

**POLICY MODIFICATIONS RIDER**

**Policy Amendment No. 1**

**Modification(s) to the Policy**

**Policyholder:** McAllen Independent School District

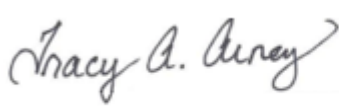
**Policy Number:** 306926

It is agreed that the Policy is amended as follows:

Effective June 1, 2023, the certificate is updated with a 60-day **Grace Period provision**.

In effect, the policy's **Table of Contents page coded UHIHIP-POL-TOC** is deleted and replaced with the attached page.

This Policy is signed for UnitedHealthcare Insurance Company by:



Tracy A. Arney, Secretary



Jessica Paik, President

**UnitedHealthcare Insurance Company  
Hartford, Connecticut 06103-3408**

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All of the provisions in the Certificate(s) of Coverage, riders, endorsements and any amendments issued for the Policyholder shown below are included and made part of this Policy.

<b>DOCUMENTS</b>	<b>DESCRIPTION</b>	<b>EFFECTIVE DATE</b>
Hospital Indemnity Plan Certificate Of Coverage	All active full-time Employees	June 1, 2023
Certificate Modifications Rider	Amends the contract as outlined	January 1, 2022
Hospital Wellness Benefit Rider	Wellness Rider	January 1, 2022

## IMPORTANT NOTICE

To obtain information or make a complaint:

You may call Zurich American Life Insurance Company's toll-free telephone number for information or to make a complaint at:

**1-800-821-7803**

You may also write to Zurich American Life Insurance Company at:

7045 College Blvd  
Overland Park, KS 66211

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights, or complaints at:

**1-800-252-3439**

You may write the Texas Department of Insurance:

P.O. Box 149104  
Austin, TX 78714-9104  
Fax: (512) 490-1007

Web: [www.tdi.texas.gov](http://www.tdi.texas.gov)  
E-mail: [ConsumerProtection@tdi.texas.gov](mailto:ConsumerProtection@tdi.texas.gov)

### **PREMIUM OR CLAIM DISPUTES:**

Should you have a dispute concerning your premium or about a claim, you should contact the company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

**ATTACH THIS NOTICE TO YOUR POLICY:** This notice is for information only and does not become a part or condition of the attached document.

## AVISO IMPORTANTE

Para obtener información o para presentar una queja:

Usted puede llamar al número de teléfono gratuito de Zurich American Life Insurance Company's para obtener información o para presentar una queja al:

**1-800-821-7803**

Usted también puede escribir a Zurich American Life Insurance Company:

7045 College Blvd  
Overland Park, KS 66211

Usted puede comunicarse con el Departamento de Seguros de Texas para obtener información sobre compañías, coberturas, derechos, o quejas al:

**1-800-252-3439**

Usted puede escribir al Departamento de Seguros de Texas a:

P.O. Box 149104  
Austin, TX 78714-9104  
Fax: (512) 490-1007  
Sitio web: [www.tdi.texas.gov](http://www.tdi.texas.gov)  
E-mail: [ConsumerProtection@tdi.texas.gov](mailto:ConsumerProtection@tdi.texas.gov)

### **DISPUTAS POR PRIMAS DE SEGUROS O RECLAMACIONES:**

Si tiene una disputa relacionada con su prima de seguro o con una reclamación, usted debe comunicarse con la compañía primero. Si la disputa no es resuelta, usted puede comunicarse con el Departamento de Seguros de Texas.

**ADJUNTE ESTE AVISO A SU PÓLIZA:** Este aviso es solamente para propósitos informativos y no se convierte en parte o en condición del documento adjunto.

# ZURICH AMERICAN LIFE INSURANCE COMPANY

1299 Zurich Way  
Schaumburg, Illinois 60196

A Stock Insurance Company

## **Group Term Life; Accidental Death and Dismemberment; And Group Disability Insurance Policy**

**Policyholder:** McAllen Independent School District  
("the *Policyholder*")

**Policy Number:** CLPEX01188

### **Agreement To Insure**

This Group Insurance Policy ("*Policy*") is a legal contract between the *Policyholder* and Zurich American Life Insurance Company. This *Policy* takes effect on the *Policy* effective date shown on the Group Insurance Policy Schedule. All provisions on this and the following pages are part of the *Policy*.

"The Company", "*we*", "*us*", and "*our*" mean Zurich American Life Insurance Company.

We agree to insure eligible *employees* of the *Policyholder*. We will pay benefits in accordance with the terms, conditions, limitations and exclusions set forth in this *Policy*. Eligible *employees* are all the classes of *employees* described in the Group Certificate(s) of Coverage, ("Certificate").

We issue this *Policy* in consideration of the application and payment of the initial premium by the *Policyholder*. The first premium is due and payable on the *Policy* effective date. Subject to the *grace period* provision of the *Policy*, all premiums after the first premium must be paid when or before they are due. No benefits will be paid in the absence of premium.

This *Policy* is governed by the *laws* of the state where it is delivered.

**THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. THE EMPLOYER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THIS POLICY. IF THE EMPLOYER IS A NON-SUBSCRIBER, THE EMPLOYER LOSES THOSE BENEFITS WHICH WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS. THE EMPLOYER MUST COMPLY WITH THE WORKERS' COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATION THAT MUST BE FILED AND POSTED.**

**This *Policy* is Non-Participating.**



David Fike, President



Laura J. Lazarczyk, Secretary

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# POLICY CONTENTS

## SECTION 1

All the provisions set forth in this document as well as the provisions found in the Certificate(s), rider(s), amendment(s), endorsement(s), Benefit Schedules, and applications, if any, shown on this page and attached to this *Policy* are made part of this Group Insurance Policy, and constitute the entire contract between the parties. A copy of the *Policyholder's* application(s) will be attached to the *Policy* when issued.

<b>Policy Forms</b>
Group Application
Group Term Life; Accidental Death and Dismemberment, and Disability Insurance Policy
Group Term Life Insurance with Accidental Death and Dismemberment Certificates of Coverage and Group Term Life Insurance with Accidental Death and Dismemberment Benefits Schedule
Group Disability Certificates of Coverage and Benefit Schedules

# SPECIAL NOTICES

## PLEASE READ THIS POLICY CAREFULLY

In the event you need to contact someone about this insurance *Policy* for any reason, please contact *your* agent or broker. If no agent or broker was involved in the sale of this insurance, or if you have additional questions you may contact *us* at the following address and telephone number:

Zurich American Life Insurance Company  
1299 Zurich Way  
Schaumburg, IL 60196

800-206-8826

Outside the United States: 719-268-2416

Written correspondence is preferable so that a record of the inquiry is maintained. Have the *Policy* number available when contacting *us*.

### **Fraud Notice**

**Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, commits insurance fraud, which is a crime and subjects the person to civil and criminal penalties.**

# GROUP INSURANCE POLICY SCHEDULE

## SECTION 2

**Policy Effective Date:** January 1, 2022  
Effective date begins at 12:01 a.m. at the address of the *Policyholder* where this *Policy* is delivered.

**Initial Term of Policy:** January 1, 2022, through December 31, 2024.

**Policy Anniversaries:** January 1 of each year beginning 2023

**Governing Jurisdiction:** State of Texas

**Minimum Participation Number:** 2

# SCHEDULE OF INITIAL PREMIUM RATES

## SECTION 3

This schedule lists the initial premium rates on the effective date of the *Policy*. Rates are subject to change in accordance with the “Premium Rate Changes” provision of this *Policy*.

**Premium Due Date:** January 1, 2022, and the first day of each calendar month thereafter.

**Grace Period:** 31 Days

**Classes of Employees to which this Schedule applies:**

*All active, full-time employees.*

**All Coverages:** The premium rates in effect on the *Policy* effective date are those determined by us. Those rates will be shown on the billing notice(s) sent to the *Policyholder* (subject to any subsequent corrections).

**Cost of Insurance:** The premium rates are for a period of one month. Initial rates are subject to change as provided in this *Policy*. The initial premiums for each *Plan* of benefits is based on the initial rate(s) shown below.

### ***Disability Benefit***

**Initial Rate:**

Option	Rate per \$100 of Monthly Benefit
14 day Elimination Period/SSNRA Duration Option	\$1.7400
14 day Elimination Period/to age 65 Duration Option	\$1.5100
30 day Elimination Period/SSNRA Duration Option	\$1.3800
30 day Elimination Period/to age 65 Duration Option	\$1.1500
60 day Elimination Period/SSNRA Duration Option	\$0.9500
60 day Elimination Period/to age 65 Duration Option	\$0.6000
90 day Elimination Period/SSNRA Duration Option	\$0.7200
90 day Elimination Period/to age 65 Duration Option	\$0.4500
180 day Elimination Period/SSNRA Duration Option	\$0.5400
180 day Elimination Period/to age 65 Duration Option	\$0.3500

### ***Basic Life Insurance***

**Initial Rate:** \$0.0300 per \$1,000 of insurance

### ***Basic Accidental Death and Dismemberment***

**Initial Rate:** \$0.0100 per \$1,000 of insurance

**Employee/Spouse Supplemental Life Insurance**

**Initial Rate:**

<b>Age</b>	<b>Rate per \$1,000 of Insurance</b>
< 30	\$0.0240
30-39	\$0.0290
40-44	\$0.0470
45-49	\$0.0840
50-54	\$0.1300
55-59	\$0.2300
60-64	\$0.3640
65-69	\$0.6250
70 and over	\$1.7490

**Child Supplemental Life Insurance**

**Initial Rate:** \$0.2000 per \$1,000 of insurance

**Supplemental Accidental Death and Dismemberment**

**Initial Rate:**

**Employee:** \$0.0200 per \$1,000 of insurance  
**Spouse:** \$0.0200 per \$1,000 of insurance  
**Child:** \$0.0200 per \$1,000 of insurance

**The premium rates are for a period of one month. Initial rates are subject to change as provided in this Policy.**

**Additional Benefits Included with the Life Insurance Plan**

The additional rate is included in the life insurance initial premium rate above.

Accelerated Death Benefit  
Premium Waiver

**Additional Benefits Included in Accidental Death and Dismemberment Plan**

The additional rate is included in the AD&D insurance initial premium rate above.

Seatbelt/Air Bag  
Child Tuition Benefit  
Common Carrier Benefit  
Exposure and Disappearance Benefit

**Additional Benefits Included with the Disability Insurance Plan**

The additional rate is included in the initial disability premium rate above.

Survivor Benefit  
Rehabilitation Program Benefit with:  
Dependent Care Expense Benefit  
Additional Monthly Benefit of 10%  
Worksite Modification Benefit

**Monthly Premium Rate Guarantee**

Initial monthly premium rates are guaranteed as follows:

<b>Insurance Coverage</b>	<b>Rate Guarantee Period</b>
Basic Life Insurance	3 years
Supplemental Life	3 years
Basic Accidental Death and Dismemberment	3 years
Supplemental Accidental Death and Dismemberment	3 years
Basic Long Term Disability	3 years

The Rate Guarantee is subject to the terms and provisions of the "Premium" Section of this *Policy*. We may change the initial premium rates during the rate guarantee period in accordance with the Premium Rate Changes provision of this *Policy*.

# PREMIUM

## SECTION 4

### PAYMENT OF PREMIUMS

The *Policyholder* must pay *us* all premiums on or before the date on which they fall due. The initial premium will be due on the *Policy* effective date. The initial premium covers the period from the *Policy* effective date to the first premium due date. The premium due date begins one month or more after the *Policy* effective date. Premiums thereafter will be due on each succeeding premium due date as stated in the Schedule of Initial Premium Rates

Premiums are to be paid by the *Policyholder* to *us*. Each premium due may be paid in accordance with *our* Administration Manual. If a premium is not paid on or before its due date, the *Policy* subject to the *grace period* will be cancelled.

*We* may accept a partial payment of premium due without waiving *our* right to collect the entire amount due. If *we* expressly agree to accept late payment of a premium without terminating this *Policy*, the *Policyholder* remains liable for all premiums and fees during the extended period.

All amounts are to be paid in United States dollars.

### COST OF THIS INSURANCE

The initial premium for each *Plan* is based on the initial rate(s) shown in the Schedule of Initial Premium Rates and any subsequent indication of rates issued by *us*.

### PREMIUM AMOUNTS

The premium due under this *Policy* on any premium due date will be the sum of the premium charges for all the insurance coverages provided under this *Policy*. The premium charges will be determined in accordance with the premium rates in effect on the premium due date and the *employees* then insured.

Premiums may be determined by other methods which: (a) yields about the same total amount; and (b) is agreeable to both the *Policyholder* and the Company.

### INITIAL RATE GUARANTEE

Refer to the Schedule of Initial Premium Rates for the initial rate guarantee.

The rate guarantee supersedes only those provisions appearing elsewhere in this *Policy* which give *us* the right to change the premium rates, and then, only for the period of time for which the rates are guaranteed. However, *we* may change the premium rates during the rate guarantee period in accordance with the Premium Rate Changes provision below in this *Policy*. The rate guarantee in no way affects amends or supersedes any other provision in the *Policy*.

### PREMIUM RATE CHANGES

*We* have the right to change premium rates as follows:

- on any date if *we* and the *Policyholder* mutually agree to change premium; or
- as of any premium due date.

*We* will notify the *Policyholder* in writing at least 60 days before a premium rate is changed.

Unless the Schedule of Initial Premium Rates or an amendment states otherwise, no change in rates will be made until 36 months after the *Policy* effective date. An increase in rates will not be made more often than once in a 12-month period. However, we reserve the right to change the rates at any time, even during a rate guarantee period if any of the following events takes place:

There is a change in the factors bearing on the risk assumed including the following:

- the terms of the *Policy* change;
- a change occurs in the *Plan* design;
- a division, subsidiary, associated company, affiliated company or *eligible class* is added or deleted;
- a new *law* is enacted; a judicial decision, or a change or clarification of any existing *law* by a regulatory agency that affects the costs or administration of this *Policy* or *Plan* of insurance;
- we determine the *Policyholder* failed to promptly furnish any necessary information requested by us, or has failed to perform any other obligations relating to the *Policy*;
- a material misrepresentation by the *Policyholder*, including but not limited to:
  - i) its reported experience during the pre-sale process; or
  - ii) the number of insured persons changes by 15% or more.

## **INCREASES OR DECREASES IN PREMIUM DUE**

Premium increases or decreases which take effect during a policy month are adjusted and due on the next premium due date following the change. Changes will not be pro-rated daily.

If premiums are payable monthly, any insurance for newly eligible *employees* becoming effective will be charged for from the first day of the policy month on or right after the date the insurance takes effect.

Premium charges for insurance, that terminates for eligible *employees* will cease as of the first day of the policy month on or right after the date the insurance terminates.

If premiums are payable less often than monthly, premium charges or credits for increases and decreases will result in pro-rated adjustment on the next premium due date for the number of policy months between the date premium charges start or cease and the end of the premium paying period.

If this *Policy* is changed to provide more coverage to take effect on a date other than the first day of a premium paying period, a pro rata premium for the coverage will be due and payable on that date. It will cover the period then starting and ending right before the start of the next premium paying period.

Each premium due will include any adjustment in past premiums which is caused by those changes which have not been taken into account at a prior date.

## **GRACE PERIOD**

We provide a *grace period* of 31 consecutive days for the payment of any premium due after the initial premium. During the *grace period*, the *Policy* will remain in force and will not be terminated for nonpayment of premium if the *Policyholder* pays all premiums due by the last day of the *grace period*. If the *Policyholder* fails to pay all premium by the last day of the *grace period*, this *Policy* automatically terminates on the date the *grace period* expires.

The *Policyholder* is liable to pay premiums to us for the time the *Policy* is in force. We may recover from the *Policyholder* the costs of collecting any unpaid premium including reasonable attorney's fees and costs of suit incurred by us in the collection of all overdue amounts.

The *Policyholder* may write to us in advance and request that the *Policy* be ended at the end of the period for which premiums have been paid or at any time during the *grace period*. Upon notice, we will cancel the *Policy* as of the earlier date. The *Policyholder* is liable to us for payment of a pro rata premium amount for the time the *Policy* was in force.

## **PREMIUM REFUNDS AND ADJUSTMENTS**

### **Retroactive Adjustments**

We may make retroactive adjustments to the *Policyholder* to correct billing errors for overpayments or underpayments. However, the *Policyholder* may only receive a maximum of six months credit for any correction. We may reduce any such credits by the amount of any payments we may have made on behalf of an *Insured* before the correction was requested. Retroactive additions will be made at our discretion based upon eligibility guidelines stated in the Certificate of Coverage and are subject to the payment of all applicable premiums.

### **Age Adjustment**

If an age is used to determine the premium charge for an *employee's* insurance and the age is found to be in error, the amount of the *employee's* insurance under any *Plan* affected by the change in age will then be adjusted to reflect the amount that the premium paid would have provided at the correct age.

## **PREMIUM CONTRIBUTIONS FROM EMPLOYEES**

The *Policyholder* determines the amount, if any, of each *employee's* contribution toward the cost of the insurance under the *Policy*.

# RESPONSIBILITIES OF THE POLICYHOLDER

## SECTION 5

### RECORDS

Either the *Policyholder* or *us*, upon mutual agreement, will keep a record of the insured *employees*. The record will contain the key facts about their insurance. All records of the *Policyholder* and of the *employee*, which bear on the insurance, must be open to *us* for its inspection at any reasonable time.

The *Policyholder* will furnish to *us*, on a monthly basis (or as otherwise required), such information as *we* may reasonably require to administer this *Policy* and to determine the premium amount. This includes, but is not limited to information about *employees*:

- who are eligible to become insured;
- changes in family status;
- whose amounts of coverage change or terminate;
- occupational information; and
- any other information required to manage a claim and any other information reasonably required.

The *Policyholder* represents that all enrollment and eligibility information that has been or will be supplied to *us* is accurate. The *Policyholder* acknowledges that *we* can and will rely on such enrollment and eligibility information in determining whether a person is eligible for coverage under this *Policy*. To the extent, the *Policyholder* supplies such information to *us* (in electronic or hard copy format), the *Policyholder* agrees to:

- maintain and make available to *us*, a reasonably complete record of such information (in electronic or hard copy format, for at least seven years or until the final rights and duties under this *Policy* have been resolved, and to make such information available to *us* upon request.
- if applicable, obtain from *employees* "evidence of insurability" authorization in the form currently being used by *us* in the enrollment process (or such other form as *we* may reasonably approve).

*We* will not be liable to *employees* for the fulfillment of any obligation prior to information being received in a form satisfactory to *us*. The *Policyholder* may correct wrong data given to *us*, if *we* have not been harmed by acting on it. Clerical error or omission by *us* or the *Policyholder* will not prevent an *employee* from receiving coverage, affect the amount of an *employee's* coverage or cause an *employee's* coverage to begin or continue when coverage would not have otherwise been effective.

The *Policyholder* must notify *us* of the date in which an *employee's* employment ceases for the purpose of termination of coverage under this *Policy*. Subject to applicable *law*, unless otherwise provided in the Certificate(s) of Coverage, *we* will consider an *employee's* employment to continue until stopped by the *Policyholder*.

The *Policyholder* must notify *employees* of the termination of the *Policy* in compliance with all applicable *laws*. However, *we* reserve the right to notify *employees* of termination of the *Policy* for any reason, including non-payment of premium. The *Policyholder* must provide written notice to *employees* of their rights upon termination of coverage.

## **ACCESS**

The *Policyholder* must make payroll and other records directly related to an *employee's* coverage under this *Policy* available to *us* for inspection, at *our* expense, at the *Policyholder's* office, during regular business hours, upon reasonable advance request. This provision will survive termination of this *Policy*.

## **FORM DISTRIBUTION**

The *Policyholder* agrees to timely distribute materials to *employees* regarding enrollment and coverage features. This includes Certificates of Coverage as described in Certificates provision of this *Policy*.

## **POLICIES AND PROCEDURES AND COMPLIANCE VERIFICATION**

The *Policyholder* must comply with all policies and procedures established by *us* in administering and interpreting this *Policy*. The *Policyholder* must, upon request, provide a certification of its compliance with *our* participation and contribution requirements. The *Policyholder* must, upon request, submit proof that it continues to meet the definition of an eligible group as provided under applicable *law* or regulation.

## **NEWLY ELIGIBLE EMPLOYEES**

From time to time all new *employees* or newly eligible *employees* for an *eligible class* for insurance and desiring the same shall be added to the group or class originally insured.

## **RIGHT TO AUDIT**

We reserve the right to audit, once every two years; the *Policyholder's* billing records and premium accounting practices. If we discover:

- an underpayment of premium by the *Policyholder*, the *Policyholder* will be obligated to remit, in a timely manner, the underpayment amount; or
- an overpayment of premium, we will return any overpayment amount in a timely manner.

## **CONTINUATION RIGHTS AND CONVERSION**

The *Policyholder* is responsible to notify all eligible *employees* of their right to continue coverage pursuant to the continuation provisions in the Certificate(s) and applicable *law*. The *Policyholder* is responsible to provide notification to each *employee* within 15 days after termination of coverage, of their conversion right, including a description of *Plans* available, premium amounts, and application forms.

The Individual Conversion Plan Option is only available to residents in the United States. It is not available for *employees* or their *dependents* who reside outside of the United States when coverage terminates under the *Policy* unless residency is established in the United States within the eligibility period.

Portability is only available to residents in the United States or jurisdiction where Zurich is authorized to offer portability.

# GENERAL PROVISIONS

## SECTION 6

### CERTIFICATES OF COVERAGE

We will issue the *Policyholder*, Certificates of Coverage (referred to as "Certificates"), riders(s), endorsement(s) and amendments, if any, which are evidence of the coverage we agree to provide under this *Policy*. We may deliver certificates in electronic or paper form as required by the *Policyholder*. The *Policyholder* must make available or distribute the Certificate(s) to each insured *employee*. The insurance in force will be set forth in the Certificate(s). Certificate values, benefits and all applicable charges are administered separately for each Certificate issued under the *Policy*.

### POLICIES AND PROCEDURES

We have the right to adopt reasonable policies, procedures, rules, and interpretations of this *Policy* and the certificate(s) in order to promote orderly and efficient administration. Our failure to implement or insist upon compliance with any provision of this *Policy* at any given time or times does not constitute a waiver of our right to implement or insist upon compliance with that provision at any other time or times. This includes, but is not limited to, the payment of premiums. This applies regardless if the circumstances are the same.

### POLICY MODIFICATION AND AMENDMENT

All agreements made by us are signed by an authorized executive officer of the Company. Only officers of the Company have authority to:

- waive any conditions or restrictions of the *Policy*;
- extend the time in which a premium may be paid;
- make or change a contract; or
- bind the Company by a promise or a representation or by information given or received.

An agent or a broker is not an officer of the Company and has none of the above listed authority, whether implied or express.

The *Policy* may be amended without the consent of the insured *employees* or of anyone else with a beneficial interest in it. An amendment does not affect a claim incurred before the date of change.

This *Policy* is deemed to be automatically amended to conform with the provisions of applicable laws and regulations.

#### Mutual Consent

The *Policy* may be amended at any time by mutual written consent of the *Policyholder* and us. This can be done through written request made by the *Policyholder* and agreed to by us.

#### All Other Changes

This *Policy* may also be amended by us with 30 days written notice to the *Policyholder*. The *Policyholder* will not have to give written agreement of a change in this *Policy* if:

- the *Policyholder* has asked for the change and we have agreed to it;
- the change is needed to correct an error in the *Policy*, including any Certificate of Coverage issued to anyone;
- the change is needed so that this *Policy* will conform to any state or federal law,

- regulation or ruling of a jurisdiction that affects a person covered under this *Policy*;
- the change has been initiated by *us* and is not resulting in either a reduction or elimination in benefits or coverage; or an increase in premium.

The *Policyholder* will have to give written agreement of a change in this *Policy*:

- that reduces or eliminates benefits or coverage; or
- that increases benefits or coverage with a concurrent increase in premium during the policy term, except if the increased benefits or coverage is required by *law*.

Payment of the applicable premium after notice of the proposed changes will be deemed to constitute the *Policyholder's* written agreement of those changes on behalf of all persons covered under this *Policy*.

## **PRIOR AGREEMENTS; SEVERABILITY**

As of the *Policy* effective date, this *Policy* replaces and supersedes all other prior agreements between the parties as well as any other prior written or oral understandings, negotiations, discussions or arrangements between the *Policyholder* and *us* related to matters covered by this *Policy*. If any provision of this *Policy* is deemed invalid or illegal, that provision is severable, and the remaining provisions of this *Policy* shall continue in full force and effect.

## **CLERICAL ERRORS**

A clerical error in keeping records, or a delay in making an entry, does not alone cause the *Policy* or the coverage for any *employee* under the *Policy* to become invalid. An equitable adjustment in premiums will be made when the error or delay is found. If the clerical error affects the existence or amount of insurance, the facts as determined by *us* will be used to decide if insurance is in force and its amount. *We* may also modify or replace a *Policy*, Certificate of Coverage or other document issued in error.

## **ADMINISTRATIVE MATTERS AND CLAIM DETERMINATIONS**

For non-ERISA claims, in accordance with state *law*, *we* review and have authority to review all claims and claim denials for benefits under this *Policy* to determine if the coverage is available and if the claimant has satisfied all conditions precedent for benefits.

The *Policyholder* is responsible for making reports and disclosures required by *law* or regulation. This includes the distribution to *employees* of Certificates of Coverage, and disclosures prepared by *us*.

## **MISSTATEMENTS**

If any fact as to the *Policyholder* or any *employee* or dependent is found to have been misstated or omitted, a fair change in premiums or benefits may be made. If the misstatement or omission affects the existence or amount of coverage, the facts will be used in determining whether coverage is or remains in force and its amount.

In the absence of fraud, all statements made by the *Policyholder* or an *employee* shall be deemed representations and not warranties. No written statement made by an *employee* shall be used by *us* in a contest unless a copy of the statement is or has been furnished to the *employee* or his *beneficiary*, or the person making the claim.

## **OTHER GOODS AND SERVICES**

From time to time, *we* may offer or provide *insureds* or their *beneficiaries* certain programs, goods and services in addition to the insurance coverage provided under this *Policy*. *We* also may arrange for third party vendors to provide programs, goods and services at a discount (including without limitation beneficiary financial counseling services and employee assistance programs) to the *insured* or their *beneficiaries*. Though *we* may make the arrangements, the third-party vendors are solely liable for providing the goods and services. Each vendor will maintain a complaint process to resolve complaints with programs, goods and services. *We* will provide *insureds* a toll-free customer service number to report unresolved complaints to *us*.

## **DELEGATION AND SUBCONTRACTING**

The *Policyholder* acknowledges and agrees that *we* may enter into arrangements with third parties to delegate functions under this *Policy* such as *we* determine appropriate in *our* sole discretion and as consistent with applicable laws and regulations. The *Policyholder* also acknowledges that *our* arrangements with third party vendors are subject to change in accordance with applicable laws and regulations.

## **INCONTESTABILITY**

As to the *Policy* in general: *We* may not contest the validity of this *Policy* after it has been in force for two years from the *Policy* effective date, except for non-payment of premiums.

