerning your policy / certificate please write or call us at:

**AMERICAN HERITAGE LIFE INSURANCE COMPANY**

**1776 American Heritage Life Drive**

**JACKSONVILLE, FLORIDA 32224-6688**

**1-800-521-3535**