As to Life Insurance Benefits: *We* may not contest the validity of the life insurance provided to an *employee* based on a representation provided in writing to *us* signed by the *employee* concerning his or her insurability if the life insurance coverage *we* provide has been in force for two years during the *employee's* lifetime except for violations of the conditions of the *Policy* relating to military or naval services in the time of war. This also applies to an increase in coverage, for the amount of the increase. If the life insurance coverage was increased, *we* may not contest the validity of the increase amount if the increased *amount of life insurance coverage* has been in force for two years during the *employee's* lifetime.

As to Disability Benefits: *we* may not use any statement made by:

- the *Policyholder* or any *employee* as the basis for voiding coverage or denying coverage or be used in defense of a claim unless it is in writing.
- the *Policyholder* as the basis for voiding this *Policy* after it has been in force for two years from the *Policy* effective date.
- an eligible employee in a defense of a claim for loss incurred or starting after coverage, as to which claim is made, has been in effect for two years.

## **CONFORMITY WITH LAW**

If the provision of the *Policy* does not conform to the requirements of any state or federal *law* or regulation that applies to the *Policy*, the *Policy* is automatically changed to conform with *our* interpretation of the requirements of that *law* or regulation.

The *Policy* conforms to the minimum requirements of the state where the *Policy* is issued. The state *law* where the *Policy* is issued supersedes any conflicting *laws* of any other state.

## **ASSIGNMENT**

No assignment of the benefits under this *Policy* or any Certificate of Coverage will be binding on *us* until the original assignment or a certified copy of the assignment is given to *us* at *our Home Office*. The assignment is subject to any action *we* may have taken before receiving it. *We* do not

assume responsibility for the validity or sufficiency of an assignment. An assignment of the Certificate operates so long as the assignment remains in force. To the extent provided under the terms of the assignment, an assignment transfers all rights and obligations of the *Insured* or the owner if other than the *Insured*. This insurance may not be levied on, attached garnished, or otherwise taken for a person's debts. This does not apply where it is contrary to *law*.

## **RELATIONSHIP BETWEEN THE PARTIES**

The relationship between the parties is a contractual relationship between independent contractors. Neither party is an agent or employee of the other in performing its obligations pursuant to this *Policy*.

# POLICY CANCELLATION AND MODIFICATION

## SECTION 7

### POLICY CANCELLATION

Either *The Company* or the *Policyholder* may cancel this *Policy* on any premium due date by giving 60 days advance written notice to the other party. This *Policy* or a *Plan* under this *Policy* can be cancelled by *us* or by the *Policyholder* at any time by the mutual written consent of the *Policyholder* and *us*. When both the *Policyholder* and the *Company* agree, this *Policy* or a *Plan* can be cancelled on an earlier date. If the *Company* or the *Policyholder* cancels this *Policy* or a *Plan*, coverage will end at 12:00 midnight on the last day of coverage at the address of the *Policyholder*.

#### **Cancellation By The Policyholder**

This *Policy*, or any coverage included may be cancelled by the *Policyholder*. The *Policyholder* may cancel this *Policy* as to all or any class of its *employees*. The *Policyholder* must give *us* written notice at least 60 days in advance of any premium due date. The notice must state when such termination shall occur. It shall not be effective during a period for which a premium has been paid to *us* for the coverage.

The *Policyholder* may cancel this *Policy* or a *Plan* by written notice delivered to *us* at least 60 days prior to the cancellation date.

#### **Cancellation By The Company**

We may cancel or modify this *Policy* upon 60 days advance written notice to the *Policyholder* if:

- there is less than 100% participation of those eligible *employees* for a *Policyholder* paid *Plan*;
- the *Policyholder* does not promptly provide *us* with information that is reasonably required;
- the *Policyholder* fails to perform any of its obligations that relate to this *Policy*;
- fewer than 2 *employees* are insured under a *Plan* or the *Policy*;
- the premium is not paid in accordance with the provisions of the *Policy* that specify whether the *Policyholder*, the *employee*, or both pays the premiums;
- the *Policyholder* does not promptly report to *us* the names of any *employees* who are added or deleted from the *eligible class*;
- we determine that there is a significant change, in the size, occupation, or age of the *eligible class* as a result of a corporate transaction such as a merger, divestiture, acquisition, sale or reorganization of the *Policyholder* and/or its *employees*;
- the *Policyholder* breaches a provision of this *Policy* and such breach remains uncured at the end of the notice period;
- the *Policyholder* ceases to meet *our* requirements for an *employer* group as defined under applicable state *law* or regulation;
- the *Policyholder* fails to meet *our* contribution or participation requirements applicable to this *Policy*;
- the *Policyholder* fails to provide the certification required by the Policies and Procedures Provision within a reasonable period of time specified by *us*; or
- the *Policyholder* changes its eligibility or participation requirements without *our* consent.

**Further, We May Cancel The Policy Immediately:**

- in accordance with the incontestability provision, upon notice to *Policyholder* if the *Policyholder* has performed any act or practice that constitutes fraud or made any intentional misrepresentation of a material fact relevant to the coverage provided under this *Policy*;
- upon notice to the *Policyholder* if a member of an association group and the *Policyholder's* membership in the association ceases;
- the *Policyholder* fails to pay any premium within the *grace period*. The *Policy* will be automatically cancelled, and no further notice will be provided.

If we modify this *Policy* or a *Plan*, for reasons other than the *Policyholder's* failure to pay premium, a written notice will be delivered to the *Policyholder* at least 31 days prior to the modification date. The *Policyholder* may cancel this *Policy* or a *Plan* if the modifications are unacceptable.

If this *Policy* or a *Plan* is cancelled, the cancellation will not affect a payable claim.

If the *Policy* terminates for any reason, the *Policyholder* remains liable for all premiums due and unpaid before the termination, including, but not limited to, premium payments for any period of time *Policy* is in force during the *grace period*. Covered *employees* also remain liable for their cost sharing and other required contributions to coverage for any period of time the *Policy* is in force during the *grace period*. We may recover from the *Policyholder* our costs of collecting any unpaid premiums or fees, including reasonable attorneys' fees and costs of suit.

**Effect Of Cancellation**

The cancellation of this *Policy* will not relieve either party from any obligation incurred before the date of cancellation. When cancelled, this *Policy* and all coverage provided hereunder will end at 12:00 midnight on the effective date of termination.

We may in *our* sole discretion reinstate cancelled coverage, provided any past due premium and reinstatement fees are paid.

**Notice To Employees**

It is the responsibility of the *Policyholder* to notify *employees* of the termination of the *Policy* in compliance with all applicable *laws*. However, we reserve the right to notify *employees* of termination of the *Policy* for any reason, including non-payment of premium. In accordance with the Certificate, the *Policyholder* shall provide written notice to *employees* of their rights upon termination of coverage.

# Zurich American Life Insurance Company

## Benefits Schedule

### Term Life Insurance With Accidental Death And Dismemberment Coverage

#### GENERAL INFORMATION

The coverages shown in this Certificate of Coverage are provided under a Group Insurance Policy issued by Zurich American Life Insurance Company to the *Policyholder*. The *Policy* governs all the coverages and payment of benefits shown in the Certificate. If a provision or term in the Certificate conflicts with a provision or term found in the *Policy*, the *Policy's* provision, or term controls. You may examine the Group Insurance Policy at the principal office of the *Policyholder* during regular working hours.

**Policyholder:** McAllen Independent School District

**Policy Number:** CLPEX01188

**Policy Effective Date:** January 1, 2022

**Plan Year:** January 1, 2022, through December 31, 2022, and each following January 1<sup>st</sup>.

**Eligible Classes:** All persons in the following class(es) are eligible for *employee* coverage:

**Class 1:** All *active, full-time employees* who opt in to the McAllen Independent School District's Basic, High, or State Medical Plan

**Class 2:** All *active, full-time employees* who opt out of McAllen Independent School District's Alternate Medical Plan

**Minimum Hours Requirement:**

*Employees must be working at least 20 regularly scheduled hours per week.*

**Service Waiting Period:**

*First of the month following your date of hire.*

**Who Pays For The Coverage:**

**Basic Life Plan:**

*Your employer pays for your coverage.*

**Supplemental Life Plan:**

*You pay for the cost of your coverage.*

**Dependent Supplemental Life Plan:**

*You pay for the cost of your coverage.*

**Premium Waiver Elimination Period:** 9 months

*Disability-based benefits begin the day after we approve your claim, and the elimination period is completed.*

<b>Benefits Schedule Term Life Insurance</b>	
<b>Employee Basic Plan</b>	
<b>Eligible Classes:</b>	<b>Life Insurance Amount</b>
<b>Class 1:</b>	\$15,000
<b>Class 2:</b>	\$50,000
<b>Guarantee Issue Amount:</b>	
<b>Class 1:</b>	\$15,000
<b>Class 2:</b>	\$50,000

<b>Employee Term Life Insurance</b>	
<b>Supplemental Plan</b>	
An <i>employee</i> must be insured for basic life insurance in order to become insured for supplemental life insurance.	
<b>Eligible Classes:</b>	<b>Employee Life Insurance Amount</b>
<b>All active, full time employees:</b>	Units of \$10,000
<b>Maximum Benefit Amount:</b>	The lesser of 10 x Annual Earnings or \$500,000
<b>Guarantee Issue Amount:</b>	\$250,000

<b>Evidence of Insurability</b>
<i>Evidence of insurability</i> is required for any amount of supplemental insurance over \$250,000
<i>Evidence of Insurability</i> is required if you request life insurance coverage for a <i>dependent spouse</i> or <i>domestic partner</i> more than 60 days after the <i>dependent</i> eligibility date.
<i>Evidence of Insurability</i> is not required for <i>amounts of life insurance</i> you had in force with your <i>employer's</i> prior carrier on the termination date of the prior carrier's plan.

**Initial Enrollment:**

New hires or newly eligible *employees* may elect up to the Guarantee Issue Amount without providing *evidence of insurability*.

**Increasing Your Coverage:**

During *your annual enrollment period*, if you are currently enrolled for supplemental coverage, *you* can elect an additional unit of \$10,000 without providing *evidence of insurability* but cannot exceed the Guarantee Issue Amount. Any elections over one unit of \$10,000 will require *evidence of insurability*. If *you* did not enroll for supplemental coverage during *your* initial enrollment period and want to elect it more than 60 days after *your eligibility date*, all amounts applied for will require *evidence of insurability*.

If we do not approve your *evidence of insurability*, the *amount of life insurance* will be limited to the Guarantee Issue Amount.

**Life Status Changes:** An *employee* who experiences a *life status change* will be eligible to add supplemental coverage of one unit of \$10,000, without *evidence of insurability*, if currently enrolled for supplemental coverage. Application must be made within 60 days of the *life status change* and the *employee* must not have previously been declined for any amount of insurance due to failure to provide satisfactory *evidence of insurability* when required. Refer to the "General Provisions" Section of the Certificate for information about *life status changes*.

**Age Reduction Rules For Basic and Supplemental Insurance Benefits**

The age reduction rule effects the amount of insurance available if *you* become insured at certain ages or have reached certain ages while insured under this *Plan*.

This change will be effective on the January 1<sup>st</sup> following the date your 70th birthday occurs, according to the schedule below:

**Age Reduction Schedule**

<b>Age:</b>	<b>Reduced By:</b>
70 to 74	35%
75 and over	50%

If *your* benefit is a percentage of *your* salary, the benefit reduction will be based on the value of *your Policy* the day before the next reduction period. If *your* benefit is a dollar amount, the original benefit amount will continue to be reduced by the percentages stated above, as *you* age.

After a reduction occurs, there will be no further increases in *your amount of life insurance*.

If *you* become insured during or after the month in which *you* reach the above ages, *your* life insurance amount will be the applicable percentage of the amount shown for *your eligible class*.

**Dependent Term Life Insurance**

**Supplemental Plan**

*A dependent's eligibility date is the date you can first elect coverage for a dependent.*

<b>Eligible Dependents</b>	<b>Life Insurance Amount</b>
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<b>Spouse or Domestic Partner:</b>	Units of \$5,000
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**AGE REDUCTION RULE**  
 The amount of *your spouse's* or *domestic partner's* life insurance will reduce by the same percentage or amount and at the same time as *your* life insurance reduces. After a reduction occurs, there will be no further increases in the amount of *your spouse's* or *domestic partner's* life insurance.

<b>Children</b>	
Each Dependent Child	
Live birth to 6 months:	\$1,000
6 months to age 26:	\$10,000

The *amount of life insurance* for a *dependent* will not be more than 50% of the amount of *your* supplemental life insurance amount under this *Plan*.

**Maximum Benefit Amount:**

<b>Spouse or Domestic Partner:</b>	\$250,000
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<b>Dependent Child:</b>	\$10,000
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**Guarantee Issue Amount**

<b>Spouse or Domestic Partner:</b>	\$60,000
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<b>Dependent Child:</b>	\$10,000
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**Dependent Evidence of Insurability**

*Evidence of insurability* is required for any amount of *your spouse's* or *domestic partner's* insurance over \$60,000.

*Evidence of Insurability* is required if you request life insurance coverage for a *dependent spouse, domestic partner, or dependent child* more than 60 days after the *dependent eligibility date*.

*Evidence of Insurability* is not required for *amounts of life insurance your dependent had in force with your employer's prior carrier* on the termination date of the prior carrier's plan.

If you add a *dependent spouse* due to marriage, you may elect up to the *Guarantee Issue Amount* for *your dependent spouse*.

An *employee* who experiences a *life status change* will be eligible to add dependent supplemental coverage of one unit of \$5,000, without *evidence of insurability*, if currently enrolled for supplemental coverage, subject to the Guarantee Issue Amount. Application must be made within 60 days of the *life status change*. If not currently enrolled for supplemental coverage, *all elections require evidence of insurability*.

If we do not approve *your dependent's evidence of insurability*, the amount of life insurance will be limited to the Guarantee Issue Amount.

<b>Accelerated Death Benefit</b>		
	<b>Employee</b>	<b>Spouse or Domestic Partner:</b>
<b>Accelerated Death Benefit Minimum:</b>	\$10,000	\$10,000
<b>Accelerated Death Benefit Maximum:</b>	Basic Class 1: \$12,000 Basic Class 2: \$40,000 Supplemental: \$250,000	\$125,000
<b>Accelerated Death Benefit Percentage:</b>	Basic: 80% Supplemental: 50%	50%

#### **Limitations Which Apply to Your Coverage:**

This Benefits Schedule summarizes some of the features and benefits of *your employer's* term life, and *accidental death and dismemberment Plan*. It is not a contract. For a complete description of the terms, conditions, exclusions, and limitations of *your employer's Plan*, refer to *your Certificate*. In the event of a discrepancy between this Benefits Schedule and the Certificate, the Certificate will control.

Your *amount of life insurance* will be reduced by any life benefit:

- paid to *you* under an Accelerated Death Benefit in the *prior plan* and in force for *you* under any disability extension provision of the *prior plan*;
- paid to *you* under an Accelerated Death Benefit in this *Plan* or paid to *you* under any disability extension provision under this *Plan*.

#### **SOME LOSSES MAY NOT BE COVERED UNDER THIS PLAN. REFER TO THE EXCLUSIONS SECTION OF THE CERTIFICATE FOR A COMPLETE LIST OF EXCLUSIONS.**

Exclusions for *accidental death and dismemberment (AD&D)* insurance are shown on the applicable Accidental Death & Dismemberment Certificate pages.

**Accidental Death and Dismemberment Insurance  
Benefits Schedule**

**Employee Basic Plan**

<b>Eligible Classes:</b>	<b>Principal Sum</b>
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Class 1 & Class 2:	100% of your Basic Life Amount.
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**AGE REDUCTION RULE:**  
 The amount of *your accidental death and dismemberment* insurance will reduce by the same percentage or amount and at the same time *your life* insurance reduces. After *your* benefit is reduced, there will be no more increases in the amount of *your accidental death and dismemberment* insurance.

**Employee Supplemental Plan**

*You do not need to be insured for supplemental life insurance in order to become insured for supplemental accidental death & dismemberment benefits.*

<b>Eligible Classes:</b>	<b>Principal Sum</b>
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All active, full-time employees:	An amount equal to the amount of <i>your</i> coverage in effect under this Plan at the time of death or loss.
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**AGE REDUCTION RULE:**  
 The amount of *your accidental death and dismemberment* insurance will reduce by the same percentage or amount and at the same time *your life* insurance reduces. After *your* benefit has been reduced, there will be no further increases in the amount of *your accidental death and dismemberment* insurance.

**Dependent Supplemental Plan**

*You must be insured for basic insurance in order for a dependent become insured for supplemental accidental death & dismemberment coverage.*

<b>Eligible Classes: Class 1 &amp; Class 2</b>	<b>Principal Sum</b>
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Spouse or Domestic Partner:	An amount equal to the amount of <i>your</i> life insurance in effect under this <i>Plan</i> at the time of death or loss.
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**AGE REDUCTION RULE:**  
 The amount of *your spouse's or domestic partner's accidental death and dismemberment* insurance will reduce by the same percentage or amount and at the same time *your accidental death and dismemberment* insurance reduces. There will be no further increases in the amount of *your spouse's or domestic partner's accidental death and dismemberment* insurance.

<b>Each Dependent Child Live Birth to age 26:</b>	An amount equal to your Child's life insurance amount.
The amount of insurance for a <i>dependent</i> will not be more than 50% of the amount of <i>your</i> supplemental insurance amount under this <i>Plan</i> .	

**BASIC, SUPPLEMENTAL & DEPENDENT SUPPLEMENTAL PLAN ADDITIONAL  
AD&D BENEFITS**

**ALL BENEFIT PERCENTS STATED ARE A PERCENTAGE OF THE VOLUNTARY AD&D  
PRINCIPAL SUM**

<b>ADDITIONAL AD&amp;D BENEFITS:</b>	<b>PLAN BENEFIT AMOUNT:</b>
<p><b>Child Tuition Benefit:</b> Basic Supplemental Dependent Supplemental</p>	<p>For each <i>child</i> that qualifies the Annual Maximum Amount payable for an academic year per eligible <i>child</i> will be the least of:</p> <ul style="list-style-type: none"> <li>• the actual Tuition Charges annually;</li> <li>• 5% of <i>your</i> Principal Sum; or</li> <li>• \$5,000.</li> </ul> <p>Maximum Benefit Period: 4 consecutive years</p> <p>One-time benefit payable to the Beneficiary if no qualified dependent <i>child</i>: \$1,000.</p>
<p><b>Common Carrier Benefit:</b> Basic Supplemental Dependent Supplemental</p>	<p>Loss of Life: The maximum amount payable is 100% of the <i>Insured Person's</i> Principal Sum.</p>
<p><b>Exposure and Disappearance Benefit:</b> Basic Supplemental Dependent Supplemental</p>	<p>The maximum amount payable is your Principal Sum.</p>
<p><b>Seat Belt Use and Air Bag Benefit:</b> Basic Class 1</p>	<p>Seat Belt: The maximum amount payable will be the least of:</p> <ul style="list-style-type: none"> <li>• 10% of <i>your</i> Principal Sum;</li> <li>• or \$1,500.</li> </ul> <p>Air Bag: The maximum amount payable will be the least of:</p> <ul style="list-style-type: none"> <li>• 10% of <i>your</i> Principal Sum;</li> <li>• or \$1,500.</li> </ul>

<p><b>Seat Belt Use and Air Bag Benefit:</b> Basic Class 2</p>	<p>Seat Belt: The maximum amount payable will be the least of:</p> <ul style="list-style-type: none"> <li>• 10% of <i>your</i> Principal Sum;</li> <li>• or \$5,000.</li> </ul> <p>Air Bag: The maximum amount payable will be the least of:</p> <ul style="list-style-type: none"> <li>• 10% of <i>your</i> Principal Sum;</li> <li>• or \$5,000</li> </ul>
<p><b>Seat Belt Use and Air Bag Benefit:</b> Supplemental Dependent Supplemental</p>	<p>Seat Belt: The maximum amount payable will be the least of:</p> <ul style="list-style-type: none"> <li>• 10% of <i>your</i> Principal Sum;</li> <li>• or \$10,000.</li> </ul> <p>Air Bag: The maximum amount payable will be the least of:</p> <ul style="list-style-type: none"> <li>• 5% of <i>your</i> Principal Sum;</li> <li>• or \$5,000</li> </ul>

Zurich American Life Insurance Company  
Certificate Of Coverage  
Term Life Insurance With  
Accidental Death And Dismemberment Coverage

**Policyholder:** McAllen Independent School District  
**Policy Number:** CLPEX01188

Zurich American Life Insurance Company is pleased to welcome *you* to the *Plan*. This is *your* Certificate of Coverage, referred to as "Certificate", as long as *you* are eligible for coverage, and *you* meet the requirements for becoming insured. *You* will want to read this Certificate carefully and keep it in a safe place.

Throughout this document the words "*we*", "*our*", "*us*", and "the Company" means Zurich American Life Insurance Company. The words "*you*" and "*your*" mean the insured *employee* and any covered *dependents*, of the *Policyholder* sponsoring this *Plan*. Some terms and provisions are written as required by insurance *law*. Important terms are defined in the "Glossary" Section of the Certificate. Defined terms appear in italic print. If *you* should have any questions about the content or provisions, please consult *us* electronically through *our* website or at the toll free number provided below. *We* will assist *you* in any way to help *you* understand *your* benefits.

The benefits described in this Certificate are subject in every way to the entire Group Insurance Policy. If the terms and provisions of the Certificate are different, the *Policy* will govern. The Group Insurance Policy includes this Certificate, the Benefits Schedule(s), and any riders or amendments issued with the Group Insurance Policy. The *Policyholder's* application and any application or *evidence of insurability* completed by *you* or on *your* behalf, when applying for coverage or an increase in coverage, are also considered part of the *Policy*.

This Certificate contains a benefit option for an Accelerated Death Benefit. The insurance benefit amount payable will be reduced by any Accelerated Death Benefit paid any *Insured* covered under this Certificate.

*Your* coverage may be cancelled or changed in whole or in part under the terms and provisions of the *Policy*. The *Policy* is delivered in and is governed by the *laws* of the governing jurisdiction.

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

Zurich American Life Insurance Company is located at:

**1299 Zurich Way  
Schaumburg, IL 60196**

*Our* toll free number is: 800-206-8826.  
*Our* website address is: <https://mygroupplifedisability.aflac.com>.

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## SPECIAL NOTICES

Zurich American Life Insurance Company

Toll Free Number:

800-206-8826

Claim Information Toll Free Number:

800-206-8826

### **Important Information Regarding The Availability Of Coverage**

No benefits are covered under this Certificate in the absence of payment of current premiums subject to the *grace period* and the "Premium" Section of the Group Insurance Policy. Unless specifically provided for in any applicable termination or continuation of coverage provision, described in this Certificate or under the terms of the Group Insurance Policy, this *Plan* does not pay benefits for the loss of life, an *accident* or a disability incurred before coverage starts under this *Plan*. This *Plan* will not pay any benefits for any losses, claims or expenses that start after coverage ends.

Benefits may be modified during the term of this *Plan* as specifically provided under the terms of the Group Insurance Policy or upon renewal. If benefits are modified, the revised benefits (including any reduction in benefits or elimination of benefits) apply to any losses incurred that start on or after the effective date of the *Plan* modification. There are no vested rights to receive any benefits described in the Group Insurance Policy or in this Certificate beyond the date of termination or renewal including if the loss, *accident*, or disability starts on or after the effective date of the *Plan* modification, but prior to *your* receipt of amended *Plan* documents.

### **Fraud Notice**

**Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, commits insurance fraud, which is a crime and subjects the person to civil and criminal penalties.**

## **DISCLOSURE NOTICES**

For Residents of the Following States:

### **INDIANA**

#### **NOTICE TO EMPLOYEES**

Questions regarding *your Policy* or coverage should be directed to:

**Zurich American Life Insurance Company  
199 Scott Swamp Road, Farmington, CT 06032  
1-888-634-6780**

If *you* (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint *you* have been unable to resolve with *your insurer you* may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance  
Consumer Services Division  
311 West Washington Street  
Suite 300  
Indianapolis, IN 46204

Consumer Hotline:  
1-800-622-4461

In the Indianapolis Area:  
1-317-232-2395

Complaints can be filed electronically at [www.in.gov/idoi](http://www.in.gov/idoi)

### **ARKANSAS**

#### **QUESTIONS OR PROBLEMS WITH YOUR POLICY?**

If *you* have any questions or problems with *your Policy*, *you* may contact *us* at the address below or one of the other organizations listed:

Zurich American Life Insurance Company  
199 Scott Swamp Road  
Farmington, CT 06032  
Telephone: (877) 678-7534

Arkansas Insurance Department  
Consumer Services Division  
1200 West Third Street  
Little Rock, Arkansas 72201-1904  
Telephone: (501) 371-2640 or (800) 852-5494

## **GEORGIA**

### **NOTICE**

The *laws* of the State of Georgia prohibit insurers from unfairly discriminating against any person based upon his or her status as a victim of family violence.

## **ILLINOIS**

### **NOTICE TO EMPLOYEES - ILLINOIS**

This notice is to advise *you* that should any complaints arise regarding this insurance, *you* may contact the following:

Zurich American Life Insurance Company  
199 Scott Swamp Road, Farmington, CT 06032  
(888) 634-6780

For *your* information, the following is *your* state's Department of Insurance contact information:

Illinois Department of Insurance  
Consumer Division  
320 W Washington St  
Springfield, IL 62767  
(217) 782-4515

## **WISCONSIN**

### **NOTICE TO EMPLOYEES – WISCONSIN**

#### **KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS**

**PROBLEMS WITH YOUR INSURANCE?** – If *you* are having problems with *your* insurance company or agent, do not hesitate to contact the insurance company or agent to resolve *your* problem.

Zurich American Life Insurance Company  
199 Scott Swamp Road, Farmington, CT 06032  
(888) 634-6780

*You* can also contact the **OFFICE OF THE COMMISSIONER OF INSURANCE**, a state agency which enforces Wisconsin's insurance *laws*, and file a complaint. *You* can contact the **OFFICE OF THE COMMISSIONER OF INSURANCE** by contacting:

Office of the Commissioner of Insurance  
Complaints Department  
P.O. Box 7873  
Madison, WI 53707-7873  
Toll-Free: (800) 236-8517  
Telephone: (608) 266-0103

# Your Life, Accidental Death and Dismemberment Insurance Plan (the "*Plan*")

## GENERAL PROVISIONS

### What Is The Certificate?

This Certificate of Coverage ("Certificate") is a written document prepared by Zurich American Life Insurance Company. *We* have provided *you* this Certificate of Coverage ("Certificate") to tell *you* about important *Plan* information such as:

- the coverage to which *you* may be entitled;
- claim processing and administrative procedures;
- to whom *we* will make a payment; and
- the limitations, exclusions and requirements that apply within the *Plan*.

The Certificate may include attachments such as amendments and riders, which describe additional provisions about *your Plan*. Please carefully read all the documents *we* provide *you* to fully understand *your Plan*.

### Eligibility

#### Who Is Eligible For Coverage?

To be eligible for coverage under this *Plan*, the following requirements must be met:

- *you* must be employed by the *Policyholder*;
- *you* must be in *active employment*;
- *you* must be in an *eligible class*; and
- *you* must be working inside of the United States.

#### Dependent Coverage

If *you* elect coverage for yourself or are insured under the *Plan*, *you* are eligible to elect *dependent* coverage for *your spouse or domestic partner* and *dependent* children. Refer to the "Dependent Coverage" Section of this Certificate for information on *dependent* eligibility and how to enroll *your dependents*.

#### Determining Your Eligible Class

*Your employer* determines the criteria that is used to define the *eligible class(es)* for insurance coverage under this *Plan*. *Your employer* determines if *you* are in an *eligible class*. Such criteria are based solely upon the conditions related to *your* employment.

The criteria describing *eligible classes* of *employees* are listed on the Benefits Schedule attached to this Certificate. Refer to the Benefits Schedule or contact *your employer* to determine if *you* are in an *eligible class*.

## When Are You Eligible For Coverage?

If *you* are working for *your employer* in an *eligible class*, the date *you* are eligible for coverage is the later of:

- the *Plan* effective date; or
- the day after *you* complete *your service waiting period*, if any.

Once *you* are eligible for coverage, *your* coverage will begin in accordance with the provisions of the Section entitled "When Does Your Coverage Begin?"

### **New Hires:**

If *you* are in an *eligible class* on the date of hire, *your eligibility date* is the later of the date *you* complete the *service waiting period*. If *you* enter an *eligible class* after *your* date of hire, *your eligibility date* is the date *you* complete *your service waiting period*. If *you* have already satisfied the *service waiting period* with the *Policyholder* before *you* enter the *eligible class*, *your eligibility date* is the date *you* enter the *eligible class*.

## What Is A Service Waiting Period?

Once *you* enter an *eligible class*, *you* will need to complete the *service waiting period* before *your* coverage under the *Plan* begins. The *service waiting period* is the continuous length of time that *you* must be in *active employment* and in an *eligible class* before *you* are eligible for coverage under this *Plan*. The *service waiting period* is shown on the Benefits Schedule.

Except as noted in the "Reinstatement Provision", if *you* terminate this insurance and later wish to reapply, or if *you* are a former *employee* who is rehired, a new *service waiting period* must be satisfied.

## Effective Date Of Coverage

### When Does Your Coverage Begin?

#### **Basic Life Coverage:**

When *your employer* pays 100% of the cost of *your* coverage under a *Plan*, *your* coverage will begin at 12:01 a.m. on the first day of the month following *your* date of hire.

#### **Supplemental Life Plan:**

*You* pay 100% of the cost of *your* coverage under a *Plan*. Once *you* are eligible for coverage, *you* have 60 days from the date *you* become eligible to apply for coverage.

*Your* coverage will begin at 12:01 a.m. on the later of:

- the date *you* are eligible for coverage, if *you* apply for insurance on or before that date for any amount of insurance that is not subject to *evidence of insurability* requirements; or
- the date *you* apply for insurance, if *you* apply within 31 days after *your eligibility date*, for any amount of insurance that is not subject to *evidence of insurability* requirements; and
- the first day of the month following the date we approve *your evidence of insurability* form, if *you* apply for insurance on or before *your eligibility date* or within 60 days after *your eligibility date*, for any amount of insurance that is subject to *evidence of insurability* requirements.

An *evidence of insurability* form can be obtained from *your employer*.

## Deferred Effective Date

If *you* are absent from work due to *injury, sickness, temporary layoff or leave of absence* on the date *your* insurance would otherwise become effective, *your* coverage, increase in coverage or new benefits will begin the date *you* return to *active employment*.

## Enrollment

### How Do You Enroll For Coverage?

#### Basic Life Plan:

*You* will be provided with *Plan* design and enrollment information when *you* first become eligible. *Your* enrollment will be handled by *your employer*.

#### Supplemental Life Plan:

*You* are required to enroll for Supplemental coverage. *You* must enroll on a group insurance enrollment form approved and provided by *us*. If an *evidence of insurability* application is required, *you* must complete it in accordance with the instructions below.

### When Do You Enroll?

If *you* are required to enroll for *your* insurance, *you* will need to enroll within 60 days of *your eligibility date*. Otherwise, *you* may be considered a *late applicant*. If *you* miss the enrollment period, *you* will not be able to participate in the *Plan* until the next *annual enrollment period*.

### Late Applicant Enrollment Requirements

*You* can apply for coverage only during the annual enrollment period. *Evidence of insurability* is required for any amount of insurance. In no event will this amount exceed the maximum benefit available under the *Plan*.

Coverage will begin at 12:01 a.m. on the first of the month following the date *we* approve *your evidence of insurability* form.

***IMPORTANT NOTE: As a late applicant, you may be denied coverage if your evidence of insurability is not satisfactory to us, the effective date of your coverage may be delayed, or your benefits may be reduced.***

### When Is Evidence of Your Insurability Required?

*Evidence of insurability* means a statement of *your* medical history which *we* will use to determine if *you* are approved for coverage or an increase in coverage. This requirement will be met when *we* decide the *evidence of insurability* is satisfactory.

If *you* are required to submit *evidence of insurability*, *you* must:

- complete and sign a health and medical history form provided by *us*;
- submit to a medical examination, if requested;
- provide any additional information that *we* require including verification of earnings and attending physician's statements, and
- furnish all such evidence at *your* own expense.

**Evidence of insurability** (EOI) is required if:

- you enroll for supplemental coverage for the first time above the Guarantee Issue Amount shown in the Benefits Schedule;
- you re-enroll for supplemental coverage after *your* coverage ends for any reason;
- you enroll for an increase in *your* supplemental coverage greater than one unit of \$10,000. You must complete new *evidence of insurability* each time you request an increase. This applies even if we have approved *evidence of your* insurability in the past. We may deny *your* increase if the *evidence of insurability* is not satisfactory to us;
- you are a *late applicant*, which means you apply for supplemental coverage more than 60 days after the date you are eligible for coverage;
- you voluntarily cancelled *your* supplemental coverage and are reapplying; or
- *your* coverage was cancelled because you did not make the required contributions.

The *Policyholder* may not waive the *evidence of insurability* requirement for any reason.

**If *your evidence of insurability* is not acceptable to us, you will not be covered under this Plan. This rule also applies to *your* request for an increase in coverage and *your* increase will not be covered.**

### **Annual Enrollment Period**

During the *annual enrollment period*, you will have the opportunity to review *your* coverage needs for the upcoming year. During this period, you have the option to apply for insurance, change *your* coverage or apply for an increase in *your* insurance. The choices you make during this *annual enrollment period* will become effective the following plan year as indicated on the Benefits Schedule.

### **After Coverage Begins**

#### **When May You Elect To Change Your Coverage?**

You can change *your* coverage by applying for additional benefit units during an *annual enrollment period*. You can increase *your* coverage any number of benefit units up to the maximum available under the *Plan*.

*Evidence of insurability* is required for any *amount of life insurance* over the amount shown in the Life Insurance Benefits Schedule.

Changes in coverage that are made during an *annual enrollment period* will begin at 12:01 a.m. on the later of:

- the first day of the next plan year for any amount of insurance that is not subject to *evidence of insurability* requirements; and
- the first of the month following the date we approve *your evidence of insurability* form for any amount of insurance that is subject to *evidence of insurability* requirements.

In addition, you can decrease *your* coverage any number of benefits units during the *annual enrollment period*. Any decrease in coverage will take effect on the first of the month following the date you provide notification to *your employer*.

An *evidence of insurability* form can be obtained from *your employer*.

## Life Status Changes

You may elect or increase coverage within 60 days after you have a *life status change*. A *life status change* is an event that qualifies you to make changes in benefit selections at a time other than an *annual enrollment period*. Changes in coverage must be appropriate and consistent with the change in status. The following events are *life status changes*:

- marriage or execution of a domestic partnership agreement;
- divorce, annulment, legal separation, or termination of a domestic partnership agreement;
- birth or adoption of a child or becoming a legal guardian of a child;
- death of a *spouse or domestic partner*
- the death or emancipation of a child;
- termination of a *spouse's or domestic partner's* employment;
- a change in the benefit *Plan* available to *your spouse or domestic partner*;
- a change in *your or your spouse's or domestic partner's* employment status that affects either person's eligibility for benefits;
- A change in classification from *part-time* to *full-time* or from *full-time* to *part-time*.

A change in coverage due to a *life status change* will begin at 12:01 a.m. on the latest of:

- the date of the change in status if you apply on or before that date;
- the date you apply, if you apply within 60 days after the date of the change in status; or
- the date we approve your *evidence of insurability* form if *evidence of insurability* is required.

An *evidence of insurability* form can be obtained from your employer.

Neither an increase nor a decrease in coverage will affect a *payable claim* that occurs prior to the increase or decrease.

## Deferred Effective Date For An Increase In Coverage

If you are not in *active employment* due to *injury or sickness*, any increased or additional coverage will begin on the date you return to *active employment*.

## How Do You Pay For Your Coverage?

### Basic Life Plan:

We will bill your employer for the premium and any amount you owe. Your employer will pay the premium on your behalf.

### Supplemental Life Plan:

Your employer requires you to pay for all of the cost of your insurance. Your employer will determine the amount of your *Plan* contributions, if any. Your employer will advise you of the required amount of your contributions and inform you of any required payroll deductions.

## When Coverage Ends

### When Does Your Coverage End?

Your coverage under this *Plan* ends on the end of the month following:

- the date the *Policy* or a *Plan* is cancelled;
- the date you voluntarily stop your coverage;
- the date you are no longer in an *eligible class*;
- the date your *eligible class* is no longer covered;

- the last day of the period for which *you* made any required contributions;
- the last day *you* are in *active employment*;
- *your* employment stops for any reason, including job elimination, or being placed on severance. This will be either the date *you* stop *active employment*, or the day before the first premium due date that occurs after *you* stop *active employment*;
- the date on which *you* retire;
- the date of *your* death; or
- the date on which *you* begin active duty in the armed forces of any country.

### **When Will Your Coverage Continue If You Are Temporarily Not Working?**

If premium payments continue to be made on *your* behalf, *we* may deem *your* employment to continue for purposes of remaining eligible for coverage under this *Plan* as described below:

If *you* are not in *active employment* due to a sabbatical *leave of absence* as agreed to by *your employer* and *us*, *your* coverage may continue through the end of *your employer's* current school contract year in which *your* sabbatical *leave of absence* begins.

If *you* are on a furlough, and if premium is paid, *you* will be covered for 90 days following the date on which *your* furlough begins.

If *you* are on an *employer* approved *leave of absence* or due to *sickness* or *injury*, and if premium is paid, *you* will be covered for the later of 180 days or until the paid leave has been exhausted.

There is no continuation of coverage if *you* are on a temporary *layoff*, or *you* have a reduction in hours below the minimum hours per week required by *your employer*.

### **What Happens To Coverage While You Are On A Family And Medical Leave Of Absence Or A Military Leave Of Absence?**

Coverage will be continued until the end of the later of:

- the leave period required by the federal Family and Medical Leave of Absence Act of 1993 and any amendments;
- the leave period required by the Uniformed Services Employment and Reemployment Rights Act of 1994 and any amendments;
- the leave period required by applicable national, state, or local *law*, or any similar *law, plan, or act*; or
- for life insurance, the leave period provided to *you* for an *injury* or *sickness*.

If the *Policyholder's* policy does not provide for continuation of *your* coverage during a family and medical *leave of absence*, *your* coverage will be reinstated when *you* return to *active employment*.

### **Reinstatement Of Coverage**

If *your* coverage ends, *you* may apply to reinstate coverage subject to the rules described in the "When Does Your Coverage Begin?" Section. If *we* approve *your* request, the reinstatement will be effective on the first day of the month coinciding with or following the approval date. *We* will notify *you* of *your* reinstatement date.

### **How Can Statements Made In Your Application For This Coverage Be Used?**

In the absence of fraud, *we* consider any statements *you* or *your employer* makes in a signed application for coverage, or that *your employer* makes in the application process, a representation and not a

warranty. If any of the statements *you* or *your employer* make are not complete and true at the time they are made, *we* may:

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

If *we* use a statement to reduce, deny, or contest a claim, or cancel *your* coverage, a copy of that statement will be furnished to *you* or, in the event of *your* death or incapacity, to *your eligible survivor* or personal representative. *We* will use only statements made by the *employer* in the application process or statements made by *you* in a signed application as a basis for doing this. If the *Policyholder* gives *us* information about *you* that is incorrect, *we* will:

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

*Our* failure to implement or insist upon compliance with any provision of the *Policy* at any given time or times shall not constitute a waiver of *our* right to implement or insist upon compliance with that provision at any other time or times. This applies whether or not the circumstances are the same.

### **Conversion Benefit**

A life conversion option may be available without a medical exam if *you* apply for it within 31 days of *your* loss of coverage under this *Plan*. For more information about the Conversion Provision, refer to the "Plan Conversion Options" Section of this Certificate.

### **Incontestability Period**

During the first two years that *your* insurance is in force, *we* may use any statement *you* have made in contesting the validity of that coverage. This also applies to any increase in *your* coverage for the two years that follow the effective date of that increase if *evidence of insurability* was required in order for the increase to take effect.

Once coverage, including an increase in coverage has been continuously in effect for two years, the validity of *your* insurance may not be contested by *us* unless *your* statement was in writing on a form signed by *you* and was fraudulently made in order to obtain that coverage or increase.

### **Recovery Of Overpayments**

If payments are made in amounts greater than the benefits that *you* are entitled to receive. *We* have the right to recover any overpayments. Refer to the "Claim Information" Section for the process *we* use to recover overpayments.

### **How We Handle Insurance Fraud**

*We* have the right and will to use all means available to *us* to detect, investigate, deter, and prosecute those who commit insurance fraud. *We* also have the right to pursue all legal remedies if *you* and/or *your employer* perpetrate insurance fraud.

Insurance fraud occurs when *you* or *your Policyholder* knowingly and with intent to defraud or deceive *us*, provide *us* with false information or file a claim for benefits that contains any false, incomplete, or misleading information, or conceals for the purpose of misleading, information concerning any material fact concerning the coverage sought or payment of benefits.

It is a crime if *you* or the *Policyholder* commit insurance fraud and *you* or the *Policyholder* may be subject to criminal and civil penalties. Such penalties include, but are not limited to fines, denial or termination of insurance benefits, recovery of any amounts paid, civil damages, criminal prosecution, and penalties.

### **Does The Policyholder Act As Our Agent?**

No. For purposes of the *Policy*, the *Policyholder* acts on its own behalf. Under no circumstances will the *Policyholder* be deemed *our* agent.

### **Non-Participation Policy**

This *Policy* is not entitled to share in surplus distribution.

# DEPENDENT COVERAGE

## Dependent Eligibility For Insurance

*Your dependent(s) can be covered under this Plan. If you elect coverage for yourself or are insured under this Plan, you are eligible to elect dependent coverage as described below for your spouse or domestic partner and dependent children.*

*Your dependents are eligible for coverage the later of:*

- the date *your* insurance begins;
- the date *you* first acquire a *dependent*.

It is important that *you* inform *your employer* when *you* first acquire a qualified *dependent*. We will rely upon *your employer* to determine if a person meets the definition of a *dependent* for coverage under the *Plan*. This determination will be conclusive and binding upon all persons for purposes of this *Plan*.

## What Dependents Are Eligible For Coverage?

The following *dependents* are eligible for coverage under the *Plan*:

- *your lawful spouse*, not including a legally separated *spouse*. *You* may cover *your spouse* as a *dependent* if *your spouse* is enrolled for coverage as an *employee*;
- *your domestic partner*. *Your domestic partner* is the person named in *your* Declaration of Domestic Partnership. *You* must execute and provide the *Plan Administrator* with such a declaration that states and gives proof that the *domestic partner* has had the same permanent residence as *you* for a minimum of six consecutive months prior to the date insurance would become effective for that *domestic partner*. *You* must not have signed a Declaration of Domestic Partnership with anyone else within the last six months of signing the latest Declaration of Domestic Partnership. Also, the *domestic partner* must be at least 18 years of age, competent to contract, not related by blood closer than would bar marriage, the sole named *domestic partner*, not married to anyone else and the Declaration of Domestic Partnership must be approved and recorded by the *Plan Administrator*. *You* may not cover *your domestic partner* as a *dependent* if *your domestic partner* is enrolled for coverage as an *employee*;
- *your* unmarried children from live birth but less than age 26. Stillborn children are not eligible for coverage;
- *your* unmarried *dependent* children aged 26 or over, are eligible, provided they are unable to earn a living because of a physical or mental disability and *you* are the main source of support and maintenance; or
- *your* unmarried *dependent* children aged 26 or over who are permanently and continuously incapable of self-sustaining support by reason of mental retardation or physical handicap existing prior to the child's attainment of age 26.

We must receive proof within 60 days of the date the child attains age 26 and as required during the first two years. After the first two years, we will ask for proof when needed, but not more than once a year.

## Dependent Children

*Children* include *you* own biological children, lawfully adopted children. They also include:

- stepchildren;
- *your domestic partner's* children; or
- a child for whom benefits must be provided by court order for which we have received notification (as set forth in a divorce decree).

A child is considered adopted on the date of placement in *your* home. A *dependent* child may be covered by more than one *employee* in the *Plan*. A *dependent* child can be covered as both an *employee* and a *dependent*.

## When Dependent Coverage Begins

You pay 100% of the cost of *your dependent* coverage under a *Plan*. Once you are eligible for *dependent* coverage, you have 60 days from the date *your dependents* become eligible to apply for *dependent* coverage.

*Your dependent* coverage will begin at 12:01 a.m. on the later of:

- the first of the month following the date *your dependents* are eligible for coverage, if you apply for *dependent* insurance on or before that date, for any amount of insurance that is not subject to *evidence of insurability* requirements; or
- the first of the month following the date you apply for *dependent* insurance, if you apply within 60 days after *your dependent's eligibility date* for any amount of insurance that is not subject to *evidence of insurability* requirements; and
- the first of the month following the date we approve *your dependent's evidence of insurability* form, if you apply for *dependent* insurance on or before *your dependent's eligibility date* or within 60 days after *your dependent's eligibility date*, for any amount of insurance that is subject to *evidence of insurability* requirements.

*Evidence of insurability* is required if:

- *your dependents* are *late applicants*, which means you apply for *dependent* coverage more than 60 days after the date *your dependents* are eligible for coverage;
- you voluntarily cancelled *your dependent* coverage and are reapplying; or
- you declined *your dependent* coverage and now are applying; or
- you are applying for any amount of *dependent* life insurance for a *domestic partner*.

*Evidence of insurability* is also required for any amount of *dependent* life insurance over the amount shown in the Life Insurance Benefits Schedule. An *evidence of insurability* form for *your dependents* can be obtained from *your employer*.

## Dependents Who Are Late Applicants

If you did not apply for *dependent* coverage within 60 days of a *life status change*, *evidence of insurability* is required for any amount of *dependent* life insurance. In no event will this amount exceed the maximum benefit available for *your dependents* under the *Plan*.

*Dependent* coverage will begin at 12:01 a.m. on the first of the month the date we approve *your dependent's evidence of insurability* form.

## Delay Of Effective Date

A qualified *dependent* may be *confined* for medical care or treatment at home or elsewhere. If a qualified *dependent* is so *confined* on the day that *your dependent's* insurance under a coverage for that qualified *dependent*, or any change in that insurance that is subject to this section, would take effect, it will not then take effect. The insurance or change will take effect upon the qualified *dependent's* final medical release from all such *confinement*. The other requirements for the insurance or change must also be met.

### **Newborn Child Exception**

This section does not apply to a child of *yours* if the child is born to *you*, becomes *your* qualified *dependent* at birth, and either:

- is *your* first qualified *dependent*; or
- becomes a qualified *dependent* while *you* are insured for *dependent's* insurance under that coverage for any other qualified *dependent*.

Also, this section does not apply to any age increase in the amount of insurance for a child under the *dependent's* life coverage.

### **Changing Your Dependent Life Insurance Coverage**

*You* can change *your dependent* coverage by applying for a different option only during an *annual enrollment period*. *You* can increase *your dependent* coverage or decrease *your dependent* coverage any number of levels.

*Evidence of insurability* is required if *you* increase *your dependent* coverage by more than one level of \$5,000 or if *you* apply for any amount of *dependent* life insurance over the Guarantee Issue amount shown in the Life Insurance Benefits Schedule.

If *your dependent* is not approved for the increase in coverage, *your dependent* will automatically remain at the same level *your dependent* had prior to *your* applying for the increase. However, if *your dependent's* current level is below the *evidence of insurability* requirements, *your dependent's* coverage will be increased to the next level as long as that level does not exceed the *evidence of insurability* requirements. A change in coverage that is made during an *annual enrollment period* will begin at 12:01 a.m. on the later of:

- the first day of the next plan year; or
- the date we approve *your dependent's evidence of insurability* form if *evidence of insurability* is required.

### **Dependents Who Are Totally Disabled On The Date Coverage Would Normally Begin**

If *your* eligible *dependent* is *totally disabled*, *your dependent's* coverage will begin on the date *your* eligible *dependent* no longer is *totally disabled*. This provision does not apply to a newborn child while *dependent* insurance is in effect.

### **Effective Date Of Changes To Dependent Coverage**

Once *your dependent's* coverage begins, any increased or additional *dependent* coverage will take effect the date we approve *your dependent's evidence of insurability* form, if *evidence of insurability* is required, provided *your dependent* is not *totally disabled*. *You* must be in *active employment*.

If *you* are not in *active employment* due to *injury* or *sickness*, any increased or additional *dependent* coverage will begin on the date *you* return to *active employment*.

### **Changes In Dependent Coverage**

An increase or decrease in the amount of coverage for *your dependent*, as the result of a change in the *dependent's* age, status, or benefit level, will become effective on the date the age, status, or benefit level change occurs. If *you* are not *actively at work* on the date of the change, the increase in any coverage will be postponed until *you* return to work for one full day.

Any decreased coverage will take effect on the first of the month following the date *you* notify *your* employer but will not affect a *payable claim* that occurs prior to the decrease.

### **When Dependent Coverage Ends**

*Your dependent's* coverage under the *Policy* or a *Plan* ends on the end of the month following:

- the date the *Policy* or a *Plan* is cancelled;
- the date *you* no longer are in an eligible group;
- the date *your* eligible group is no longer covered;
- the date of *your* death;
- the last day of the period for which *you* made any required contributions; or
- the last day *you* are in *active employment* unless continued due to a *covered layoff or leave of absence* or due to an *injury or sickness*; or
- due to retirement, as described in this Certificate.

Coverage for any one *dependent* will end on the earliest of:

- the date *your* coverage under a *Plan* ends;
- the date *your dependent* ceases to be an eligible *dependent*;
- for a *spouse*, the date of divorce or annulment; or
- for a *domestic partner*, the date *your* domestic partnership ends.

### **Continuation Coverage For A Child Aged 26 Or Over Who Become Disabled While Covered Under The Plan**

Coverage will continue for a child aged 26 or over who became physically or mentally disabled while covered under the *Plan* provided:

- the child is unmarried;
- the disability was acquired before the child's coverage would have ended; the child is incapable of self-support and remains so incapable; and
- *you* are the main source of support and maintenance.

### **Continuation Coverage For A Child Aged 26 Or Over**

Coverage will continue for a child aged 26 or over who is permanently and continuously incapable of self-sustaining support by reason of mental disability or physical handicap, insured under the *Plan*, provided:

- the child is unmarried; and
- *you* are the main source of support and maintenance.

We must receive proof within 60 days of the date the child attains age 26 and as required during the first two years. After the first two years, we will ask for proof when needed, but not more than once a year.

# TERM LIFE INSURANCE BENEFITS

## HOW THE PLAN WORKS

### Life Insurance Benefits

Life insurance is an important component of *your* financial planning. This life insurance *Plan* pays a benefit to the named beneficiary (ies) if the *Insured* dies from any cause except as otherwise limited or excluded in this Certificate, while coverage is in effect.

A life insurance benefit is payable in the *amount of the life insurance benefit* shown on the Benefit Schedule for *you* upon written proof of death.

The benefit for *you* will be paid in accordance with the Beneficiary Rules of this Certificate.

The benefit for a covered *dependent* will be paid to *you*, if living, otherwise at *our* option we may pay the benefit to *your* surviving *spouse* or to the executors or administrators of *your* estate.

Refer to the "Accidental Death and Dismemberment" Section for a description of *your accidental death and dismemberment* benefits, exclusions, and conditions for this coverage.

### Beneficiary Rules

#### Choosing Your Beneficiary

*You* should choose *your* beneficiary(ies) as soon as *you* are covered under the *Plan*.

A primary beneficiary is the person *you* designate to receive life and *accidental death* insurance benefits if *you* should die while *you* are covered under this *Plan*. The beneficiary(ies) *you* select will apply to all death benefits payable under the *Policy*. *You* may name anyone as *your* beneficiary. *You* may name more than one beneficiary. *You* will need to complete a Beneficiary Designation Form, which *you* can get from the *Policyholder* or *us*.

If *you* name more than one primary beneficiary, benefits will be paid out equally unless *you* stipulate otherwise on the form. If *you* name more than one primary beneficiary and the amount or percentage of the payment to *your* primary beneficiaries does not equal 100% of *your* benefit amount, the difference will be paid equally to *your* named primary beneficiary(ies).

*You* may also name a contingent beneficiary. A contingent beneficiary is the person who will receive the life insurance benefit if there are no living primary beneficiaries at the time of *your* death.

It is important that *you* name *your* beneficiary(ies) and keep *your* designation current. If *you* do not name a beneficiary, or if all named beneficiaries do not survive *you*, or if *your* named beneficiary is disqualified, *your* death benefit may be paid to *your* estate or to surviving family members as described below.

In addition, if *you* do not survive *your spouse* or *domestic partner* and *dependent* life coverage is continued, then *your* surviving *spouse* or *domestic partner* should name a beneficiary according to the requirements specified for *you* in this Certificate.

#### Changing Your Beneficiary(ies)

*You* may change *your* beneficiary choice at any time by completing a new Beneficiary Designation Form unless *you* have assigned this *Policy* to someone else. Send the completed form to the *Policyholder* or to *us*. The beneficiary change will be effective on the date *you* sign a new Beneficiary Designation Form.

Prior to *your* death, *you* are the only person who can name or change *your* beneficiary. No other person may change *your* beneficiary on *your* behalf, including, but not limited to, any agent under power of attorney, whether durable or non-durable, or other power of appointment unless the appointment specifically states that the agent may change the beneficiary under this *Plan*.

The Company will pay death benefits in accordance with the beneficiary designation *we* have on record. Any payment made before *we* receive *your* request for a beneficiary change will be made to *your* previously designated beneficiary. The Company will be fully discharged of its duties if the payment is made before *we* receive notification of a change in beneficiary.

If *you* wish to change *your* beneficiary, please contact *us* for a Beneficiary Change Form.

### **If Your Beneficiary Dies Before You**

If one of *your* named primary beneficiaries dies before *you*, his or her share will be payable in equal shares to any other named primary beneficiaries who survive *you*. If *you* have named a contingent beneficiary, *your* contingent beneficiary will only be paid if all primary beneficiaries die before *you*.

If *you* have not named a primary or contingent beneficiary, *we* have the right to make payment to the surviving family members instead of making payment to *your* Estate in the following order:

- *your* surviving spouse or *your* registered domestic partner, if any;
- *your* child or in equal shares to *your* children;
- *your* surviving parents in equal shares;
- *your* brothers and sisters in equal shares; or
- if none of the above survives, to *your* estate.

### **If Your Beneficiary Is A Minor Or Lacks Legal Capacity**

The method of payment will differ if *your* beneficiary is a minor or a person who lacks legal capacity to give *us* a valid release for payment of any death benefit. *We* will issue the payment, as permitted by applicable state *law* as follows:

- to the guardian of *your* beneficiary's estate; or
- the custodian of the beneficiary's estate under the Uniform Transfer to Minors Act; or
- an adult caretaker/legal guardian.

The Company will be fully discharged of its duties once *we* have paid *your* benefit. The Company is not responsible for how the payment is used.

## **Documents Required For Proof Of Death**

*We* will require a certified copy of the death certificate and a completed Proof of Claim form. Refer to the Life Insurance "Claim Information" Section of this Certificate for information on the documentation needed and the procedure to file a claim for benefits.

## **Payment Of Benefits**

### **For Your Claim**

*Your* beneficiary(ies) will receive payment within two months of *our* receipt of the necessary written proof supporting the death claim, including any accidental death benefits. Refer to the "Life Claim Information" Section in this certificate for information on the required documentation and process to file a claim.

Benefit payments for your life insurance are made in a lump sum.

*Your beneficiary(ies)* will receive payment when *we* approve *your* death claim. Benefit payments for *your* life insurance are made in a lump sum.

If *you* do not survive *your* spouse, and *dependent* life coverage is continued, then *your* surviving *spouse's* death claim will be paid to *your* surviving *spouse's* beneficiary.

### **For A Dependent Claim**

*You* will receive payment. "within two months of *our* receipt of the necessary written proof supporting the death claim, including any accidental death benefits. Refer to the "Life Claim Information" Section in this certificate for information on the required documentation and process to file a claim. All *dependent* benefits will be paid to *you*. Benefit payments for *your dependent's* life and accidental death insurance are made in a lump sum.

### **Assignment**

An assignment is the transfer of *your* rights under the Group Policy to a person *you* name. *You* have the right to absolutely assign all of *your* rights and interest under the *Policy* including, but not limited to the following:

- the right to make any contributions required to keep the insurance in force;
- the privilege of converting;
- the right to name and change a beneficiary.

Absolute assignment may only be made to one assignee.

No absolute assignment of rights and interest shall be binding on *us* until and unless:

- the original of the form documenting the absolute assignment; or
- a true copy of it is received and acknowledged by *us* at *our Home Office*.

The Company and *your employer* must *give written* consent to the assignment. To request assignment of *your* life insurance *you* must complete an assignment form. Forms are available from *your employer* and *us*. Send the *completed* form to *us* for consent. *You* may wish to contact legal counsel prior to assigning *your* life insurance rights. Neither *your employer* nor the Company guarantees or assumes any obligation concerning the sufficiency or validity of any assignment for purposes of *your* tax or estate planning.

*We* will not decide if an assignment does what it is intended to do. *We* will not be held to know that one has been made unless it or a copy is filed with *us* through the *Policyholder*.

This provision applies only to insurance for which *you* have the right to choose a beneficiary when that right is assigned. If an assigned amount of insurance becomes payable on account of *your* death and, at *your* death, there is no beneficiary chosen by the assignee, it will be payable to:

- the assignee if living; or
- the estate of the assignee if the assignee is not living.

It will not be payable as stated in the Beneficiary Rules.

## Claims Of Creditors

Life and *accidental death and dismemberment* benefit payments are exempt from legal or equitable process for *your* debts, where permitted by *law*. The exemption also applies to the debts of *your* beneficiary.

## Benefit Reductions

### When Life And Accidental Death And Dismemberment Amounts Are Reduced

#### Age Reduction Rules

Life insurance and *accidental and death and dismemberment* coverage amounts will be reduced at age 70, then continue to the Age Reduction Rules in the Benefits Schedule.

Reductions are based on the amount of life and *accidental death and dismemberment* in force on the day prior to the first of the month in which *you* attain age 70.

The reduction will take effect on the January 1<sup>st</sup> following the date *you* attain the limiting age.

Once *your* benefit has been reduced, there will be no further increases in *your* insurance amount even if *your* salary or *eligible class* changes.

*You* may become eligible for coverage after *you* reach age 70. *Your* amount of life insurance will be figured by multiplying:

- the amount of insurance *you* would have been eligible for prior to age 70; times
- the applicable percentage, based on *your* current age.

#### Impact On Benefits When You Retire

Life insurance and *accidental death and dismemberment* coverage ends when *you* retire.

## Life Insurance Coverage When You Become Disabled

*Your* life insurance coverage may be continued for a specific time if *you* qualify as described below.

### How Do We Define A Total Disability?

*You* are disabled when we determine that:

- *you* are not working in any occupation and, due to *your injury* or *sickness*, are unable to perform the duties of any *gainful occupation* for which *you* are reasonably fitted by training, education, or experience; and
- *you* presumably will, for the duration of *your* life, be unable to perform the duties of any *gainful occupation* for which *you* are reasonably fitted by training, education, or experience.

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

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

We may require *you* to be examined by a *physician*, other medical practitioner, or vocational expert of *our* choice. We will pay for this examination. We can require an examination as often as it is reasonable to do so. We may also require *you* to be interviewed by *our* authorized representative.

## Premium Waiver Benefit

Your basic and supplemental life insurance coverage may be extended for a specific time and *your* life insurance premium will be waived if *we* determine that *you* have become disabled while *you* are insured under this *Plan* and *you* meet the conditions as described below.

### How Long Must You Be Disabled Before You Are Eligible To Have Life Insurance Premiums Waived?

*You* must be *totally disabled* through *your elimination period*. *Your elimination period* is 9 months.

### Applying For The Life Insurance Premium Waiver

Ask *your employer* for a Life Insurance Premium Waiver Claim form. The form has instructions on how to complete and where to send the claim.

*You* or *your employer* must continue to make life insurance payments for the first 9 months following the date *you* become disabled or until *we* determine that *you* are *totally disabled*, whichever occurs first. If *we* then determine that *you* are *totally disabled*, the basic and supplemental life insurance coverage *you* had prior to *your* disability will continue. *We* will not require further premium payments for *you* while *you* remain disabled according to the terms and provisions of the *Plan*.

### Amount Of Insurance

*Your* extended life insurance benefit under the premium waiver feature will be the *amount of life insurance* that was in force for *you* at the time *your* disability began. This amount may be subject to Age Reduction Rules outlined in this Certificate.

### When Your Life Insurance Premium Waiver Begins

*Your* life insurance Premium Waiver will begin when *we* approve *your* claim if the *elimination period* has ended and *you* meet the following conditions. *Your employer* may continue premium payments until *we* notify *your employer* of the date *your* life insurance premium waiver begins.

*Your* life insurance premium will be waived if *you* meet these conditions:

- *you* are less than 60 years and insured under the *Plan*;
- *you* become disabled and remain disabled during the *elimination period*;
- *you* meet the notice and proof of claim requirements for disability while *your* life insurance is in effect or within three months after it ends; and
- *your* claim is approved by *us*.

After *we* approve *your* claim, *we* do not require further premium payments for *you* while *you* remain disabled according to the terms and provisions of the *Plan*.

*Your* life insurance amount will not increase while *your* life insurance premiums are being waived. *Your* life insurance amount will reduce or cease at any time it would reduce or cease if *you* had not been disabled.

### Continued Proof Of Disability

*You* must furnish evidence of *your* disability when requested by *us*. *We* also have the right to examine *you* at *our* own expense and will use this information to determine if *you* are *totally disabled*.

### When Your Life Insurance Premium Waiver Ends

The life insurance premium waiver will automatically end if:

- *you* recover and *you* no longer are disabled;

- *you* are able to work at any *gainful occupation* for pay or profit;
- *you* fail to give *us* proper proof that *you* remain disabled;
- *you* refuse to have an examination by a doctor chosen by *us*;
- *you* reach age 65 or *your* retirement date, whichever occurs first.

*You* will not be considered retired or reaching *your* retirement date if *you* are receiving disability payments under:

- the United States Social Security Act; or
- any similar *law, plan, or act*; or
- *your employer's retirement plan*.

However, *you* will be considered retired if *you* are receiving retirement benefits.

### **Total Disability Extended Benefit**

If *your* death occurs within one year after the last day *you* are in *active employment*, and the *Policyholder* continues to pay premiums on *your* behalf, the amount of *your* death benefit will be paid if the following conditions are met:

- *you* became *totally disabled* while insured;
- *you* became *totally disabled* before *your* 65<sup>th</sup> birthday;
- *you* stayed *totally disabled* until *your* death; and
- within one year after *your* death, *your* authorized representative furnishes proof to *us* that *you* met the conditions listed above.

The amount of insurance payable at death will be the same amount for which *you* would have been eligible if *you* were not *totally disabled*, subject to any benefit reduction indicated in this Certificate or any life benefit paid under this *Plan* prior to *your* death.

At any time during the period in which the insurance is extended, we may require *you* to provide medical proof of the continuing *total disability*. At *our* expense, we may require *you* to submit to an independent exam by a *physician* we choose.

There will be no extension of insurance under the provisions of this section if an individual policy of life insurance is issued to *you* under the Conversion Privilege unless the individual policy is surrendered to the Company without claim except for the return of any premium paid.

Coverage extended on any *Insured* under the provisions of this section will automatically terminate:

- when premium payments stop;
- if *you* cease to be *totally disabled*, except that if *you* return to *active employment* in an *eligible class*, *your* insurance will be continued subject to payment of premiums by the *Policyholder*;
- if *you* refuse to submit to any physical examination required by the Company;
- if *you* fail to provide proof of *total disability* in accordance with the terms of this section; or
- the Group Policy is cancelled.

Upon termination of *your* insurance, *you* will be entitled to the benefits described in the section entitled "Plan Conversion Options".

## Life Insurance Limitations And Exclusions

No supplemental life or dependent supplemental life insurance benefit is payable under this *Policy* if death is caused by, contributed to by or results from:

- suicide, while sane or insane, or from an intentionally self-inflicted injury, within two years from the initial effective date of coverage under the *Policy*, and
- suicide, while sane or insane, or from an intentionally self-inflicted injury, within two years from the effective date of an increase in coverage under the *Policy*. The death benefit is limited to the amount of coverage in force prior to the increase.

The suicide exclusions applies only to supplemental life and dependent supplemental life coverage.

If benefits are denied under this exclusion, all premiums which have been paid by *you* for the denied benefit or the portion of denied benefit, will be returned to *you* in accordance with the Beneficiary Rules.

## Plan Conversion Options

### Conversion Insurance Option While You Are Satisfying The Disability Requirements

*You* may use the life Conversion Privilege when *your* life insurance terminates while *you* are satisfying the disability requirements. Please refer to the Conversion Privilege below. *You* are not eligible to apply for the life conversion option if *you* return to work and, again, become covered under the *Plan*.

If an individual conversion life insurance policy is issued to *you* by *us*, any benefit for *your* death under this *Plan* will be paid only if the individual policy is returned for surrender to *us*. *We* will refund all premiums paid for the individual *Policy*.

The amount of *your* death benefit will be paid to *your* named beneficiary for the *Plan*. If, however, *you* named a different beneficiary for the individual policy and the policy is returned to the Company for surrender, that different beneficiary will not be paid. If *you* want to name a different beneficiary for this Group Plan, *you* must change *your* beneficiary as described in the Beneficiary Designation page of this Group Plan.

### Conversion Policy When Coverage Ends Under This Option

When coverage ends under the *Plan*, *you* and *your dependents* may convert *your* group term life coverages to individual life policies, without *evidence of insurability*. The maximum amounts that *you* can convert are the amounts *you* and *your dependents* are insured for under the *Plan*. *You* may convert a lower *amount of life insurance*.

*You and your dependents* must apply for Individual Life Insurance under this life conversion privilege and pay the first premium within 31 days after the date:

- *your* employment terminates; or
- *you or your dependents* are no longer are eligible to participate in the coverage of the *Plan*.

If *you* convert to an individual life policy, then return to work, and again, become insured under the *Plan* *you* must surrender that individual life policy when *you* return to work.

Converted insurance may be of any type of the level premium whole life *plans* then in use by the Company or any subsidiaries or affiliates. The person may elect one year of preliminary term insurance under the level premium whole life policy. The individual policy will not contain disability or other extra benefits.

## **Optional Conversion Policy When The Group Policy Or The Plan Is Cancelled**

*You and your dependents* may convert a limited *amount of life insurance* if *you* have been insured under *your employer's* Group Plan with the Company for at least five years and the *Policy* or the *Plan*.

- is cancelled with *us*; or
- changes so that *you* no longer are eligible.

The individual life policy maximum for each of *you* will be the lesser of:

- \$10,000; or
- *your* and *your dependents* coverage amounts under the *Plan* less any amounts that become available under any other group life plan offered by *your employer* within 31 days after the date the *Policy* or the *Plan* is cancelled.

## **Premiums For Conversion Plans**

Premiums for the converted insurance will be based on:

- the person's then attained age on the effective date of the individual life policy;
- the type and amount of insurance to be converted;
- the Company's customary rates in use at that time; and
- the class of risk to which the person belongs.

If the premium payment has been made, the individual life policy will be effective at the end of the 31 day Conversion application period.

## **Payable Life Insurance Benefit During The Conversion Period**

A term life insurance benefit is payable for an *Insured* during the conversion period who dies:

- within 31 days after group coverage under this *Plan* ends; and
- while entitled to convert coverage under this *Plan* to an individual contract.

The amount of the benefit is equal to the *amount of life insurance* benefit, under this *Plan*; the *Insured* was entitled to convert. It is payable even if *you* did not apply for Conversion. It is payable when *we* receive written proof of death, and *we* approve the claim.

## **Applying For Conversion Insurance**

Ask *your employer* for a Conversion application form which includes cost information. When *you* complete the application, send it with the first premium amount to:

Paylogix LLC FBO Aflac PLADS  
P.O. Box 1635  
New York, NY 10008-1625

## ACCELERATED DEATH BENEFIT OPTION

The Accelerated Death Benefit option allows *you* to receive a one-time partial life insurance benefit if, while covered under the *Plan*, *you*, and *your dependent spouse or domestic partner* are diagnosed with a *terminal illness* and not expected to survive more than 12 months. The Accelerated Death Benefit is subject to the terms and conditions of the *Policy*.

This benefit option does not apply to any *terminal illness* resulting from an intentionally self-inflicted *injury* or suicide attempt.

*You* may request and receive an Accelerated Death Benefit under this *Plan* only once on *your own* behalf and only once on behalf of *your dependent spouse or domestic partner*.

The amount of the Accelerated Death Benefit available is a percentage of the amount of *employee* term life insurance that *you* elected under the *Plan*. *You* may request up to 80% of the basic term life insurance, or 50% of the supplemental term life insurance that is currently in effect for *you* or the person for whom *you* are making the request on the date *we* receive proof that *you or your spouse or domestic partner* are *terminally ill*. But the amount *you* request may not be:

- less than the Accelerated Death Benefit minimum; or
- more than the Accelerated Death Benefit maximum.

Refer to the Benefits Schedule for specific amounts.

The benefit may be reduced if, within 6 months after the date *we* receive such proof, a reduction on account of age would have applied to the amount of *your employee* term life insurance. In that case, the amount of the benefit payable may not exceed the amount of the term life insurance after applying the reduction.

The *amount of life insurance* after the Accelerated Death Benefit has been paid will remain in force and be paid in accordance with the terms of the Certificate describing *your* coverage, subject to the terms and conditions of the *Policy*.

### Tax Consequences

The Accelerated Death Benefit under this certificate may or may not qualify for favorable tax treatment under the Internal Revenue Code of 1986. Whether such benefits qualify depends on factors such as *your* life expectancy at the time benefits are accelerated or whether *you* use the benefits to pay for necessary long-term care expenses, such as nursing home care. If the Accelerated Death Benefit qualifies for favorable tax treatment, the benefits will be excludable from *your* income and not subject to federal taxation.

Tax laws relating to Accelerated Death Benefits are complex. Benefits paid may be taxable. As with all tax matters, *you or your dependent* should consult *your* personal tax advisor to assess the impact of this benefit. *We* are not responsible for any tax or other effects of any benefit paid.

Receipt of an accelerated benefit may affect *your, your spouse or your family's* eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children (AFDC), supplementary Social Security Income (SSI), and drug assistance programs. *You* are advised to consult with a qualified tax advisor and with social service agencies concerning how receipt of such a payment will affect *you, your spouse and your family's* eligibility for public assistance.

## Electing The Accelerated Death Benefit Option

Your or your spouse's or domestic partner's right to exercise this option and to receive payment is subject to the following conditions:

- you or your spouse or domestic partner must be *terminally ill* at the time of payment of the Accelerated Death Benefit;
- your employee term life insurance must not be assigned (please see the "Assignment" Section below);
- our claims handling rules apply to the payment of benefits under this option;
- you or your spouse or domestic partner must request the Accelerated Death Benefit election in writing on a form acceptable by us and submit the request form to us; and
- you must also provide us the following:
  - 1) A physician's certification that you or your spouse or domestic partner are suffering from a non-correctable *terminal illness* and your or your spouse's or domestic partner's life expectancy has been reduced to less than 12 months. The physician's certification must be deemed satisfactory to us.
  - 2) A copy of:
    - all medical test results;
    - laboratory reports; and
    - all supporting documentation and information on which the physician's statement is based.

We may, at our own expense, require you or your spouse or domestic partner to submit to an independent medical exam by a physician we choose. We will not process your Accelerated Death Benefit request until the exam has been completed and we have received the results.

### We May Refuse Your Election Request

We may stop processing your request or refuse your request if:

- the Group Policy terminates coverage for your eligible class before we approve your request (even if all or part of your life insurance coverage continues for any reason);
- all of your or your spouse's or domestic partner's life insurance coverage terminates under the Group Policy for any reason before we approve your request; or
- you die before we issue the Accelerated Death payment.

### Assignment

If you have assigned your rights under the Plan to an assignee or made an irrevocable beneficiary designation, we must receive consent, in writing, that the assignee or irrevocable beneficiary has agreed to the Accelerated Death Benefit payment on your behalf in a form acceptable to us before benefits are payable.

### Accelerated Death Benefit Payment

If your request is approved, we will pay you the Accelerated Death Benefit in a lump sum. Benefits are payable to you.

The Accelerated Death Benefit is available on a voluntary basis. Therefore, you or your spouse or domestic partner are not eligible for benefits if:

- *you or your spouse or domestic partner* are required by *law* to use this benefit to meet the claims of creditors, whether in bankruptcy or otherwise; or
- *you or your spouse or domestic partner* are required by a government agency to use this benefit in order to apply for, get, or otherwise keep a government benefit or entitlement.

### **Premium Payments**

Premium payments must continue to be paid on the full *amount of life insurance* unless *you* qualify to have *your* life premium waived.

Also, premium payments must continue to be paid on the full amount of *your dependent's* life insurance.

### **Effect Of An Accelerated Death Benefit Payment On Your Plan**

This benefit is in lieu of the benefits that would have been paid on *your* death. Accordingly, an election to receive an Accelerated Death Benefit will have the following effect on other benefits:

#### **Your Life Insurance Benefit**

The *amount of life insurance* covering *you or your spouse or domestic partner* including any amount under an extended death benefit, will be reduced by the amount of any Accelerated Death Benefit payment.

#### **Life Continuation And Conversion**

Any *amount of life insurance* that would be continued under a disability continuation provision or that may be available under the Conversion Privilege will be reduced by the amount of the Accelerated Death Benefit payment. The converted amount will be limited to the reduced *amount of life insurance* remaining after the benefit payment subject to any reduction and termination provisions.

Refer to the "Plan Conversion Options" Section for more information about the Conversion Privilege.

#### **Statement Of Benefits**

Upon payment of *your* Accelerated Death Benefit *we* will issue *you* a statement specifying the amount of benefits paid, the amount by which *your* life insurance benefit was reduced due to the acceleration benefit payment.

#### **Claims Of Creditors**

To the extent allowed by *law*, *you* are not required to request an Accelerated Death Benefit in order to satisfy claims of creditors.

# ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) BENEFITS

## HOW THE PLAN WORKS

The *accidental death and dismemberment* benefit covers losses *you* or *your covered dependents* suffer solely and as a direct result of an *accidental bodily injury* that occurs while coverage is in effect. The *accidental death and dismemberment* benefits are payable in addition to any other coverage *you* may have from *your employer*.

Covered losses are described as a percentage of the Principal Sum. The Principal Sum is the full benefit payable by the *Plan*. The Principal Sum amount is described on *your* Accidental Death and Dismemberment Benefits Schedule. The "Covered Loss Schedule" below defines the covered losses and the benefit payable for each type of covered loss under this *Plan*.

### Covered Loss Schedule

Covered Losses	Benefit Amount
Loss of Life	The Principal Sum
Loss of Both Hands and Both Feet	The Principal Sum
Loss of One Hand and One Foot	The Principal Sum
Loss of One Hand or One Foot and Sight of One Eye	The Principal Sum
Loss of Speech and Hearing in Both Ears	The Principal Sum
Loss of One Arm or One Leg	75% of the Principal Sum
Loss of One Hand or One Foot	50% of the Principal Sum
Loss of Sight of One Eye	50% of the Principal Sum
Loss of Speech or Hearing	50% of the Principal Sum
Loss of Thumb and Index Finger of Same Hand	25% of the Principal Sum
Loss of Big Toe (permanent loss)	25% of the Principal Sum
Loss of Toes on One Foot	25% of the Principal Sum

\*Refer to the Glossary for a description of each covered loss.

Refer to the "Accidental Death and Dismemberment Claim Information" Section of this Certificate for information on the documentation needed and the process to file a claim for benefits.

**If more than one of the above covered losses results from one incident, the benefit payable will be the Principal Sum, or the sum of the benefits payable for each covered loss, whichever is less.**

### Accidental Death Benefit

An accidental death benefit is payable if *you* or *your dependents* suffer solely, and as a direct result of an *accidental bodily injury*, loss of life while coverage is in effect. The loss of life must be caused directly by that *bodily injury*, and apart from any other cause, within 365 days after the *accident*. The *accident* must occur while *you* are insured under the *Plan*.

We will pay the amount of the benefit shown on the Covered Loss Schedule and the Benefits Schedule for *you* or *your dependents* upon approval of *your* claim provided certain conditions are met. The benefit for *you* will be paid in accordance with *your* life insurance *beneficiary* designation. If no beneficiary was selected, the benefit will be paid in accordance with the Beneficiary Rules shown in the "Term Life Insurance Benefits" Section of this Certificate.

The benefit for a covered *dependent* will be paid to *you*, if living; otherwise, at *our* option we may pay the benefit to *your* surviving *spouse* or to the executors or administrators of *your* estate.

## Accidental Dismemberment Benefits

A benefit is payable if *you* or *your* covered *dependent* suffer solely, and as a direct result of an *accidental bodily injury* a covered loss listed in the Covered Loss Schedule shown above, while coverage is in effect. The loss must be caused directly and apart from any other cause, by that *accidental bodily injury* within 365 days after the *accident*. The *accident* must occur while *you* are insured under the *Plan*.

If we approve the claim, we will determine the payment according to the Covered Loss Schedule above. The most we will pay for any combination of covered losses from any one *accident* is the Principal Sum. The Principal Sum is shown in the Accidental Death and Dismemberment Benefit Schedule. The benefit for a covered loss will be paid to *you*. No benefit is payable for any loss which is not shown on the Covered Loss Schedule unless otherwise described in this Certificate as a covered benefit.

## Exclusions- Accidental Losses Not Covered Under Your Plan

*Your Plan* does not cover any accidental losses caused by, contributed to by, or resulting from:

- a suicide, self-destruction while sane, intentionally self-inflicted *injury* while sane, or self-inflicted injury while insane;
- active participation in a riot or an act of insurrection, rebellion, or civil commotion;
- the presence of that percentage of alcohol in the blood which raises a presumption that the *Insured* was under the influence of alcohol as determined by the *laws* of the state, country, province, territory, or location in which the *accident* occurred;
- the use of any prescription or non-prescription drug, poison, fume, or other chemical substance unless used according to the prescription or direction of *your* or *your dependent's physician*. This exclusion will not apply to *you* or *your dependents* if the chemical substance is ethanol;
- service or full-time active duty in the Armed Forces of any country or international authority;
- air or space travel. This does not apply if a person is a passenger, with no duties at all, on an aircraft being used only to carry passengers (with or without cargo);
- war or act of war; or
- inhalation of poisonous gasses.

## ADDITIONAL BENEFITS UNDER THE ACCIDENTAL DEATH AND DISMEMBERMENT COVERAGE

This section describes additional losses that may be covered by *your accidental death and dismemberment* coverage if the losses are a direct result of an *accidental bodily injury* while coverage is in effect. *You* or *your dependent* must be covered by the *Plan* at the time of the *accident* that causes the loss. In order to be eligible to receive additional benefits under this section, an *accidental death* or *dismemberment* benefit must be payable under *your* basic coverage.

All the exclusions and limitations of *your accidental death and dismemberment* coverage listed in the Certificate Section, "Exclusions- Accidental Losses Not Covered Under Your Plan" apply to any additional benefits in this section.

### SEATBELT(S) AND AIR BAG BENEFIT

This *Plan* will pay *you* or *your* authorized representative an additional benefit if *you* or *your dependent* sustain an *accidental bodily injury* which causes *your* or *your dependent's* death while *you* or *your dependent* are driving or riding in a *private passenger car*, provided:

### **For Seatbelt(s):**

- the *private passenger car* is equipped with seatbelt(s);
- the seatbelt(s) were in actual use and properly fastened at the time of the covered *accident*, and
- the position of the seatbelt(s) are certified in the official report of the covered *accident*, or by the investigating officer. A copy of the police accident report must be submitted with the claim.

Also, if such certification is not available, and it is clear that *you* or *your dependent* were properly wearing seatbelt(s), then we will pay the additional seatbelt benefit. However, if such certification is not available, and it is unclear whether *you* or *your dependent* were properly wearing seatbelt(s), then we will pay a fixed benefit of \$1,000.

We will only pay the seatbelt benefit for the death of a minor, *dependent child*, if the *child* is correctly strapped and fastened in the appropriate seat for the *child's* age and weight as defined by state or federal guidelines. The seatbelt device must also be approved by the state or federal government for the *dependent child's* age and weight.

An automatic harness seatbelt will not be considered properly fastened unless a lap belt is also used.

### **For Air Bag:**

- the *private passenger car* is equipped with an air bag for the seat in which *you* or *your dependent* are seated; and
- the seatbelt(s) must be in actual use and properly fastened at the time of the covered *accident*.

No benefit will be paid if we verify that the air bag(s) had been disengaged prior to the *accident*. The *accident* causing *your* or *your dependent's* death must occur while *you* or *your dependent* are insured under the *Plan*.

No benefit will be paid if *you* or *your dependent* are the driver of the *private passenger car* and do not hold a current and valid driver's license.

The benefit payable and the maximum benefit amount is shown in the Accidental Death and Dismemberment Benefits Schedule.

## **CHILD TUITION BENEFIT**

### **Qualified Student** means:

- for purposes of the Tuition Benefit, any of *your* unmarried *dependent* children who, on the date of *your* death as a result of an *accidental bodily injury*, meet the definition of a "*dependent*" and were either:
  - enrolled as full-time students in an accredited post-secondary institution of higher learning beyond the 12th grade level; or
  - at the 12th grade level and enroll as full-time students in an accredited post-secondary institution of higher learning beyond the 12th grade level within 365 days following the date of *your* death.

*Your Plan* includes a Tuition Benefit. We will pay a benefit to *your* authorized representative on behalf of each of *your* qualified students a lump sum payment if *you* or *your spouse* or *domestic partner* lose *your* life as a result of an *accidental bodily injury* within 365 days after the date of the *accident* causing the *accidental bodily injury* and:

- the *accident* causing *your accidental bodily injury* occurred while *you* were insured under the *Plan*;
- proof is furnished to *us* that the *child* is a qualified student; and
- the qualified student continues to be enrolled as a *full-time* student in an accredited post-secondary institution of higher learning beyond the 12th grade level.

The benefit amount per academic year, maximum benefit payments, maximum benefit amount and maximum benefit period are shown in the Accidental Death and Dismemberment Benefits Schedule.

The Education benefit will terminate for each student on the earliest of the following dates:

- the date *your* qualified student fails to furnish proof as required by *us*;
- the date *your* qualified student no longer qualifies as a *dependent child* for any reason except *your* death; or
- the end of the maximum benefit period.

If you have no dependents or no dependent qualifies as a *qualified student*, then *we* will pay a benefit in the amount of \$1,000 to *your* beneficiary or to *your* estate if there is no beneficiary.

#### **COMMON CARRIER AND MOTOR VEHICLE BENEFIT**

*We* will pay an additional benefit if *you* or *your dependents* die from an *accidental bodily injury* received in an *accident*, which is not an occupational *injury* and occurs:

- while *you* or *your dependent* are driving or riding in a private pleasure car; when *you* or *your dependent* are struck by a motor vehicle; or
- while *you* or *your dependent* are riding as a passenger in a common public passenger carrier.

The maximum benefit amount is shown in the Accidental Death and Dismemberment Benefits Schedule.

#### **EXPOSURE BENEFIT**

This *Plan* will pay an *accidental death* benefit for loss of life of *you*, or *your* covered *dependent* caused by unavoidable exposure to natural elements if the exposure was a direct result of an *accident*.

#### **DISAPPEARANCE**

*We* will presume *you* or *your dependents* suffered loss of life due to an *accident* and the *Plan* will pay an *accidental death* benefit if:

- *you* or *your dependents* are riding in a common public passenger carrier that is involved in an *accident* covered under the *Policy*;
- as a result of the *accident*, the common public passenger carrier is wrecked, sinks, is stranded, or disappears;
- the *accident* occurs while *you* or *your dependents* are insured under the *Plan*;
- no contrary evidence about the circumstance of the disappearance arises; and
- *your* or *your dependents* bodies are not found within one year of the *accident*.

The maximum benefit amount is shown in the Accidental Death and Dismemberment Benefits Schedule.

# ADDITIONAL BENEFIT FEATURES

## Continuity Of Coverage

### Effect Of Prior Coverage - Transferred Business

(Continuity of Coverage when *you* are not in *active employment* when the *Policyholder* changes insurance carriers to *us*).

If *your* coverage under any part of this *Plan* replaces any prior coverage that *you* had, the following rules apply:

"Prior coverage" means any plan of group coverage sponsored by *your employer* that has been replaced by coverage under all or part of this *Plan* (e.g. transferred business). The replacement coverage under the new *Plan* may be for all or part for the *eligible class* to which *you* belong. Any such plan is prior coverage if provided by another group policy or any benefit section of this *Plan*.

When this *Plan* becomes effective, we will provide group life, *accidental death*, and *dismemberment* insurance coverage for *you* as long as *you* are not receiving benefit payments for extended life disability benefits (e.g. Waiver of Premium, or Extended Death Benefit) under the prior carrier's plan, and:

- *you* are not in *active employment* because of a *sickness* or *injury*;
- *you* were covered by the prior carrier's plan on its termination date; and
- *your* name is shown on the listing, that has been approved by *us* and the *Policyholder*, contained in *our* file.

We will also provide group *dependent* life and *accidental death and dismemberment* insurance coverage for *your dependent* if:

- *your dependent* is totally disabled;
- *your dependent* was covered by the prior carrier's plan on its termination date; and
- *your dependent's* name is shown on the listing that has been approved by *us*, contained in *our* file.

### Premium Payments

Premium payments are required for *you* and *your dependents* during the period this coverage continues in force. In effect, we will not waive premium during the period Continuity of Coverage continues.

Coverage provided under this Continuity of Coverage provision will automatically end on the date *you* return to *active employment*, on the date *you* or *your dependents* recover and no longer are disabled, or on the date this Group Policy or a *Plan* is cancelled.

### Discontinuance And Replacement

In addition, the amounts of insurance *you* elect are subject to the provisions of the prior carrier's plan. Any and all exclusions, reductions, limitations, and/or specific termination dates or provisions of the prior carrier's plan will apply

# CLAIM INFORMATION

## TERM LIFE INSURANCE

### Reporting Of Claims

We encourage *you* or *your* authorized representative to notify *us* as soon as possible, so that a claim decision can be made in a timely manner.

If a claim is based on *your* disability, telephonic notice as authorized by *us* or written notice and proof of claim must be provided no later than 90 days after the end of the *elimination period*.

If a claim is based on death, telephonic notice as authorized by *us* or written notice and proof of claim must be provided no later than 90 days after the date of death.

If it is not possible to give proof within these time limits, it must be given no later than one year after the time proof is required as specified above. These time limits will not apply during any period *you* or *your* authorized representative lacks the legal capacity to give *us* proof of claim.

If *you* choose to file a written notice of claim, the claim form is available from *your employer*, or *you* or *your* authorized representative can request a claim form from *us*. If *you* or *your* authorized representative does not receive the form from *us* within 15 days of *your* request, send *us* written proof of claim without waiting for the form.

If *you* submit a claim before *you* have been notified of *our* decision on any coverage amount requiring *evidence of insurability*, *your* amount of coverage will be determined as if *our* final underwriting decision had been made prior to the date of claim.

If *you* have a disability, *you* must notify *us* immediately when *you* return to work in any capacity, regardless of whether *you* are working for *your employer*.

### Filing A Claim For A Disability

*You* may file proof of claim by telephonic means. Contact *your employer* for more information on how to file *your* claim by telephone. *You* will be required to sign an authorization form in order for *us* to obtain medical information from *your* attending *physician*. If *we* are unable to obtain *your* medical information, *we* will send a letter and appropriate forms to *you* for completion to be returned to *us* by the date determined in the letter.

If *you* choose to file written notice of claim, *you* or *your* authorized representative and *your employer* must complete *your* own sections of the claim form and then give it to *your* attending *physician*. *Your physician* should complete his or her section of the form and send it directly to *us*.

### Information Required For Proof Of Your Disability Claim

If the claim is based on *your* disability, proof of claim, provided at *your* expense, must show:

- that *you* are under the *regular care* of a *physician*;
- the date *your* disability began;
- the cause of *your* disability;
- the extent of *your* disability, including restrictions and limitations preventing *you* from performing *your regular occupation* or any *gainful occupation*; and

- the name and address of any *hospital* or *institution* where *you* received treatment, including all attending *physicians*.

We may request that *you* send proof of continuing disability indicating that *you* are under the *regular care* of a *physician*. This proof, provided at *your* expense, must be received within 30 days of a request by *us*.

In some cases, *you* will be required to give *us* authorization to obtain additional medical and non-medical information as part of *your* proof of claim or proof of continuing disability. We may not be able to process *your* claim if the appropriate information is not submitted. We may deny *your* claim or terminate *your* payments until we receive the required information.

### **Information Required For Proof Of Death**

A certified copy of the death certificate must be given to *us* with proof the claimant is entitled to the insurance proceeds. Proof of claim for death must show the cause of death and be provided at *your* or *your* authorized representative's expense. We may not be able to process *your* claim if the appropriate information is not submitted. We may deny *your* claim until we receive the required information.

### **Claim Notification**

We will notify a claimant in writing of the acceptance or rejection of a claim no later than the 15th business day after the date we receive all items, statements, and forms required by *us* to secure final proof of loss.

If we are unable to accept or reject the claim, we will notify the claimant of the reasons that we need additional time within 15 business days of *our* receipt of the claim information. We will accept or reject the claim within 45 days after the date of this notice.

If we reject the claim, the notice we will state the reasons for the rejection.

### **Death Claim Payment**

We will settle a death claim within two months following *our* receipt of satisfactory proof of loss as described above. We will pay interest on the proceeds from the date we receive satisfactory proof of loss until the date we approve the claim. The interest rate will be the rate at which interest accrues on proceeds that are left on deposit with the company.

### **When Can We Request An Autopsy?**

In case of death, we will have the right and opportunity to request an autopsy where not forbidden by *law*.

### **What Happens If We Overpay Your Claim?**

We have the right to recover any overpayments due to fraud or *our* error. *You*, *your* authorized representative, or *your beneficiary* must reimburse *us* in full. We will not recover more money than the amount we paid *you*. We will determine the method by which the repayment will be made.

We have the right to do any one or all of the following:

- require *you* to return the overpayment on request;
- take any legal action needed to recover the overpayment; and
- place a lien, if not prohibited by *law*, in the amount of the overpayment on the proceeds of any other income, whether on a periodic or lump sum basis.

## **Unpaid Premium Due**

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

## **What Are The Time Limits For Legal Proceedings?**

*You* can start legal action regarding *your* claim 60 days after proof of claim has been given to *us* and up to 3 years from the time proof of claim is required, unless otherwise provided under federal *law*.

## **What Are Your Assignability Rights for the Death Benefits Under Your Life Insurance (Assignability Rights)**

The rights provided to *you* by the *Plan(s)* for *life* insurance benefits are owned by *you*, unless:

- *you* have previously assigned these rights to someone else (known as an "assignee"); or
- *you* assign *your* rights under the *Plan(s)* to an assignee.

*We* will recognize an assignee as the owner of the rights assigned only if:

- a) the assignment is in writing, signed by *you*, and acceptable to *us* in form; and
- b) a signed or certified copy of the written assignment has been received and registered by *us* at *our Home Office*.

*We* will not be responsible for the legal, tax or other effects of any assignment, or for any action taken under the *Plan(s)* provisions before receiving and registering an assignment.

# CLAIM INFORMATION

## ACCIDENTAL DEATH AND DISMEMBERMENT COVERAGE

### Reporting Of Claims

We encourage *you* or *your* authorized representative to notify *us* as soon as possible, so that a claim decision can be made in a timely manner.

If a claim is based on death or other covered loss, notice as authorized by *us* or written notice and proof of claim must be provided no later than 90 days after the date of death or the date of any other covered loss.

If a claim is based on the Tuition Benefit, notice as authorized by *us* or written notice and proof of claim must be provided no later than 60 days after the date of *your* death.

If it is not possible to give proof within these time limits, it must be given no later than 1 year after the time proof is required as specified above. These time limits will not apply during any period *you* or *your* authorized representative lacks the legal capacity to give *us* proof of claim.

The claim form is available from *your employer*, or *you* or *your* authorized representative can request a claim form from *us*. If *you* or *your* authorized representative does not receive the form from *us* within 15 days of *your* request, send *us* written proof of claim without waiting for the form.

If *you* submit a claim before *you* have been notified of *our* decision on any coverage amount requiring *evidence of insurability*, *your* amount of coverage will be determined as if *our* final underwriting decision had been made prior to the date of claim.

### Filing A Claim For A Covered Loss

Contact *your employer* for more information on how to file *your* claim *you* will be required to sign an authorization form in order for *us* to obtain medical information from *your* attending *physician*. If *we* are unable to obtain *your* medical information, *we* will send a letter and appropriate forms to *you* for completion to be returned to *us* by the date determined in the letter.

*You* or *your* authorized representative and *your employer* must complete *your* own sections of the claim form and then give it to *your* attending *physician*. *Your physician* should complete his or her section of the form and send it directly to *us*.

### Information Required For Proof Of Death

A certified copy of the death certificate must be given to *us* with proof the claimant is entitled to the insurance proceeds. Proof of claim for death must show the cause of death and be provided at *your* or *your* authorized representative's expense. *We* may not be able to process *your* claim if the appropriate information is not submitted. *We* may deny *your* claim until *we* receive the required information.

### Information Required For Proof Of Other Accidental Covered Loss

If the claim is based on a covered loss other than death, proof of claim for the covered loss, provided at *your* or *your* authorized representative's expense, must show:

- the cause of the covered loss;

- the extent of the covered loss;
- the date of the covered loss; and
- the name and address of any *hospital* or *institution* where treatment was received, including all attending *physicians*.

In some cases, *you* will be required to give us authorization to obtain additional medical and non-medical information as part of *your* proof of claim or proof of continuing disability. *We* may not be able to process *your* claim if the appropriate information is not submitted. *We* may deny *your* claim or terminate *your* payments until *we* receive the required information.

If claim is based on the Tuition Benefit, proof of claim, provided at *your* authorized representative's expense, must show:

- the date of enrollment of *your* qualified child in an accredited post-secondary institution of higher learning;
- the name of the institution;
- a list of courses for the current academic term; and
- the number of credit hours for the current academic term.

### **Claim Notification**

*We* will notify a claimant in writing of the acceptance or rejection of a claim no later than the 15th business day after the date *we* receive all items, statements, and forms required by *us* to secure final proof of loss.

If *we* are unable to accept or reject the claim, *we* will notify the claimant of the reasons that *we* need additional time within 15 business days of *our* receipt of the claim information. *We* will accept or reject the claim within 45 days after the date of this notice.

If *we* reject the claim, the notice *we* will state the reasons for the rejection.

### **Claim Payment**

*We* will settle a claim within two months following *our* receipt of satisfactory proof of loss as describe above. *We* will pay interest on the proceeds of an accidental death claim from the date *we* receive satisfactory proof of loss until the date *we* approve the claim. The interest rate will be the rate at which interest accrues on proceeds that are left on deposit with the company.

### **When Can We Request An Autopsy?**

In case of death, *we* will have the right and opportunity to request an autopsy where not forbidden by *law*.

### **What Happens If We Overpay Your Claim?**

*We* have the right to recover any overpayments for amounts paid greater than the benefits that *you* are entitled to receive. This includes but is not limited to fraud or *our* error. *You*, *your* authorized representative, or *your beneficiary* must reimburse *us* in full. *We* will not recover more money than the amount *we* paid *you*. *We* will determine the method by which the repayment will be made.

*We* have the right to do any one or all of the following:

- require *you* to return the overpayment on request;
- take any legal action needed to recover the overpayment; and
- place a lien, if not prohibited by *law*, in the amount of the overpayment on the proceeds of any other income, whether on a periodic or lump sum basis.

## **Unpaid Premium Due**

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

## **What Are The Time Limits For Legal Proceedings?**

*You* can start legal action regarding *your* claim 60 days after proof of claim has been given to *us* and up to three years from the time proof of claim is required, unless otherwise provided under federal *law*.

## **What Are Your Assignability Rights for the Death Benefits Under Your Life Insurance (Assignability Rights)?**

The rights provided to *you* by the *Plan(s)* for *accidental death* insurance benefits are owned by *you*, unless:

- *you* have previously assigned these rights to someone else (known as an "assignee"); or
- *you* assign *your* rights under the *Plan(s)* to an assignee.

We will recognize an assignee as the owner of the rights assigned only if:

- the assignment is in writing, signed by *you*, and acceptable to *us* in form; and
- a signed or certified copy of the written assignment has been received and registered by *us* at *our Home Office*.

We will not be responsible for the legal, tax or other effects of any assignment, or for any action taken under the *Plan(s)* provisions before receiving and registering an assignment.

# GLOSSARY

## General definitions used throughout this Certificate include:

**Accident** means a sudden external trauma that is unexpected and unforeseen and is an identifiable occurrence or event producing, at the time, objective symptoms of an external bodily injury. The *accident* must have occurred while the person is covered under this *Policy*. The occurrence or event must be definite as to time and place. It must not be due to or contributed to by an *illness* or disease of any kind. This includes a reaction to a condition that manifests within the human body or a reaction to a drug or medication regardless of the reason *you* have consumed the drug or medication.

**Accidental Bodily Injury** means bodily harm caused solely by external, violent, and accidental means and not contributed to by any other cause.

**Accidental Death and Dismemberment** means the total benefit amount for which an individual is insured under this *Plan* subject to the maximum benefit.

**Accredited School** means an accredited post-secondary institution of higher learning for *full-time* students beyond the 12th grade level.

**Actively at Work, Active at Work or Actively Working** means at work with *your employer* on a day that is one of *your employer's* scheduled workdays. On that day, *you* must be performing for wage or profit, all of the regular duties of *your* job in the usual way; and for *your* usual number of hours.

**Active Employment** means *you* are working for *your employer* for earnings that are paid regularly and that *you* are performing the *material and substantial duties of your regular occupation*. *You* must be working at least the minimum number of hours as described under Eligible Group(s) in each *Plan*.

*Your* work site must be:

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

Normal vacation or a holiday is considered *active employment*. Temporary and seasonal workers are excluded from coverage.

**Administrator** means the person(s) or organization(s) that are designated by the *Policyholder* to perform certain functions on behalf of the *Policyholder*.

References to the *Policyholder* mean the *Administrator* when the *Administrator* is acting on behalf of the *Policyholder*.

**Amount of Life Insurance** means both the Basic and Supplemental Life Amounts unless otherwise stated in specific provisions and benefits.

**Annual Earnings** means *your* gross annual income from *your employer* in effect on the July/August payroll run just prior to the date of loss. It includes *your* total income before taxes. It is prior to any deductions made for pre-tax contributions to a qualified deferred compensation, Section 125 *Plan*, or flexible spending account. It does not include income received from commissions, bonuses, overtime pay, any other extra compensation, or income received from services other than *your employer*.

For purposes of calculating benefits payable to *you*, *annual earnings* means *your* actual earnings as defined above, as of the date *your* employer most recently reported *your* earnings to *us* prior to *your* date

of loss. Check with *your employer* to determine the amount of earnings it reports to *us* for *you* and how frequently earnings are reported

**Dependent** means *your spouse or domestic partner* and dependent children. A *dependent* must be a citizen or legal resident of the United States, its territories, and protectorates. Any person who is in full-time military service cannot be a *dependent*.

**Eligible Classes:** *your employer* determines if *you* are in an *eligible class*. Such criteria are based solely upon the conditions related to *your* employment established by *your employer*. We will rely upon the representation of the employer as to *your* eligibility for coverage under this *Plan* and as to any fact concerning such eligibility.

**Eligibility Date** means the date *you* become eligible for insurance.

**Elimination Period** means a period of continuous disability which must be satisfied before *you* are eligible to have *your* life premium waived by *us* or receive a permanent disability benefit.

**Employee** means a person who is in *active employment* with the *Policyholder* and the *employees*, individual proprietors, and partners of one or more affiliated corporations, proprietorships, or partnerships if the business of the *Policyholder* and such affiliated corporations, proprietorships or partnerships is under common control. *Employee* shall exclude in any case, *part-time employees*, temporary *employees*, and *employees* who work for the *participating employer* less than the number of hours per week indicated in the Benefits Schedule. This term does not include *employees* who normally work less than 30 hours a week for the *Policyholder*.

**Employer** means the *Policyholder*, and includes any division, subsidiary or affiliated company named in the *Policy*.

**Evidence of Insurability** means a statement of *your* or *your spouse's* or *domestic partner's* medical history which we will use to determine if *you* or *your spouse* or *domestic partner* is approved for coverage. *Evidence of insurability* will be at *your* expense.

**Full-Time** as used for a student means a full course load as defined by the accredited post-secondary school.

**Full-Time** as used for an *Insured* means the number of hours set by the *Policyholder* as a regular work day for *full-time employees* in the *Insured's eligible class*.

**Gainful Occupation/Gainful Employment** means an occupation that within 12 months of *your* return to work is or can be expected to provide *you* with an income that is at least equal to 60% of *your annual earnings* in effect just prior to the date *your* disability began.

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

**Home Office** means 1299 Zurich Way, Schaumburg, IL 60196.

**Hospital or Institution** means an accredited facility licensed to provide care and treatment for the condition causing *your* disability.

**Illness** means a pathological condition of the body that presents a group of clinical signs and symptoms and lab findings peculiar to it and that sets the condition apart as an abnormal entity differing from other normal or pathological body states.

**Injury** means:

- for purposes of Portability, a bodily *injury* that is the direct result of an *accident* and not related to any other cause.
- for all other purposes, a bodily *injury* that is the sole and direct result of an *accident* and not related to any other cause. Disability must begin while *you* are covered under the *Plan*.

**Insured** means any person covered under a *Plan* for which premium has been paid.

**Intoxicated** means that *your* or *your dependent's* blood alcohol level equals or exceeds the legal limit for operating a motor vehicle in the jurisdiction, province, country, state where the *accident* occurred.

**Late Applicant** means *you* apply for coverage for yourself or *your dependents* more than 60 days after the date *you* or *your dependents* are eligible for coverage.

**Law, Plan or Act** means the original enactments of the *law*, *Plan* or *act* and any amendments.

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

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

**Life Insurance Benefit** means the total benefit amount for which an *employee* is insured under this *Plan* subject to the maximum benefit.

**Life Status Change** means a change in status as defined in the regulations under Internal Revenue Code Section 125 unless *your employer's cafeteria Plan* document or human resource *Policy* contains more restrictive provisions. In that event, *your employer* may restrict the situations where *you* can change *your* coverage.

**Life Threatening Condition** is a critical health condition that may possibly result in *your* or *your spouse's* or *domestic partner's* loss of life.

**Loss of a Foot** means that all of the foot is cut off at or above the ankle joint.

**Loss of a Hand** means that all four fingers are cut off at or above the knuckles joining each to the hand.

**Loss of Hearing** means the total and irrecoverable loss of hearing in both ears.

**Loss of Sight** means the eye is totally blind and that no sight can be restored in that eye.

**Loss of Speech** means the total and irrecoverable loss of speech.

**Loss of Thumb and Index Finger** means that all of the thumb and index finger are cut off at or above the joint closest to the wrist.

**Normal Retirement Age** means the Social Security normal Retirement Age as stated in the 1983 revision of the United States Social Security Act. It is determined by *your* date of birth.

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

**Physician** means:

- a person performing tasks that are within the limits of his or her medical license; and a person who is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or

- a person with a doctoral degree in Psychology (Ph.D. or Psy.D.) whose primary practice is treating patients; or
- a person who is a legally qualified medical practitioner according to the laws and regulations of the governing jurisdiction.

We will not recognize *you*, or *your spouse*, children, parents, or siblings as a *physician* for a claim that *you* send to us.

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

**Policyholder** means the *employer* to whom the *Policy* is issued.

**Prescription Drug** means a drug, biological, or compounded prescription which, by State and Federal *Law*, may be dispensed only by prescription and which is required to be labeled "Caution: Federal *Law* prohibits dispensing without prescription."

**Prior Plan** means a group term life insurance plan sponsored by the *Policyholder* which was in force on the day before the *Policy* effective date of this *Plan*.

**Private Passenger Car** means a validly registered four-wheel *private passenger car* (including *employer-owned cars*), station wagons, jeeps, pick-up trucks, and vans that are used only as *private passenger cars*.

**Regular Care** means:

- *you* personally visit a doctor as frequently as is medically required, according to standard medical practice, to effectively manage and treat *your* disabling condition(s); and
- *you* are receiving appropriate treatment and care of *your* disabling condition(s) by a doctor whose specialty or experience is appropriate for *your* disabling condition(s).

**Regular Occupation** means the occupation *you* are routinely performing when *your* disability begins.

**Service Waiting Period** means the continuous period of time that *you* must be in *active employment* in an *eligible class* before *you* are eligible for coverage under a *Plan*. The *employer* and we must agree upon the period.

**Sickness** means:

- for purposes of Portability, an illness, disease, or symptoms for which a person, in the exercise of ordinary prudence, would have consulted a health care provider.
- For all other purposes, an *illness* or disease. Disability must begin while *you* are covered under the *Plan*.

**Spouse** means the *Insured's* lawful *spouse*.

**Supplement Plan** means the option to purchase additional insurance beyond the Basic *Plan*. This insurance is elected and paid for by the *Insured*.

**Terminally Ill Terminal Illness** means an illness or physical condition, including a physical *injury* that can reasonably be expected to result in death in 12 months or less.

**We, Us** and **Our** mean Zurich American Life Insurance Company, and in connection with the making of all benefit determinations under the *Plan* means Zurich American Life Insurance Company, acting directly or through their agents and delegates.

**You, Your** means an insured *employee* who is eligible for *our* coverage under this *Plan*.

# Zurich American Life Insurance Company

1299 Zurich Way  
Schaumburg, IL 60196

## Group Term Life Certificate Endorsement

**Endorsement Effective Date:** January 1, 2022  
**Policyholder:** McAllen Independent School District  
**Policy Number:** CLPEX01188  
**Eligible Class(es):** All active, full-time employees

This Endorsement is attached to and made a part of Group Policy No. CLPEX01188 ("Policy") issued by the Zurich American Life Insurance Company to the POLICYHOLDER,

McAllen Independent School District

All benefits are subject in every way to the entire Policy which includes the Certificate of Insurance ("Certificate"). It alone forms the agreement under which payment of insurance is made.

The Certificate is amended as described in this Endorsement. Only those references to benefits, provision, or terms actually included in your Certificate will affect your coverage. All the provisions of the Policy and Certificate apply to this Endorsement unless otherwise stated below.

Refer to the Glossary in your Certificate or the end of this Endorsement for the meaning of defined terms. In addition, any reference made herein to dependent coverage will only apply if dependent coverage was in force under The Plan on the date a qualifying event for Portability coverage occurred.

## Group Term Life Portability Coverage

In addition to your Conversion Rights described in your Certificate, you also have a Group Portability option as described as follows:

This Endorsement describes when and how you may become covered for group term life insurance under a Portability Plan when your Employee Term Life Coverage under the Policy is cancelled, due to certain qualifying events. Enrollment in this Plan is voluntary and provided as an option to the individual conversion plan.

Coverage under the Portability Plan will be issued under a Group Insurance Policy ("Policy"), offered by Zurich American Life Insurance Company. You must enroll for Portability coverage to become covered under the Policy. The Policyholder will provide you with an enrollment form.

The terms and condition of the Policy will **Not** be the same as those under your current plan (The Plan). The amount of insurance available under the Policy may **Not** be the same as the amount under The Plan. Premiums for insurance under the Policy are payable by you.

### **Certain Benefits Not Available Under The Portability Plan**

The following benefits, even if applicable to your current group plan, are **Not** available under the Portability Plan:

- Accelerated Death Benefit;
- Premium Waiver;
- Any Total Disability Provisions or Riders; and
- Accidental Death and Dismemberment Benefits.

## **Right To Apply For Coverage Under The Portability Plan**

A right under this section is subject to the rest of this provision. You will have the right to apply for group term life insurance under the Portability Policy if you meet all these Qualifying Events and conditions:

### **Qualifying Events For You Are:**

Your Basic, Supplemental Employee Term Life or Supplemental Dependent Term Life Coverage ends for any reason other than:

- your failure to pay, when due, any contribution required for it; or
- you retire.

In addition, you must meet all of the following conditions:

- be Actively-at-Work on the day your life insurance ends;
- be less than age 70;
- the Amount of your Insurance in force under the Policy meets or exceeds the Portability Minimum Benefit on the day your insurance under the Policy ends; and
- be covered under the Plan for the 12 months immediately preceding the date your group life coverage terminated.

### **You Are Not Eligible To Apply For Portable Coverage For Yourself If:**

- the Policyholder cancels the Policy with us prior to your election of Portability coverage;
- you retired;
- you elected to convert to an individual life policy in accordance with the conversion privilege;
- you are in active military service;
- you failed to pay the required premium under the terms of the Policy;
- your Employee Term Life coverage is being continued in The Plan, or you have applied to have your coverage continued under the Policy for any reason;
- you have applied for, or been approved for Premium Waiver;
- you have an injury or sickness which has a material effect on life expectancy; or
- the Policy is cancelled and is replaced by group life insurance from any carrier for which you are, or become eligible within the Portability Application Period.

## **Portability Application Period**

You have the right to apply for coverage under the Portability Plan during the Portability Application Period. Evidence of Insurability is not required to become insured under the Portability Plan for any amount of Basic and Supplemental life insurance up to the amount in force for The Plan on the date coverage ended under The Plan.

The Portability Application Period is the 31-day period following the date your life insurance coverage under The Plan ends.

## **Portable Insurance Coverage Amounts**

You may elect Portable insurance coverage up to the amount of your Basic and Supplemental life insurance coverage in force for you under the Policy on the date coverage terminated, subject to the Portability Maximum Benefit and Portability Minimum Benefit stated below.

### **Portability Maximum Benefit Amount**

The amount of life insurance that may be continued will not exceed:

- \$500,000 of combined Basic and Supplemental Life coverage for you;
- \$250,000 for a Spouse;
- \$10,000 for a child.

### **Portability Minimum Benefit**

The minimum amount of Life Insurance that can be ported is:

- \$15,000 in Basic Life and \$10,000 in Supplemental Life coverage for you;
- \$10,000 for an eligible Spouse; and
- \$2,500 for an eligible child.

### **Portability Effective Date Of Coverage**

If you have met all your eligibility requirements, you have enrolled in the plan, and premium has been paid, your coverage takes effect at 12:01 a.m. on the date you are eligible for coverage.

### **Effect Of Portability On Other Provisions Of The Plan**

Portability is not available for any Amount of Life Insurance which was continued, enrolled, or is being applied for under provisions of the Policy in accordance with the:

- Conversion Privilege;
- Waiver of Premium Provision; or
- Continuation Provisions.

If you have received an Accelerated Death Benefit under The Plan, you are not eligible to convert to the Portability Plan.

However, coverage amounts **Not** eligible for Portability may be converted to an individual policy in accordance with the Policy's conversion provision.

If during the Portability Application Period you apply for coverage under the Portability Plan and then elect to convert all of your insurance under the Policy to an individual conversion contract, your application under the Portability Plan will not be processed.

The right to elect coverage under the Portability Plan does not affect your coverage under the "Death Benefit During the Conversion Period" provision of the Policy.

### **Right To Apply For Dependent Coverage Under The Portability Plan**

This right applies to the Supplemental Dependent Term Life Coverage under the Policy. It describes when and how a Dependent may become covered for coverage under the Portability Plan when a Dependent's term life coverage under the Policy terminates. The terms and condition of the Portability Plan will **Not** be the same as those under the Policy. The amount of insurance available under the Portability Plan may **Not** be the same as the amount under the Policy.

In case of your death, or due to divorce, an insured Dependent also may elect portable coverage for themselves. However, children cannot become insured for portable coverage unless the Spouse also becomes insured for portable coverage.

A right under this section is subject to the rest of these provisions.

You will have the right to apply for Dependent term life coverage under the Portability Plan for a qualified Dependent if all of these Qualifying Events and conditions for your Dependent are met:

### **Qualifying Events For Your Dependent Are:**

- your employment ends for any reason except retirement;
- your death;
- your membership in an eligible class under the Policy ends;
- divorce or dissolution of a Domestic Partnership.

In addition, your Dependent must meet all of the following condition(s):

- be covered under the Policy with Us for 12 months immediately preceding the date coverage for them under the Policy terminated; and
- their Amount of Insurance in force under the Policy meets or exceeds the applicable Portability Minimum Benefit on the day your insurance under the Policy ends.

**You Are Not Eligible To Apply For Portable Coverage For A Dependent If:**

- you do not elect portable coverage for yourself;
- in consideration of portable coverage for Your Spouse, the Spouse is age 75 or over;
- the Policy is canceled by the Policyholder prior to their enrollment in the Portability Plan;
- you failed to pay the required dependent premium under the terms of The Plan.
- your dependent was not covered under The Plan with Us on the date coverage ended and the immediate 12 months prior to termination;
- you have applied for, or been approved for Premium Waiver;
- your Dependent is in active military service.

**Portability Application Period**

You have the right to apply for term life coverage under the Portability Plan for a qualified Dependent during the Portability Application Period. In the case of your death or divorce, your Spouse has the right to apply for coverage under the Portability Plan during the Portability Application Period. Evidence of Insurability is not required for a Dependent to become insured under the Portability Plan.

**Applying For Conversion, If Portable Coverage Ends**

If you or your dependent are not eligible to apply for portable coverage or portable coverage ends, then you or your dependent may qualify for conversion coverage. Refer to the Conversion Privilege under The Plan.

**Cost Of The Portability Plan**

You will be responsible for the entire cost of the premiums for the Portability Plan.

## **Glossary**

**General definitions used throughout this Endorsement include:**

**Portability Plan** means the Group Term Life Plan that you may be eligible to enroll when coverage ends under The Plan. The Portability Plan is an option to Individual Conversion Insurance.

**Portability Policy** means the Group Insurance Policy under which you may apply for Portability group term life insurance. The Policy is issued by Zurich American Insurance Company.

## General Provisions

This Endorsement applies to the Eligible Class(es) stated above. All other provisions in the Policy and Certificate remain valid. Nothing contained in this Endorsement shall be held to vary, waive, alter, or extend any of the terms, conditions, or provisions of the Policy and the Certificate, other than as herein stated.

This Endorsement takes effect as of 12:01 a.m. on the Endorsement Effective Date at the address of the Policyholder. This Endorsement terminates on the date, and at the time the Policy terminates, or sooner, if agreed to by the Policyholder and Us, subject to the cancellation provisions specified in the Policy.

This Endorsement is signed by the Zurich American Life Insurance Company:



David Fike, President



Laura J. Lazarczyk, Secretary

# Zurich American Life Insurance Company

## Disability Plan

### Benefits Schedule

This Disability Plan provides financial protection for *you* by paying a portion of *your* income if *you* become disabled due to an *illness* or *injury* while covered under this *Plan*. The amount *you* receive is based on the amount *you* earned before *your* disability began. In some cases, *you* can receive disability payments even if *you* work while *you* are disabled.

This Benefits Schedule (hereinafter "Schedule") is a summary of some of the features and benefits of *your employer's* Disability Plan. It is not a contract. *You* are not necessarily entitled to insurance because *you* received this Schedule. *You* are only entitled to insurance if *you* are eligible in accordance with the terms of the Certificate, *you* have met *your employer's* eligibility requirements and premium has been paid. For a complete description of the terms, conditions, exclusions, and limitations of *your employer's Plan*, refer to *your* Certificate. In the event of a discrepancy between this Schedule and the Certificate, the Certificate will control.

<b>Policyholder:</b>	McAllen Independent School District
<b>Policy Number:</b>	CLPEX01188
<b>Policy Effective Date:</b>	January 1, 2022
<b>Plan Year:</b>	January 1, 2022, through December 31, 2022, and each following January 1 <sup>st</sup> .
<b>Eligible Classes:</b> All persons in the following class(es) are eligible for <i>employee</i> coverage: <i>All active, full-time employees.</i>	
<b>Minimum Hours Requirement For Active Employment:</b> <i>Employees must be working at least 20 regularly scheduled hours per week.</i>	
<b>Service Waiting Period:</b> <i>First of the month following <i>your</i> date of hire.</i>	
<b>Who Pays For The Coverage:</b> <i>You are required to pay the entire cost of <i>your</i> coverage.</i>	
<b>Premium Waiver:</b> <i>If <i>you</i> become disabled, no premium payments are required for <i>your</i> coverage while <i>you</i> are receiving benefits under this <i>Plan</i>, provided the premium was paid during the <i>elimination period</i>.</i>	
<b>Elimination Period:</b>  <b>Option 1:</b> <i>Sickness or injury: 14 days</i> <i>If <i>you</i> are hospital confined as an inpatient due to <i>your</i> sickness or injury, benefits begin on the first day of hospital confinement.</i>	

**Option 2:**

*Sickness or injury: 30 days*

If *you* are hospital confined as an inpatient due to *your sickness or injury*, benefits begin on the first day of hospital confinement.

If *you* are working while *you* are disabled, as defined under this *Plan*, only the days *you* are determined to be disabled will count toward *your elimination period*. We will treat *your* disability as continuous if *your* disability stops for 3 days or less during the *elimination period*.

**Option 3:**

*Sickness or injury: 60 days*

If *you* are working while *you* are disabled, as defined under this *Plan*, only the days *you* are determined to be disabled will count toward *your elimination period*. We will treat *your* disability as continuous if *your* disability stops for 5 days or less during the *elimination period*.

Benefits begin the day after the *elimination period* is completed.

**Option 4:**

*Sickness or injury: 90 days*

If *you* are working while *you* are disabled, as defined under this *Plan*, only the days *you* are determined to be disabled will count toward *your elimination period*. We will treat *your* disability as continuous if *your* disability stops for 30 days or less during the *elimination period*.

Benefits begin the day after the *elimination period* is completed.

**Option 5:**

*Sickness or injury: 180 days*

If *you* are working while *you* are disabled, as defined under this *Plan*, only the days *you* are determined to be disabled will count toward *your elimination period*. We will treat *your* disability as continuous if *your* disability stops for 30 days or less during the *elimination period*.

Benefits begin the day after the *elimination period* is completed.

<b>Monthly Benefit</b>	
<p><b>Monthly Benefit Percentage:</b> Units of \$100, with a minimum of \$200 and a maximum of the lesser of 66 2/3% rounded to the nearest \$100 or \$8,000, less <i>deductible sources of income</i>.</p> <p><b>Your benefit may be reduced by <i>deductible sources of income</i> and <i>disability earnings</i>. Some disabilities may not be covered or may have limited coverage under this <i>Plan</i>.</b></p>	
<b>The Maximum Monthly Benefit is:</b>	The lesser of 66 2/3% rounded to the nearest \$100 or \$8,000.
<b>The Minimum Monthly Benefit is:</b>	<p>25% of the <i>gross disability benefit</i></p> <p><b>You are not eligible for the <i>minimum monthly benefit</i> during periods of overpayment until the overpayment has been recovered by <i>us</i> or offset by <i>your monthly benefit</i>.</b></p>
<b>Survivor Benefit</b>	3 times the <i>gross disability benefit</i>
<p><b>Rehabilitation Program Benefit</b></p> <p>Ten percent of <i>your gross disability benefit</i> to a maximum of \$1,000 per month. Refer to the Certificate for program details.</p>	
<p><b>Dependent Care Expense Benefit</b></p> <p>While <i>you</i> are participating in <i>our rehabilitation program</i>, <i>you</i> may receive payments to cover certain childcare expenses limited to the following amounts</p> <p><b>Dependent Expense Benefit Amount:</b> \$350 per month per dependent.</p> <p><b>Dependent Expense Maximum Benefit Amount:</b> \$1,000 per month for all dependents.</p>	
<p><b>Limited Benefits for Mental Illness, Mental Disorders, and Self-Reported Disabilities:</b></p> <p>Benefits for <i>mental illness</i>, mental disorders, and <i>self-reported symptoms</i> are limited to 24 months while insured under the <i>Policy</i> unless <i>you</i> are confined as a resident inpatient in a <i>hospital</i> at the end of the 24-month period. The <i>monthly benefit</i> will continue to be paid during such confinement.</p>	
<b>Pre-Existing Condition Exclusion:</b>	3/12 applies. Refer to the Certificate for a full description.

### Maximum Benefit Duration Table

The table below shows the maximum duration for which benefits may be paid. You may choose Option 1 or Option 2. All other limitations of the *Policy* will apply.

**Option 1:**

Age At Disability	Maximum Benefit Period
Less than age 62	To Social Security Normal Retirement Age
Age 62	60 months
Age 63	48 months
Age 64	42 months
Age 65	36 months
Age 66	30 months
Age 67	24 months
Age 68	18 months
Age 69 or older	12 months
Year of Birth	Social Security Normal Retirement Age
1937 or before	65 years
1938	65 years 2 months
1939	65 years 4 months
1940	65 years 6 months
1941	65 years 8 months
1942	65 years 10 months
1943-1954	66 years
1955	66 years 2 months
1956	66 years 4 months
1957	66 years 6 months
1958	66 years 8 months
1959	66 years 10 months
1960 and after	67 years

**Option 2: Disabilities due to Injury**

Age At Disability	Maximum Benefit Period
Less than age 60	To age 65 but not less than 5 years
Age 60	5 years
Age 61	5 years
Age 62	5 years
Age 63	5 years
Age 64	5 years
Age 65	To age 70, but not less than 1 year
Age 66	To age 70, but not less than 1 year
Age 67	To age 70, but not less than 1 year
Age 68	To age 70, but not less than 1 year
Age 69 and over	1 year

**Option 2: Disabilities due to Sickness**

<b>Age At Disability</b>	<b>Maximum Benefit Period</b>
Less than age 65	5 years
Age 65	To age 70, but not less than 1 year
Age 66	To age 70, but not less than 1 year
Age 67	To age 70, but not less than 1 year
Age 68	To age 70, but not less than 1 year
Age 69 and over	1 year

**Limited And Excluded Conditions And Disabilities:**

Total Benefit: The total benefit payable to *you* on a monthly basis (including all benefits provided under this *Plan*) will not exceed 100% of *your covered monthly earnings* unless otherwise stated in the Certificate under specific conditions.

*Your Plan* does not cover disabilities related to all *injuries, illness, or disease*. Refer to *your* Certificate for a complete list of exclusions and limitations.

The following disabilities have limited benefits under this *Plan*: *mental illness*, mental disorders, and self-reported disabilities. Refer to the Certificate for a detailed description of the benefits and the limitations.

If *you* are receiving or are eligible to receive benefits for a disability under a prior disability plan that was sponsored by *your employer* or was terminated before the effective date of this *Plan*, then no benefits will be payable for the disability under this *Policy*.

**IMPORTANT: THIS SCHEDULE SHOULD BE ATTACHED TO YOUR CERTIFICATE. THIS SCHEDULE REPLACES ANY PRIOR SCHEDULES ISSUED TO YOU WITH RESPECT TO THE COVERAGES DESCRIBED IN THE CERTIFICATE.**

Zurich American Life Insurance Company  
Certificate of Coverage

**Disability Plan**

**Policyholder:** McAllen Independent School District

**Policy Number:** CLPEX01188

Zurich American Life Insurance Company is pleased to welcome *you* to the *Plan*. This is *your* Certificate of Coverage, hereinafter "Certificate", as long as *you* are eligible for coverage, and *you* meet the requirements for becoming insured. *You* will want to read this Certificate carefully and keep it in a safe place. This Certificate may be delivered electronically when agreed to by the *Policyholder* and *us*.

This Disability Plan provides financial protection for *you* by paying a portion of *your* income if *you* become disabled due to an *illness* or *injury* while covered under this *Plan*. The amount *you* receive is based on the amount *you* earned before *your* disability began. In some cases, *you* can receive disability payments even if *you* work while *you* are disabled.

Throughout this document the words "*we*", "*our*", "*us*", and "the Company" means Zurich American Life Insurance Company. The words "*you*" and "*your*" mean the insured *employee* of the *Policyholder* sponsoring this *Plan*. Some terms and provisions are written as required by insurance *law*. Important terms are defined in the "Glossary" Section of the Certificate. Defined terms appear in italic print. If *you* should have any questions about the content or provisions, please consult *us* at the toll-free number provided below. *We* will assist *you* in any way to help *you* understand *your* benefits.

The benefits described in this Certificate are subject in every way to the entire Group Insurance Policy. If the terms and provisions of the Certificate are different, the *Policy* will govern. The Group Insurance Policy includes this Certificate, the benefit schedule(s), and any riders or amendments issued with the Group Insurance Policy. The *Policyholder's* application and any application or *evidence of insurability* completed by *you* or on *your* behalf, when applying for coverage or an increase in coverage, are also considered part of the *Policy*.

*Your* coverage may be cancelled or changed in whole or in part under the terms and provisions of the *Policy*. The *Policy* is delivered in and is governed by the *laws* of the governing jurisdiction.

**THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.**

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

Zurich American Life Insurance Company is located at:

**1299 Zurich Way.  
Schaumburg, Illinois 60196**

*Our* toll-free number is: 800-206-8826.

*Our* website address is: <https://mygrouplifedisability.aflac.com>.

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## Special Notices

Zurich American Life Insurance Company	
Toll Free Number	800-206-8826
Claim Information Toll Free Number	800-206-8826

No benefits are covered under this Certificate in the absence of payment of current premiums subject to the *grace period* and the "Premium" Section of the Group Insurance Policy. Unless specifically provided for in any applicable termination or continuation of coverage provision, described in this Certificate or under the terms of the Group Insurance Policy, this *Plan* does not pay benefits for a disability incurred before coverage starts under this *Plan*. This *Plan* will not pay any benefits for any losses, claims or expenses that start after coverage ends.

Benefits may be modified during the term of this *Plan* as specifically provided under the terms of the Group Insurance Policy or upon renewal. If benefits are modified, the revised benefits (including any reduction in benefits or elimination of benefits) apply to any losses incurred that start on or after the effective date of the *Plan* modification. There are no vested rights to receive any benefits described in the Group Insurance Policy or in this Certificate beyond the date of termination or renewal including if the loss, *accident*, or disability starts on or after the effective date of the *Plan* modification, but prior to *your* receipt of amended *Plan* documents.

This *Policy* prohibits a distinction on the basis of marital status for lack of marital status between an *Insured* and the other parent in the determination of the *dependents* for the beneficiary(ies) of the *Insured*, or both.

### **Fraud Notice**

**Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, commits insurance fraud, which is a crime and subjects the person to civil and criminal penalties.**

## **DISCLOSURE NOTICES**

For Residents of the Following States:

### **INDIANA**

#### **NOTICE TO EMPLOYEES**

Questions regarding *your Policy* or coverage should be directed to:

**Zurich American Life Insurance Company  
199 Scott Swamp Road, Farmington, CT 06032  
1-888-634-6780**

If *you* (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint *you* have been unable to resolve with *your* insurer *you* may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance  
Consumer Services Division  
311 West Washington Street  
Suite 300  
Indianapolis, IN 46204

Consumer Hotline:  
1-800-622-4461

In the Indianapolis Area:  
1-317-232-2395

Complaints can be filed electronically at [www.in.gov/idoi](http://www.in.gov/idoi)

### **ARKANSAS**

#### **QUESTIONS OR PROBLEMS WITH YOUR POLICY?**

If *you* have any questions or problems with *your Policy*, *you* may contact *us* at the address below or one of the other organizations listed:

Zurich American Life Insurance Company  
199 Scott Swamp Road  
Farmington, CT 06032  
Telephone: (877) 678-7534

Arkansas Insurance Department  
Consumer Services Division  
1200 West Third Street  
Little Rock, Arkansas 72201-1904  
Telephone: (501) 371-2640 or (800) 852-5494

## **GEORGIA**

### **NOTICE**

The *laws* of the State of Georgia prohibit insurers from unfairly discriminating against any person based upon his or her status as a victim of family violence.

## **ILLINOIS**

### **NOTICE TO EMPLOYEES - ILLINOIS**

This notice is to advise *you* that should any complaints arise regarding this insurance, *you* may contact the following:

Zurich American Life Insurance Company  
199 Scott Swamp Road, Farmington, CT 06032  
(888) 634-6780

For *your* information, the following is *your* state's Department of Insurance contact information:

Illinois Department of Insurance  
Consumer Division  
320 W Washington St  
Springfield, IL 62767  
(217) 782-4515

## **WISCONSIN**

### **NOTICE TO EMPLOYEES – WISCONSIN**

#### **KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS**

**PROBLEMS WITH YOUR INSURANCE?** – If *you* are having problems with *your* insurance company or agent, do not hesitate to contact the insurance company or agent to resolve *your* problem.

Zurich American Life Insurance Company  
199 Scott Swamp Road, Farmington, CT 06032  
(888) 634-6780

*You* can also contact the **OFFICE OF THE COMMISSIONER OF INSURANCE**, a state agency which enforces Wisconsin's insurance *laws*, and file a complaint. *You* can contact the **OFFICE OF THE COMMISSIONER OF INSURANCE** by contacting:

Office of the Commissioner of Insurance  
Complaints Department  
P.O. Box 7873  
Madison, WI 53707-7873  
Toll-Free: (800) 236-8517  
Telephone: (608) 266-0103

# GENERAL PROVISIONS

## Your Disability Plan

This Disability Plan provides *you* with a source of monthly income if *you* should become disabled and unable to work because of a *sickness* or *injury* while covered under this *Plan*.

### What Is The Certificate?

This Certificate of Coverage ("Certificate") is a written document prepared by Zurich American Life Insurance Company. It tells *you* important information about *your Plan* such as:

- the coverage to which *you* may be entitled;
- claim processing and administrative procedures;
- to whom *we* will make a payment; and
- the limitations, exclusions and requirements that apply within the *Plan*.

The Certificate may include attachments such as amendments and riders, which describe additional provisions about *your Plan*. Please read the entire document carefully to fully understand *your* Disability Plan.

## Eligibility

### Who Is Eligible For Coverage?

To be eligible for coverage under this *Plan*, the following requirements must be met:

- *you* must be employed by the *Policyholder*;
- *you* must be in *active employment*;
- *you* must be in an *eligible class*; and
- *you* must be working inside of the United States.

### Determining Your Eligible Class

*Your employer* determines the criteria that are used to define the *eligible class(es)* for insurance coverage under this *Plan*. Such criteria are based solely upon the conditions related to *your* employment.

The criteria describing *eligible classes* of *employees* are listed on the Benefits Schedule attached to this Certificate. Refer to the Benefits Schedule or contact *your employer* to determine if *you* are in an *eligible class*.

### When Are You Eligible For Coverage?

If *you* are working for *your employer* in an *eligible class*, the date *you* are eligible for coverage is the later of:

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

## **New Hires**

If *you* are in an *eligible class* on the date of hire, *your eligibility date* is the date *you* complete the *service waiting period*. If *you* enter an *eligible class* after *your* date of hire, *your eligibility date* is the date *you* complete *your service waiting period*. If *you* have already satisfied the *service waiting period* with the *Policyholder* before *you* enter the *eligible class*, *your eligibility date* is the date *you* enter the *eligible class*.

## **What Is A Service Waiting Period?**

Once *you* enter an *eligible class*, *you* will need to complete the *service waiting period* before *your* coverage under the *Plan* begins. The *service waiting period* is the continuous length of time that *you* must be in *active employment* and in an *eligible class* before *you* are eligible for coverage under this *Plan*. The *service waiting period* is shown on the Benefits Schedule.

Except as noted in the "Reinstatement Provision", if *you* terminate this insurance and later wish to reapply, or if *you* are a former *employee* who is rehired, a new *service waiting period* must be satisfied.

## **Effective Date Of Coverage**

### **When Does Your Coverage Begin?**

When *you* and *your employer* share the cost of *your* coverage under a *Plan* or when *you* pay 100% of the cost of *your* coverage, *you* will be covered at 12:01 a.m. on the latest of:

- the date *you* are eligible for coverage, if *you* apply for insurance on or before that date;
- the date *you* apply for insurance if *you* apply within 31 days after *your eligibility date*;
- the date *we* approve *your* application if *evidence of insurability* is required; or
- the date *your* required premium payment is received by *us*.

### **What If You Are Absent From Work On The Date Your Coverage Would Normally Begin?**

If *you* are absent from work due to *injury, sickness, a mental illness, temporary layoff* or *leave of absence*, on the date *your* insurance would otherwise become effective, *your* coverage, increase in coverage or new benefit will begin the date *you* return to *active employment*.

## **Enrollment**

### **How Do You Enroll For Coverage?**

*You* will be provided with *Plan* design and enrollment information when *you* first become eligible. If *you* elect to purchase coverage at the time of enrollment *you* are required to enroll for coverage. To do so, *you* must complete and sign a group insurance enrollment form, satisfactory to *us*, and deliver it to *your employer*.

### **Late Applicant Enrollment Requirements**

If *you* do not enroll for coverage within 31 days after becoming eligible, but wish to do so later, *your employer* will provide *you* with information on when and how *you* can enroll as a *late applicant*.

You may not enroll until the next *annual enrollment period*. You must return your completed enrollment form and submit it to *your employer* before the end of the next *annual enrollment period*.

*Late applicants* are subject to the *pre-existing condition* exclusion.

## **Annual Enrollment Period**

During the *annual enrollment period*, you will have the opportunity to review *your* coverage needs for the upcoming year. During this period, *you* have the option to apply for insurance, change *your* coverage or apply for an increase in *your* insurance. The choices *you* make during this *annual enrollment period* will become effective the following *Plan* year as indicated on the Benefits Schedule. *You* will be subject to any *pre-existing condition* exclusion as described in this Certificate.

## **After Coverage Begins**

### **When Will Changes To Your Coverage Take Effect?**

#### **Effective Date For Benefit Changes By Election**

Once *your* coverage begins, any increased or additional coverage will take effect on the following *Plan* year if *you* are in *active employment*. If *you* are not in *active employment* due to *injury* or *sickness*, any increased or additional coverage will begin on the date *you* return to *active employment*.

An increase in *your* disability coverage will be subject to a *pre-existing condition* exclusion as described in this Certificate.

#### **Effective Date For Benefit Changes Due To A Change In Covered Monthly Earnings**

A change in *your monthly benefit* due to a change in *your covered monthly earnings* will be effective on the date of the change if *you* are in *active employment*. If *you* are not in *active employment* due to *injury* or *sickness*, any increased or additional coverage will begin on the date *you* return to *active employment*.

#### **Effective Date For Benefit Changes By Policy Amendment**

A change in *your covered monthly benefit* due to a change in the *Policy* by an amendment elected by the *Policyholder*, will be effective on the date of the change, if *you* are in *active employment*. If *you* are not in *active employment* on the date a benefit payable change would otherwise be effective, any increased or additional coverage will begin on the date *you* return to *active employment*.

A change in *your* benefit payable because of a change made by the Company will normally be effective on the *Policy anniversary date*, or as otherwise determined by state or federal *law*, or by *us*. However, if *you* are not in *active employment* on the date a benefit payable change would otherwise be effective, the benefit payable change will not be in force until *you* return to *active employment*.

Neither an increase nor a decrease in coverage will affect a *payable claim* that occurs prior to the increase or decrease.

## How Do You Pay For Your Coverage?

*Your employer* requires *you* to pay for all of the cost of *your* insurance. *Your employer* will determine the amount of *your Plan* contributions *if any*. *Your employer* will advise *you* of the required amount of *your* contributions and inform *you* of any required payroll deductions.

Once *you* have satisfied the *elimination period*, *your* premium and contributions, *if any*, will be waived for any period *you* are eligible to receive monthly benefits.

## When Coverage Ends

### When Does Your Coverage End?

*Your* coverage under this *Plan* ends on the earliest of:

- the date the *Policy* or a *Plan* is cancelled;
- the date *you* voluntarily stop *your* coverage;
- the date *you* are no longer in an *eligible class*;
- the date *you* are no longer eligible for coverage;
- the date *your eligible class* is no longer covered;
- the last day of the period for which *you* made any required contributions;
- the last day *you* are in *active employment* except as provided under the covered *layoff* or *leave of absence* provision;
- the date *your* employment stops for any reason, including job elimination, or being placed on severance. This will be the date *you* stop *active employment*;
- the date on which *you* retire;
- the date on which *you* voluntarily or involuntarily lose *your* professional license; or
- the date on which *you* begin active duty in the armed forces of any country.

### When Will Your Coverage Continue If You Are Temporarily Not Working?

If premium payments continue to be made on *your* behalf, *we* may deem *your* employment to continue for purposes of remaining eligible for coverage under this *Plan* as described below:

If *you* are not in *active employment* due to a sabbatical *leave of absence* as agreed to by *your employer* and *us*, *your* coverage may continue through the end of *your employer's* current school contract year in which *your* sabbatical *leave of absence* begins.

If *you* are on a furlough, and if premium is paid, *you* will be covered for 90 days following the date on which *your* furlough begins.

If *you* are on an *employer* approved *leave of absence*, and if premium is paid, *you* will be covered for the later of 180 days or until the paid leave has been exhausted.

There is no continuation of coverage if *you* are on a temporary *layoff*, or you have a reduction in hours below the minimum hours per week required by *your employer*.

### Reinstatement Of Coverage

If *your* Disability coverage ends, *you* may apply to reinstate coverage subject to the rules described in the "When Does Your Coverage Begin?" Section. If *we* approve *your* request, the reinstatement will be effective on the first day of the month following the approval date.

## What Happens To My Coverage Under This Policy While I Am On A Family And Medical Leave Of Absence Or A Military Leave Of Absence?

Coverage will be continued until the end of the later of:

- the leave period required by the federal Family and Medical Leave of Absence Act of 1993 and any amendments;
- the leave period required by the Uniformed Services Employment and Reemployment Rights Act of 1994 and any amendments;
- the leave period required by applicable national, state, or local *law*, or any similar *law, plan, or act*; or
- for life insurance, the leave period provided to *you* for an *injury* or *sickness*.

If the *Policyholder's* policy does not provide for continuation of *your* coverage during a family and medical *leave of absence*, *your* coverage will be reinstated when *you* return to *active employment*.

## How Can Statements Made In Your Application For This Coverage Be Used?

In the absence of fraud, *we* consider any statements *you* or *your employer* makes in a signed application for coverage or an *evidence of insurability* form, or that *your employer* makes in the application process, a representation and not a warranty. If any of the statements *you* or *your employer* make are not complete and/or not true at the time they are made, *we* can:

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

*We* will use only statements made by the *employer* in the application process and statements made by *you* in a signed application as a basis for doing this. If a statement is used in a contest, a copy of that statement will be furnished to *you* or, in the event of *your* death or incapacity, to *your eligible survivor* or personal representative.

If the *Policyholder* gives *us* information about *you* that is incorrect, *we* will:

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

*Our* failure to implement or insist upon compliance with any provision of this *Policy* at any given time or times shall not constitute a waiver of *our* right to implement or insist upon compliance with that provision at any other time or times. This applies whether or not the circumstances are the same.

## Incontestability

During the first two years that *your* insurance is in force, *we* may use any statement *you* have made in contesting the validity of that coverage. This also applies to any increase in *your* coverage for the two years that follow the effective date of that increase if *evidence of insurability* was required in order for the increase to take effect.

Once coverage, including an increase in coverage has been continuously in effect for two years, in the absence of fraud the validity of *your* insurance may not be contested by *us* unless *your* statement was in writing on a form signed by *you* and was fraudulently made in order to obtain that coverage or increase.

## **Subrogation And Right Of Reimbursement**

This provision does not reduce or delay disability benefits. As used herein, the term "third party," means any party that is, or may be, or is claimed to be responsible for *illness or injuries* to *you* that caused *your* disability. Such *illness or injuries* are referred to as "third party Injuries". "Third party" includes any party responsible for payment of benefits for loss of time or wages as a result of third party injuries.

By accepting benefits under this *Plan*, *you* specifically acknowledge *our* right of subrogation. When this *Plan* pays benefits for disabilities incurred due to third party injuries, *we* shall be subrogated to *your* right of recovery against any party to the extent of all benefits provided by this *Plan*. *We* may proceed against any party with or without *your* consent.

By accepting benefits under this *Plan*, *you* or *your* representatives further agree to:

- notify *us* within 30 days and in writing when notice is given to any party, including an insurance Company or attorney, of the intention to investigate or pursue a claim to recover damages or obtain compensation due to third party Injuries sustained by *you*;
- cooperate with *us* and do whatever is necessary to secure *our* rights of subrogation and recovery under this Certificate;
- give *us* a first-priority lien on any recovery, settlement, or judgment or other source of compensation which may be had from any party to the extent of the full cost of all benefits associated with third party injuries provided by this *Plan* (regardless of whether specifically set forth in the recovery, settlement, judgment, or compensation agreement);
- pay, as the first priority, from any recovery, settlement judgment, or other source of compensation, any and all amounts due *us* as recovery of the full cost of all benefits associated with third party injuries paid by this *Plan* (regardless of whether specifically set forth in the recovery, settlement, judgment, or compensation agreement), unless otherwise agreed to by *us* in writing;
- do nothing to prejudice *our* rights as set forth above. This includes, but is not limited to, refraining from making any settlement or recovery, which specifically attempts to reduce or exclude the full cost of all benefits paid by the *Plan*;
- serve as a constructive trustee for the benefits of this *Plan* over any settlement or recovery funds received as a result of third party injuries.

*We* may recover full cost of all benefits paid by this *Plan* under this Certificate without regard to any claim of fault on *your* part, whether by comparative negligence or otherwise.

## **Does The Coverage Under A Plan Replace Or Affect Any Workers' Compensation Or State Disability Insurance?**

The coverage under a *Plan* does not replace or affect the requirements for coverage by Workers' Compensation or state disability insurance. However, any Workers' Compensation benefits are considered a *deductible source of income*.

## **Recovery Of Overpayments**

If payments are made in amounts greater than the benefits that *you* are entitled to receive, *we* have the right to recover any overpayments. Refer to the "Claim Information" Section for the process *we* use to recover overpayments.

### **How Will We Handle Insurance Fraud?**

We shall have the right and promise to use all means available to *us* to detect, investigate, deter, and prosecute those who commit insurance fraud. We shall have the right to pursue all legal remedies if *you* and/or *your employer* perpetrate insurance fraud.

Insurance fraud occurs when *you* or *your Policyholder* knowingly and with intent to defraud or deceive *us*, provide *us* with false information or file a claim for benefits that contains any false, incomplete, or misleading information, or conceals for the purpose of misleading, information concerning any material fact.

It is a crime if *you* or the *Policyholder* commit insurance fraud and may subject such person to criminal and civil penalties. Such penalties include, but are not limited to fines, denial or termination of insurance benefits, recovery of any amounts paid, civil damages, criminal prosecution, and penalties.

### **Does The Policyholder Act As Our Agent?**

No. For purposes of the *Policy*, the *Policyholder* acts on its own behalf. Under no circumstances will the *Policyholder* be deemed *our* agent.

# DISABILITY BENEFITS

## How Do We Define A Disability?

During the *elimination period*, you are disabled when we determine that:

- you are unable to perform the *material and substantial duties* of your regular occupation due solely to your *sickness or injury*;
- you are under the *regular care* of a *physician*;
- (Option 1) you are not working at any job for compensation or profit; or
- (Option 2, 3, 4 & 5) you have a 20% or more loss in your *indexed monthly earnings* due to that *sickness or injury*.
- 

After the *elimination period*, you are disabled when we determine that:

- you are unable to perform the *material and substantial duties* of your regular occupation due solely to your *sickness or injury*;
- you are under the *regular care* of a *physician*; and
- you have a 20% or more loss in your *indexed monthly earnings* due to that *sickness or injury*.

After 24 months *benefits* have been payable, you are disabled when we determine that due to the same *sickness or injury*:

- you are unable to perform the duties of any *gainful occupation* for which you are reasonably fitted by education, training, or experience;
- you are under the *regular care* of a *physician*; and
- you have a 40% or more loss in your *indexed monthly earnings* due to the same *sickness or injury*.

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

We will assess your ability to work and the extent to which you are able to work by considering the facts and opinions from your *physicians*, and *physicians* and medical practitioners or vocational experts of our choice.

We may require you to be examined by a *physician*, other medical practitioner and/or vocational expert of our choice. We will pay for this examination. We can require an examination as often as it is reasonable to do so. We may also require you to be interviewed by our authorized representative. Refusal to be examined or interviewed may result in denial or termination of your claim.

## How Long Must You Be Disabled Before You Are Eligible To Receive Benefits?

You must be continuously disabled through your *elimination period*. The days that you are not disabled will not count toward your *elimination period*. We will treat your disability as continuous if your disability stops for the number of days during the *elimination period* listed on the Benefits Schedule for the option you selected. No benefit is payable for or during the *elimination period*.

Your *elimination period* is described in the Benefits Schedule.

### **Can You Satisfy Your Elimination Period If You Are Working (Option 1)?**

No, *you* may not satisfy this *Plan's elimination period* while working.

### **Can You Satisfy Your Elimination Period If You Are Working (Options 2, 3, 4, & 5)?**

Yes. If *you* are working while *you* are disabled, as defined under this *Plan*, only the days *you* are determined to be disabled will count toward *your elimination period*.

### **When Will You Begin To Receive Benefits?**

You will begin to receive benefits when we approve *your* claim, providing the *elimination period* has been satisfied and *you* are disabled, but not beyond the maximum monthly benefit period shown in the Benefits Schedule. No benefits are payable during the *elimination period*.

We will send *you* a *monthly benefit* for any period for which we are liable.

### **What Are Your Covered Monthly Earnings?**

**"Covered monthly earnings"** means *your* gross monthly income from *your* employer in effect just prior to *your* date of disability. It includes *your* total income before taxes. It is prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plans, or flexible spending account.

It will only include stipends paid for the following:

- participating as a coach or a leader in any school extracurricular activity for which you are paid; and
- any oil or refinery stipends.

It does not include income received from car, housing or moving allowances, commissions, bonuses, overtime pay, *employer* contributions to a qualified deferred compensation plan or any other extra compensation, or income received from sources other than *your employer*.

### **How is Your Benefit Determined if You Are Disabled And Not Working?**

We will follow this process to calculate *your* benefit amount:

- 1) Multiply *your covered monthly earnings* by the *monthly benefits* percentage shown in the Benefits Schedule.
- 2) The *maximum monthly benefit* is listed in *your* Benefits Schedule.
- 3) Compare the answer from Item 1 with the *maximum monthly benefit*. The lesser of these two amounts is *your gross disability benefit*.
- 4) Subtract from *your gross disability benefit* any deductible sources of income.

The amount figured in Item 4 is *your monthly benefit*. The *monthly benefit* will be recalculated when *your income* changes or *you* receive any new deductible sources of income.

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

**Monthly benefit** means *your* benefit amount after any deductible sources of income have been subtracted from *your gross disability benefit*.

**Maximum monthly benefit** means the maximum benefit amount for which are insured under this *Plan* as shown in the Benefits Schedule.

**Gross disability benefit** means the benefit amount before we subtract *deductible sources of income* and *disability earnings*.

**Deductible sources of income** means other *income* from deductible sources listed in the *Plan* that you receive or are entitled to receive while you are disabled. This *income* will be subtracted from your *gross disability benefit*.

## How Is Your Benefit Determined If You Are Disabled And Working?

For the first 12 months of payable benefits:

1. If you are disabled and return to work, we will not reduce your *monthly benefit* for *disability earnings* if:
  - your *monthly disability earnings*, if any, are less than 20% of your *indexed monthly earnings* due to the same *sickness* or *injury*; and
  - you have satisfied the *elimination period*.
2. If you are disabled and your *monthly disability earnings* are 20% or more of your *indexed monthly earnings*, due to the same *sickness* or *injury*, we will calculate your *monthly benefit* as follows:
  - During the first 12 months of payable benefits, while working, your *monthly benefit* will not be reduced by your *disability earnings* as long as *disability earnings* plus the *gross disability benefit* does not exceed 100% of *indexed monthly earnings*.
    - 1) Add your *monthly disability earnings* to your *gross disability benefit*.
    - 2) Compare the answer in item 1 to your *indexed monthly earnings*.

If the answer from item 1 is less than or equal to 100% of your *indexed monthly earnings*, we will not further reduce your *monthly benefit*.

If the answer from item 1 is more than 100% of your *indexed monthly earnings*, we will subtract the amount over 100% from your *monthly benefit*.

- After benefits have been payable for 12 months, while working, the amount of your *monthly benefit* will change, and we will consider a portion of your *disability earnings* to be a *deductible source of income*. Fifty percent of your *disability earnings* will be added to your other *deductible sources of income*, if any. The sum will be deducted from your *gross disability benefit*. This amount will be your *monthly benefit*.

We may require you to send proof of your *disability earnings* on a monthly basis. We will recalculate your benefit each month and adjust your *monthly benefit* based on your *monthly disability earnings*.

As part of your proof of *disability earnings*, we can require that you send us appropriate financial records, including copies of your IRS federal income tax return, W-2's and 1099's, which we believe are necessary to substantiate your income.

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

## When Will Your Monthly Benefits End If Working While Disabled?

During the first 24 months of *disability benefits*, if *your monthly disability earnings* exceed 80% of *your indexed monthly earnings*, we will stop *your* benefits and *your* claim will end.

Beyond 24 months of *disability benefits*, if *your monthly disability earnings* exceed 60% of *your indexed monthly earnings*, we will stop *your* benefits and *your* claim will end.

**Disability earnings** means the earnings which *you* receive while *you* are disabled and working, plus the earnings *you* could receive if *you* were working to *your* greatest extent possible. This would be based on *your* restrictions and limitation:

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

*Salary continuance* paid to supplement *your disability earnings* will not be considered payment for work performed.

We will review *your* status from time to time. We will require satisfactory proof of earnings and continued disability. No *disability benefits* will be paid, and insurance will end if we determine *you* are able to work under a transitional work arrangement or other modified work arrangement and *you* refuse to do so without *good cause*.

## What Will We Use For Covered Monthly Earnings If You Become Disabled During A Covered Layoff Or Leave Of Absence?

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

## How Can We Protect You If Your Disability Earnings Fluctuate?

If *your disability earnings* routinely fluctuate widely from month to month, we may average *your disability earnings* over the most recent 3 months to determine if *your* claim should continue.

If we average *your disability earnings*, we will terminate *your* claim if:

- during the first 24 months of *disability benefits*, the average of *your disability earnings* from the last 3 months exceeds 80% of *indexed monthly earnings*; or
- beyond 24 months of *disability benefits*, the average of *your disability earnings* from the last 3 months exceeds 60% of *indexed monthly earnings*.

We will not pay for any month during which *disability earnings* exceed the above amounts. The *minimum monthly benefit* will not be paid when *disability earnings* exceed the above amounts.

## What Are "Deductible Sources Of Income" And How Do They Affect My Benefits?

**Deductible sources of income** are other income benefits *you*, *your spouse* and *your dependent* children may be entitled to receive because of *your* disability or retirement. These benefits are taken into consideration when *your monthly benefit* is calculated and may reduce *your monthly benefit*.

We will subtract from *your gross disability benefit* the following *deductible sources of income*:

1. The amount that *you* receive or are entitled to receive under:
  - a Workers' Compensation law;
  - an occupational disease law; or
  - any other *plan, act, or law* with similar intent.
  
2. The amount that *you* receive or are entitled to receive as disability income *benefits* under any:
  - state compulsory benefit *act or law*;
  - automobile liability insurance policy;
  - other group insurance plan; or
  - governmental retirement system as a result of *your job with your employer*.
  
3. The gross amount that *you, your spouse, and children* receive or are entitled to receive as disability *benefits* because of *your disability* under:
  - the United States Social Security Act;
  - the Canada Pension Plan;
  - the Quebec Pension Plan;
  - the Railroad Retirement Act; or
  - any similar *plan, act, or law* of any country, state, or province.

Amounts paid to *your former spouse* or to *your children* living with such *spouse* will not be included.

4. The gross amount that *you* receive as retirement payments or the amount *your spouse and children* receive as retirement payments because *you* are receiving retirement payments under:
  - the United States Social Security Act;
  - the Canada Pension Plan;
  - the Quebec Pension Plan;
  - the Railroad Retirement Act; or
  - any similar *plan, act, or law* of any country, state, or province.

This does not include benefits for any month before *you* reach normal retirement age, as defined under the Social Security Act, unless *you* choose to receive these benefits.

Benefits paid to *your former spouse* or *your children* living with such *spouse* will not be included.

5. The amount that *you*:
  - receive as *disability benefits* under *your employer's retirement plan*;
  - voluntarily elect to receive as retirement *benefits* under *your employer's retirement plan*;
  - receive as retirement benefits when *you* reach the later of age 62 or normal retirement age, as defined in *your employer's retirement plan*.

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

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

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

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

6. One hundred percent of the amount *you* receive under Title 46, United States Code Section 688 (The Jones Act).
7. Third party payments, damages, settlements, or judgments received for *your* disability (after subtracting attorney's fees).
8. One hundred percent of the amount *you* receive under the maritime doctrine of maintenance, wages, and cure. This includes only the "wages" part of such benefits.
9. The amount of loss of time benefits that *you* receive or are entitled to receive under any *salary continuation* or *accumulated sick leave*.
10. The amount *you* receive or are entitled to receive under any unemployment income *act* or *law* due to the end of employment with *your employer* or payable by insured and uninsured plans or as a result of *your* membership or association in any group, union, or other organization.
11. The amount of earnings *you* receive from the *employer's* sabbatical leave plan, or similar *leave of absence* plan, less the cost of paying a substitute teacher if *you* are required to do so.
12. The amount of earnings *you* receive from *your employer's* assault leave plan, or similar *leave of absence* plan, as a result of *your* being physically assaulted while acting in *your* official capacity.
13. The amount of earnings *you* receive from an extended sick leave plan as described in Louisiana Revised Statutes 17:1202, 17:500.2 or any other act or law with similar intent.
14. The amount *you* receive from a Paid Family Leave Plan.

With the exception of retirement payments, or amounts that *you* receive from a partnership, proprietorship, or any similar draws, *we* will only subtract *deductible sources of income* which are payable as a result of the same disability.

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

## What Are Not Deductible Sources Of Income?

We will not subtract from *your gross disability benefit income* you receive from, but not limited to, the following:

- 401(k) plans;
- profit sharing plans;
- thrift plans;
- tax sheltered annuities;
- stock ownership plans;
- non-qualified plans of deferred compensation;
- military pension and disability income plans;
- credit disability insurance;
- franchise disability income plans;
- individual retirement accounts (IRA);
- individual disability income plans;
- 457 deferred compensation plans;
- 403(b) tax sheltered annuity plans;
- retirement benefits from a former employer.

## What If Subtracting Deductible Sources Of Income Results In A Zero Benefit (Minimum Monthly Benefit)?

If *your monthly benefit* is reduced to zero due to subtracting *deductible sources of income*, you will receive a *minimum monthly benefit*. Your *minimum monthly benefit* is listed on the Benefits Schedule.

We may apply *your minimum monthly benefit* toward any outstanding overpayment.

## What Happens When You Receive A Cost Of Living Increase From Deductible Sources Of Income?

Once we have subtracted any *deductible source of income* from *your gross disability benefit*, we will not further reduce *your monthly benefit* due to a cost of living increase from that source.

## What If We Determine You May Qualify For Deductible Income Benefits?

When we determine that *you* may qualify for benefits in the “Deductible Sources Of Income” Section, we will estimate *your* entitlement to these benefits. We can reduce *your monthly benefit* by the estimated amounts if such benefits:

- have not been awarded or received; and
- have not been denied; or
- have been denied, and the denial is being appealed, if appeal rights are provided.

*Your monthly benefit* may **NOT** be reduced by the estimated amount if *you*:

- apply for the *disability benefits* in the “Deductible Sources Of Income” Section, and appeal *your* denial to all administrative levels we feel are necessary; and
- sign *our* reimbursement agreement form. This form states that *you* promise to pay *us* any overpayment caused by an award.

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

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

### **What Happens If You Receive A Lump Sum Payment?**

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

### **What Is The Maximum Benefit Period?**

*You* will receive a benefit for each month *you* remain disabled up to the *maximum benefit period*. Your *maximum benefit period* is based on *your* age when disability occurs. Refer to the Benefits Schedule for specific *maximum benefit period* durations for Option 1 or Option 2.

### **When Will Benefits Stop?**

*Your* claim will end, and benefits will stop on the end of the month following:

- the end of the maximum benefit period;
- the date *you* are no longer disabled under the terms of the *Plan*;
- during the first 24 months of benefits, when *you* are able to work in *your regular occupation* on a part-time basis, but *you* choose not to;
- after 24 months of benefits, when *you* are able to work in any *gainful occupation* on a *part-time* basis, but *you* choose not to;
- during the first 24 months of benefits, if *you* are working and *your* monthly *disability earnings* exceed 80% of *your indexed monthly earnings*, the date *your* earnings exceed 80%;
- after 24 months of benefits, if *you* are working and *your* monthly *disability earnings* exceed 60% of *your indexed monthly earnings*, the date *your* earnings exceed 60%;
- the date *you* fail to submit proof of continuing disability;
- if *you* are incarcerated;
- the date *you* die;
- the date *your employer* offers *you* another or modified job position, which *physicians* agree *you* are able to perform, at a pay rate that exceeds 80% of *your indexed monthly earnings*.

### **Disability Benefits Will Not Be Paid For Any Period Of Disability During Which You:**

- are not following a plan of *appropriate care* for *your* disability, or complications of *your* disability;
- are not receiving *appropriate care*;
- refuse to participate in a worksite modification program, a transitional work arrangement or other modified work arrangement which may be for *your regular occupation* or *any reasonable occupation*;
- *you* fail to cooperate with *us* in the administration of the claim. Such cooperation includes but is not limited to providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

## What Disabilities Have A Limited Pay Period Under Your Plan?

We will pay *disability benefits* on a limited basis for a disability caused by, or contributed to by, any one or more of the following conditions:

- disabilities, which as determined by *us*, due in whole or in part to *mental illness* have a limited pay period during *your* lifetime;
- disabilities due to a *sickness* or *injury*, which as determined by *us*, are primarily based on *self-reported symptoms* have a limited pay period during *your* lifetime.

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

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

### Benefit Extension

We will continue *your* benefits beyond the 24 month period if *you* meet one or both of these conditions:

1. If *you* are *confined* to a *hospital* or *institution* at the end of the 24-month period, we will continue *your* benefits during *your* *confinement*. If *you* are still disabled when *you* are discharged, we will continue *your* benefits for a recovery period of up to 90 days.

If *you* become re-*confined* at any time during the recovery period and remain confined for at least 14 days in a row, we will continue *your* benefits during that additional *confinement* and for one additional recovery period up to 90 more days.

2. In addition to item 1, if, after the 24-month period for which *you* have received benefits, *you* continue to be disabled and subsequently become *confined* to a *hospital* or *institution* for at least 14 days in a row, we will continue benefits during the length of the re-*confinement*.

We will not pay beyond the limited pay period as indicated above, or the *maximum benefit period*, whichever occurs first. We will not apply any period of *confinement* to *your* lifetime cumulative maximum.

### Exceptions

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

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

## What Disabilities Are Not Covered Under Your Plan?

*Your Plan* does not cover any disabilities caused by, contributed to by, or resulting directly or indirectly from:

- a *pre-existing condition*;

- intentionally self-inflicted injuries or attempted suicide;
- active participation in a riot or an act of insurrection, rebellion, or civil commotion;
- commission of a crime for which *you* have been convicted, this includes but is not limited to local, state, country, provincial or federal *law*, or the disability results from commission of, or attempting to commit a criminal act; or
- the *Insured's* active participation in declared or undeclared war or any act of declared or undeclared war.

### **What Is A Pre-Existing Condition?**

*You have a pre-existing condition if both 1 and 2 are true:*

1. *you* received medical treatment, consultation, care, or services including diagnostic measures, or were prescribed drugs or medicines in the 3 months just prior to *your* effective date of coverage or the date an increase in benefits through amendment or *your* enrollment in another *Plan* option, would otherwise be available;
2. the disability begins in the first 12 months after *your* effective date of coverage.

### **How Does A Pre-Existing Condition Affect An Increase In Your Benefits?**

If there is an increase in *your* benefits due to an amendment of the *Plan*; or *your* enrollment in another *Plan* option, a benefit limit will apply to the increased amount only if *your* disability is due to a *pre-existing condition*.

*You* will be limited to the benefits *you* had on the day before the increase if *your* disability begins during the 12 months period starting with the date the increase in benefits would have been effective. The increase will not take effect until *your* disability ends.

### **What If You Are Not In Active Employment When Your Employer Changes Insurance Carriers To Us (Continuity of Coverage)?**

When the *Plan* becomes effective, *we* will provide coverage for *you* if:

- *you* are not in *active employment* because of a *sickness* or *injury*; and
- *you* were covered by the prior *Policy*.

*Your* coverage is subject to payment of premium.

*Your monthly benefit* will be limited to the amount that would have been paid by the prior carrier. *We* will reduce *your monthly benefit* by any amount for which *your* prior carrier is liable.

### **How Does The Pre-Existing Condition Work If You Were Covered Under Your Employer's Prior Plan (Continuity of Coverage)?**

*You* may be eligible for a *monthly benefit* even if *your* disability results from a *pre-existing condition* if, *you* were:

- in *active employment* and insured under the *Plan* on its effective date; and
- insured by the prior policy at the time of change.

In order to receive a *monthly benefit*, *you* must satisfy the *pre-existing condition* provision under:

1. *our Plan*; or
2. the prior carrier's plan, if benefits would have been paid had that policy remained in force.

If *you* do not satisfy item 1 or item 2 above, we will not pay benefits under *our Plan*.

If *you* satisfy item 1, we will determine *your* benefits according to *our Plan* provisions.

If *you* only satisfy item 2, we will administer *your* claim according to *our Plan* provisions. However, *your monthly benefit* will be the lesser of:

- the *monthly benefit* that would have been payable under the terms of the *prior plan* if it had remained in force;
- the *monthly benefit* under *our Plan*.

*Your* benefits will end on the earlier of the following dates:

- the end of the *maximum benefit period* under *our Plan*; or
- the date benefits would have ended under the *prior plan* if it had remained in force.

### **What Happens If You Return To Work Full Time With Your Employer And Your Disability Occurs Again?**

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

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

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

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

If *you* become covered under any other group disability plan, *you* will not be eligible for benefits under this Disability Plan.

## ADDITIONAL DISABILITY BENEFITS AND PROGRAMS

### Survivor Benefit

#### What Benefits Will Be Provided To Your Family If You Die ?

#### Death Benefit

When we receive proof that *you* have died, while totally disabled, we will pay *your eligible survivor* a lump sum benefit equal to 3 months of *your gross disability monthly benefit* if, on the date of *your* death:

- *your* disability had continued for 14 days (Option 1); 30 days (option 2); 60 days (Option 3); 90 days (Option 4) or 180 days (Option 5); and
- *you* were receiving or were entitled to receive payments under this *Plan*.

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

If you have no *eligible survivors*, payment will be made to *your* estate.

### Rehabilitation Program

#### A Program To Help You Return To Work

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

*Your* claim file will be reviewed by one of *our* rehabilitation professionals to determine if a *rehabilitation program* might help *you* return to *gainful employment*. As *your* file is reviewed, medical and vocational information will be analyzed to determine an appropriate return to work program. We will make the final determination of *your* eligibility for participation in the program. We will provide *you* with a written rehabilitation plan developed specifically for *you*.

The *rehabilitation program* may include at *our* sole discretion, but is not limited to, the following services and benefits:

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

#### Additional Benefits While You Participate In Our Rehabilitation Program

We will pay an additional benefit of 10% of *your gross disability benefit* to a maximum benefit of \$1,000 per month. This benefit is not subject to *Policy* provisions which would otherwise increase or reduce the benefit amount such as *deductible sources of income*. However, the maximum benefit and maximum benefit period will apply.

This benefit payment may be paid in a lump sum.

### **When Will The Rehabilitation Program Benefits End?**

Benefits for the *rehabilitation program* will end on the earliest of the following dates:

- the date *we* determine that *you* are no longer eligible to participate in *our rehabilitation programs*; or
- any other date on which benefits would stop in accordance with this *Plan*.

### **Dependent Care Expense Benefits While You Participate In A Rehabilitation Program**

While you are participating in *our rehabilitation program*, we will pay a Dependent Care Expense Benefit when you are disabled, and you are incurring expenses:

- to provide care for a child under the age of 15; and/or
- to provide care for a child aged 15 or older incapable of providing their own care due to their own physical or mental handicap; or
- for a family member who requires personal care assistance on a daily basis

The payment of the Dependent Care Expense Benefit will begin immediately after *you* start *our rehabilitation program*. *Our* payment of the dependent care expense benefit will:

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

To receive this benefit, *you* must provide satisfactory proof that *you* are incurring expenses that entitle *you* to the dependent care expense benefit.

Dependent care expense benefits will end on the earlier of the following:

- the date *you* are no longer incurring expenses for *your dependent*;
- the date *you* no longer participate in *our rehabilitation program*; or
- any other date benefits would stop in accordance with this *Plan*.

### **Worksite Modification Benefit**

#### **How Can We Help Your Employer Identify And Provide Worksite Modification?**

A worksite modification might be what is needed to allow *you* to perform the *material and substantial duties of your regular occupation with your employer*. One of *our* designated professionals will assist *you* and *your employer* to identify a modification *we* agree is likely to help *you* remain at work or return to work. This agreement will be in writing and must be signed by *you*, *your employer* and *us*. When this occurs, *we* will assist *your employer* with the cost of the modification, up to \$2,000. This benefit is available to *you* on a one-time only basis.

# CLAIM INFORMATION

## Long Term Disability

### Reporting Of Claims

You are required to submit a claim to us in writing by mail or fax. Claim forms may be obtained from *your employer* or from us. Follow the procedure chosen by *your employer* to report a disability claim to us.

### When Do You Notify Us Of A Claim?

We encourage you to notify us of your disability claim as soon as possible, so that a claim decision will be made in a timely manner. Written notice of a claim should be sent within 90 days after the date your disability begins. Failure to give notice within the time prescribed does not invalidate or reduce any claim if it is shown that it was not reasonably possible to give the notice within that time, and notice was given as soon as was reasonably possible. However, must send us written proof of your claim no later than 90 days after your *elimination period*. If it is not possible to give proof within 90 days, it must be given no later than two year(s) after the time proof is otherwise required except in the absence of legal capacity.

If you submit a claim before you have been notified of our decision on any coverage amount requiring *evidence of insurability*, your amount of coverage will be determined as if our final underwriting decision had been made prior to the date of claim.

The claim form is available from *your employer*, or you can request a claim form from us. If you do not receive the form from us within 15 days of your request, send us written proof of claim without waiting for the form.

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

### How Do You File A Claim?

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

### What Information Is Needed As Proof Of Your Claim?

Your proof of claim must be provided at your expense. It must include the following information:

1. that you are under the *regular care* of a licensed *physician*;
2. appropriate documentation of your *monthly covered income*;
3. the cause of your disability;
4. the extent of your disability, including restrictions and limitations preventing you from performing your *regular occupation*; and
5. the name and address of any inpatient or outpatient facility, *hospital*, or *institution* where you received treatment, including all attending *physicians*.

We may request that provide us with proof of continuing disability indicating that you are under the *regular care* of a *physician*. This proof shall be in writing and satisfactory to us.

*You* will be required to give *us* authorization to obtain additional medical information from *your* medical providers. *You* may also be required to provide *us* with non-medical information such as copies of *your* IRS Federal Income Tax return, W-2's and 1099's, as part of *your* proof of continuing disability.

This proof must be provided at *your* own expense and must be received within 30 days of a request by *us*. *We* will deny *your* claim or stop sending *you* payments if the appropriate information is not submitted.

### **Who Will We Make Benefit Payment To?**

Benefits will be paid to *you*.

### **What Happens If We Overpay Your Claim?**

*We* have the right to recover any overpayments for amounts paid greater than the benefits that *you* are entitled to receive. This includes but is not limited to *our* error, *your* receipt of *deductible sources of income* or fraud. *We* will not recover more money than the amount *we* paid *you*.

*We* have the right to do any one or all of the following:

- require *you* to return the overpayment on request;
- stop payment of benefits until the overpayment is recovered;
- take any legal action needed to recover the overpayment; and
- place a lien, if not prohibited by *law*, in the amount of the overpayment on the proceeds of any other income, whether on a periodic or lump sum basis.

If the overpayment occurred as a result of *your* receipt of *deductible sources of income*, during the period for which *you* have received a benefit under this *Plan*, *we* will exclude from the amount to be recovered, any advocate or legal fees incurred by *you* to obtain such *deductible sources of income*, provided *you* return the overpayment to *us* within 30 days of *our* written request. If *you* do not return the overpayment to *us* within 30 days, such fees will not be excluded. *You* will remain responsible for repayment of the total overpaid amount.

Examples of *deductible sources of income* are:

- Workers' Compensation;
- Federal Social Security benefits;
- Disability payments made by, or on behalf of, a third party as a result of any person's action or inaction.

All full list of *deductible sources of income* is located in the "Long Term Disability Benefits" Section of the Certificate.

### **Unpaid Premium Due**

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

### **When Will We Require You To Obtain Physical Examinations And Evaluations?**

*We will have the right and opportunity to have a **physician**, dentist, vocational expert or other medical or vocational professional of **our** choice examine **you** when **you** request benefits for new and ongoing claims under this **Plan**. Multiple exams, evaluations and functional capacity exams may be required during **your** disability for an ongoing claim. This will be done at all reasonable times while a claim for benefits is pending or under review. This will be done at **our** expense at no cost to **you**.*

### **What Are The Time Limits For Legal Proceedings?**

***You** can start legal action regarding **your** claim 60 days after proof of claim has been given to **us** and up to three years from the time proof of claim is required, unless otherwise provided under federal **law**.*

# CLAIM PROCEDURES AND APPEAL INFORMATION

## How To File A Claim

If *you* wish to file a claim for benefits, *you* should follow the claim procedures described in *your* Certificate of Coverage. To complete *your* claim filing, *we* must receive the claim information it requests from *you* (or *your* authorized representative), *your* attending *physician*, and *your* employer. If *you* or *your* authorized representative has any questions about what to do, *you* or *your* authorized representative should contact *us* directly.

## Claims Procedures

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

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

- state the specific reason(s) for the determination;
- reference specific *Plan* provision(s) on which the determination is based;
- describe additional material or information necessary to complete the claim and why such information is necessary;
- describe *Plan* procedures and time limits for appealing the determination, and *your* right to obtain information about those procedures following an adverse determination from *us* on appeal; and
- disclose any internal rule, guidelines, protocol, or similar criterion relied on in making the adverse determination (or state that such information will be provided free of charge upon request).

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

## Appeal Procedures

*You* have 180 days from the receipt of notice of an adverse benefit determination to file an appeal. Requests for appeals should be sent to the address specified in the claim denial. A decision on review will be made no later than 45 days following receipt of the written request for review. If *we* determine that special circumstances require an extension of time for a decision on review, the review period may be extended by an additional 45 days (90 days in total). *We* will notify *you* in writing if an additional 45-day extension is needed.

If an extension is necessary due to *your* failure to submit the information necessary to decide the appeal, the notice of extension will specifically describe the required information, and *you* will be afforded at least 45 days to provide the specified information. If *you* deliver the requested information within the time specified, the 45-day extension of the appeal period will begin after

*you* have provided that information. If *you* fail to deliver the requested information within the time specified, *we* may decide *your* appeal without that information.

*You* will have the opportunity to submit written comments, documents, or other information in support of *your* appeal. The review of the adverse benefit determination will take into account all new information, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination.

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

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

- the specific reason(s) for the determination;
- a reference to the specific *Plan* provision(s) on which the determination is based;
- a statement disclosing any internal rule, guidelines, protocol, or similar criterion relied on in making the adverse determination (or a statement that such information will be provided free of charge upon request);
- the statement that *you* are entitled to receive upon request, and without charge, reasonable access to or copies of all documents, records, or other information relevant to the determination; and
- the statement that "*you* or *your Plan* may have other voluntary alternative dispute resolution options, such as mediation".

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

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

## **Other Rights**

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

## **Delegation Of Authority**

The *Plan*, acting through the *Plan Administrator*, Zurich American Life Insurance Company delegates to and its affiliate's discretionary authority to make benefit determinations under the *Plan*. The Company may act directly or through their employees and agents or further delegate their authority through contracts, letters or other documentation or procedures to other affiliates, persons, or entities. Benefit determinations include determining eligibility for benefits and the amount of any benefits, resolving factual disputes, and interpreting and enforcing the provisions of the *Plan*. All benefit determinations must be reasonable and based on the terms of the *Plan* and the facts and circumstances of each claim.

## GLOSSARY

General definitions used throughout this Certificate include:

**Accident** means a sudden unforeseeable external event that caused bodily injury to an *Insured* while coverage is in force under the *Policy*.

**Active Employment** means *you* are working for *your employer* for earnings that are paid regularly and that *you* are performing the *material and substantial duties of your regular occupation*. *You* must be working at least the minimum number of hours as described under *eligible class(es)* in each *Plan*.

*Your* work site must be:

- *your employer's* usual place of business;
- an alternative work site at the direction of *your employer*, other than *your* home unless clear specific expectations and duties are documented;
- a location to which *your* job requires *you* to travel; or
- at a location to which *your employer's* business requires *you* to relocate live for an extended period of time.

Normal vacation is considered *active employment*.

If *your* employment status is being continued under a severance or termination agreement, *you* will not be considered in *active employment*.

Temporary and seasonal workers are excluded from coverage

**Administrator** means Zurich American Life Insurance Company.

**Appropriate Care** means the determination of an accurate and medically supported diagnosis of the *Insured's* disability, or ongoing medical treatment and care of the *Insured's* disability by a *physician* that conforms to generally-accepted medical standards, including frequency of treatment and care.

**Covered Monthly Earnings** means *your* gross monthly income from *your* employer in effect just prior to *your* date of disability. It includes *your* total income before taxes. It is prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plans, or flexible spending account.

It will only include stipends paid for the following:

- participating as a coach or a leader in any school extracurricular activity for which you are paid; and
- any oil or refinery stipends.

It does not include income received from car, housing or moving allowances, commissions, bonuses, overtime pay, *employer* contributions to a qualified deferred compensation plan or any other extra compensation, or income received from sources other than *your employer*.

**Deductible Sources of Income** means income from the deductible sources listed in the *Plan* that *you* receive or are entitled to receive while *you* are disabled. This income will be subtracted from *your gross disability benefit*.

**Disability Benefit** when used with the term *retirement plan*, means money which:

- is payable under a *retirement plan* due to a disability, as defined in the *Plan*, and

- does not reduce the amount of money, which would have been paid as retirement benefits which would have been paid as retirement benefits under the *Plan* if the disability had not occurred. If the payment does cause a reduction, it will be considered a retirement benefit as defined in this Certificate.

**Eligible Classes** means the classes of *employees* that *your employer* has selected as being eligible to receive coverage under a *Plan*. *Your employer* alone determines the criteria that is used to define the *eligible class(es)* for insurance coverage under this *Plan*.

**Eligibility Date** means the date *you* become eligible for insurance.

**Eligible Survivor** means *your spouse*, if living, otherwise *your children* under age 25 equally.

**Elimination Period** means a period of continuous disability that must be satisfied before *you* are eligible to receive benefits from this *Plan*.

**Employee** means a person who is in *active employment* with the *employer* and the *employees*, individual proprietors, and partners of one or more affiliated corporations, proprietorships, or partnerships if the business of the *employer* and such affiliated corporations, proprietorships or partnerships is under common control. *Employee* shall exclude in any case, *part-time employees*, temporary *employees*, and *employees* who work for the *employer* less than the number of hours per week indicated in the Benefits Schedule. This term does not include *employees* who normally work less than 30 hours a week for the *employer*.

**Employer** means the *Policyholder* and subsidiaries or affiliates of the *Policyholder* that the *Policyholder* has requested in writing to have included under the *Policy*, and which request we have approved such request.

**Full-Time** means the number of hours set by the *employer* as a regular work day for *full-time employees* in the *Insured's eligible class*.

**Gainful Occupation** means an occupation for which *you* are or become reasonably fitted by training, education, or experience.

**Good Cause** means a medical reason preventing *your* participation in the *rehabilitation program* or in a *transitional work arrangement*. Satisfactory proof of *good cause* must be provided to *us*.

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

**Gross Disability Benefit** means the total benefit amount for which an *employee* is insured under this *Plan* before we subtract *deductible sources of income* and *disability earnings* subject to the maximum benefit.

**Home Office** means 1299 Zurich Way, Schaumburg, Illinois 60196.

**Hospital or Institution** means an accredited facility licensed to provide care and treatment for the condition causing *your* disability.

**Income** means income *you* earn, while disabled and working, from *your employer* or any other *employer*. However, any income earned by working for another *employer* will be considered income only to the extent that it exceeds the amount of income *you* were earning from such *employer* immediately before *you* became disabled.

**Indexed Monthly Earnings** means for the first year *you* are disabled *your indexed monthly earnings* will be equal to *your monthly covered earnings*. After *you* have been disabled for one year, *your indexed monthly earnings* means *your covered monthly earnings* adjusted on each anniversary of benefit payments, after a 12 month period of disability by the lesser of 10% or the

current annual percentage increase in the Consumer Price Index. *Your indexed monthly earnings* may increase or remain the same but will never decrease.

The U.S. Department of Labor publishes the consumer price Index (CPI-W). We reserve the right to use some other similar measurement if the Department of Labor changes or stops publishing the CPI-W. Indexing is only used as a factor in the determination of the percentage of lost earnings while *you* are disabled and working in the determination of any *gainful occupation*.

**Injury** means bodily injury that is a direct result of an *accident* and independent of all other causes. The injury must occur, and the disability must begin while *you* are covered under this *Plan*. Exception: any disability that occurs more than 60 days after the *injury* will be considered a *sickness* for the purpose of determining benefits under this *Policy*.

**Insured** means any person covered under this *Plan* for whom premium has been paid.

**Law, Plan or Act** means the original enactment of the *law, plan* or *act* and all amendments.

**Layoff or Leave of Absence** means *you* are temporarily absent from *active employment* for a period of time that has been agreed to in advance in writing by *your employer*. *Your* normal vacation time or any period of disability is not considered a *temporary layoff* or *leave of absence*.

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

- are normally required for the performance of *your regular occupation*; and
- cannot be reasonably omitted or modified, except that if *you* are required to work an average in excess of 40 hours per week, we will consider *you* able to perform that requirement if *you* are working or have the capacity to work 40 hours per week.

**Maximum Capacity** means based on *your* restrictions and limitations:

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

**Maximum Period of Payment** means the longest period of time we will make payments to *you* for any one period of disability.

**Mental Illness** means a psychiatric or psychological condition classified in the Diagnostic and Statistical Manual of Mental Health Disorders (DSM) published by the American Psychiatric Association, most current as of the start of a disability. Such disorders include, but are not limited to, psychotic, emotional or behavioral disorders, schizophrenia, depression, bipolar illness, or disorders relating from stress or to substance abuse or dependency. If the DSM is discontinued or replaced, these disorders will be those classified in the diagnostic manual then used by the American Psychiatric Association as of the start of the disability. These conditions are usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs, or other methods of treatment as standardly accepted in the practice of medicine.

**Monthly Benefit** means *your* benefit amount after any *deductible sources of income* and *disability earnings* have been subtracted from *your gross disability benefit*.

**Part-Time Basis** means the ability to work and earn between 20% and 80% of *your indexed monthly earnings*.

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

**Physician** means a person performing tasks that are within the limits of his or her medical license; and:

- a person who is licensed to practice medicine, and prescribe and administer drugs and medicines, or to perform surgery; or
- a person with a doctoral degree in Psychology (Ph.D. or Psy.D.) whose primary practice is treating patients; or
- a person who is a legally qualified medical practitioner according to the *laws* and regulations of the governing jurisdiction.

We will not recognize *you* or a person related to *you* as a *physician* for a claim that *you* send to us. This includes but not limited to *your spouse*, children, parents, siblings, brothers-in-law, sisters-in-law, or step children.

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

**Policy** means the *Policy* provided to the *employer*.

**Policyholder** means an *employer* who as applied for coverage under the *Policy* for eligible *employees*.

**Pre-Existing Condition** means a condition for which *you* received medical treatment, consultation, care, or services including diagnostic measures, or took prescribed drugs or medicines for *your* condition during the given period of time as stated in the *Plan*.

**Prior Plan** means the plan of insurance providing similar benefits sponsored by the *employer* in effect directly prior to the Policy Effective Date.

**Reasonable Accommodation** means modifications or adjustments to a job, an employment practice or the work environment that makes it possible for a disabled person to perform the material duties of their occupation without causing undue hardship to any *employer*. It must meet federal standards of Reasonable Accommodation as detailed in the Americans with Disabilities Act of 1991 and any later amendments.

**Reasonable Occupation** means any gainful activity for which *you* are, or may reasonably become fitted by education, training, or experience.

**Recurrent Disability** means a disability, which is:

- caused by a worsening in *your* condition; and
- due to the same cause(s) as *your* prior disability for which we made a Disability payment or
- *you* satisfied *your elimination period*.

**Regular Care** means:

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

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

**Rehabilitation Program** means a program, approved by *us*, designed to assist *you* to return to work.

**Retirement Plan** means a defined contribution plan or defined benefit plan. These are plans which provide retirement benefits to *employees* and are not funded entirely by *employee* contributions. *Retirement plan* includes but is not limited to any plan that is part of any federal, state, county, municipal or association retirement system.

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

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

**Sickness means** an *illness*, disease or disabling pregnancy. The sickness must begin while *you* are covered under this *Plan*.

**Total Covered Payroll** means the total amount of *monthly earnings* for which *employees* are incurred under this *Plan*.

**Spouse** means the *Insured's* lawful spouse.

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

**You, Your** means an insured *employee* who is e

## How you're protected if your life or health insurance company fails

The Texas Life and Health Insurance Guaranty Association protects you by paying your covered claims if your life or health insurance company is insolvent (can't pay its debts). **This notice summarizes your protections.**

The Association will pay your claims, with some exceptions required by law, if your company is licensed in Texas and a court has declared it insolvent. You must live in Texas when your company fails. If you don't live in Texas, you may still have some protections.

### For each insolvent company, the Association will pay a person's claims only up to these dollar limits set by law:

- **Accident, accident and health, or health insurance (including HMOs):**
  - o Up to \$500,000 for health benefit plans, with some exceptions.
  - o Up to \$300,000 for disability income benefits.
  - o Up to \$300,000 for long-term care insurance benefits.
  - o Up to \$200,000 for all other types of health insurance.
- **Life insurance:**
  - o Up to \$100,000 in net cash surrender or withdrawal value.
  - o Up to \$300,000 in death benefits.
- **Individual annuities:** Up to \$250,000 in the present value of benefits, including cash surrender and net cash withdrawal values.
- **Other policy types:** Limits for group policies, retirement plans and structured settlement annuities are in Chapter 463 of the Texas Insurance Code.
- **Individual aggregate limit:** Up to \$300,000 per person, regardless of the number of policies or contracts. A limit of \$500,000 may apply for people with health benefit plans.
- **Parts of some policies might not be protected:** For example, there is no protection for parts of a policy or contract that the insurance company doesn't guarantee, such as some additions to the value of variable life or annuity policies.

To learn more about the Association and your protections, contact:

**Texas Life and Health Insurance Guaranty Association**

515 Congress Avenue, Suite 1875  
Austin, TX 78701

1-800-982-6362 or [www.txlifega.org](http://www.txlifega.org)

For questions about insurance, contact:

**Texas Department of Insurance**

P.O. Box 149104  
Austin, TX 78714-9104

1-800-252-3439 or [www.tdi.texas.gov](http://www.tdi.texas.gov)

**Note:** You're receiving this notice because Texas law requires your insurance company to send you a summary of your protections under the Texas Life and Health Insurance Guaranty Association Act (Insurance Code, Chapter 463). These protections apply to insolvencies that occur on or after September 1, 2019. **There may be other exceptions that aren't included in this notice.** When choosing an insurance company, you should not rely on the Association's coverage. Texas law prohibits companies and agents from using the Association as an inducement to buy insurance or HMO coverage.

Chapter 463 controls if there are differences between the law and this summary.



## Privacy Notice

### We Take Important Steps to Protect the Nonpublic Personal Information We Collect About You

Dear Customer:

rev. January 2020

We care about your privacy. That is why we believe in your right to know what nonpublic personal information (“NPI”) we collect about you and what we do with that information. This Privacy Notice describes the NPI we collect about you and how we share and protect that information.

Overview	UNDERSTANDING HOW WE USE YOUR PERSONAL INFORMATION
<b>Why are you receiving this Notice?</b>	Financial institutions, which include the Company, choose how they share your NPI. Federal and state law gives consumers the right to limit some but not all sharing of that information. Federal law also requires us to tell you how we collect, share and safeguard your NPI. You are receiving this Privacy Notice because our records show either that you are a customer who is obtaining or has obtained insurance coverage or non-insurance products or services.
<b>What types of Information do we collect?</b>	<p>The types of NPI we collect depend on the product or service you have with us. This information can include:</p> <ul style="list-style-type: none"><li>• Information about you we receive on applications or other forms, such as your name, address, telephone number, date of birth, your social security number, driver’s license number, employment information, information about your income, assets and net worth, and medical information;</li><li>• Information about your transactions with the Company and its affiliates;</li><li>• Information about your insurance coverage, premiums, claims history, and payment history;</li><li>• Data from insurance support organizations, government agencies, insurance information sharing bureaus;</li><li>• Property information and similar data about you or your property, such as property appraisal reports; and</li><li>• Information we receive from a consumer reporting agency or insurance information sharing bureau, such as a credit or fraud report.</li></ul> <p>When your relationship with us ends, we may continue to share information about you as described in this Privacy Notice.</p>
<b>What do we do with the NPI we collect?</b>	<p>We share your NPI in the course of supporting your insurance coverage or non-insurance products or services, as authorized by law, or with your consent. This includes sharing, as permitted by law, your NPI with affiliated parties and nonaffiliated third parties, as applicable, in the course of supporting your insurance coverage or non-insurance products.</p> <p>These affiliates and nonaffiliated third parties include:</p> <ul style="list-style-type: none"><li>• Financial service providers, such as banks and other insurance companies;</li><li>• Non-financial companies, such as medical providers and nonaffiliated service providers that perform marketing services on our behalf; and</li><li>• Others, such as consumer reporting agencies and insurance information sharing bureaus.</li></ul> <p>In the section below, we list the reasons we can share your NPI, whether we actually share your NPI, and whether you can opt out of this sharing (or if you are a resident of Vermont, whether you</p>

	have the right to opt in to allowing this sharing).
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Reasons we can share your personal information	Does Company Share?	Can you opt out of this sharing or limit this sharing or is your authorization required for this sharing?  [For residents of Vermont: Do you have the right to opt in to allow this sharing?]
<b>For our everyday business purposes</b> – such as to process your transactions, administer insurance coverage, products or services, maintain your account, prevent fraud and report to credit bureaus	Yes	No
<b>For our marketing purposes</b> - to offer our products and services to you	Yes	No
<b>For joint marketing with other financial companies</b>	No	Not Applicable
<b>For our affiliates' everyday business purposes</b> – transaction and experience information	Yes	No
<b>For our affiliates' everyday business purposes</b> – information about your creditworthiness	No	Not Applicable
<b>For our affiliates to market to you</b>	Yes	No
<b>For non-affiliates to market their products to you</b>	No	Not Applicable

Collecting and safeguarding information	
<b>How often do you notify me about your privacy practices?</b>	We must notify you about our sharing practices when you receive your policy, open an account or purchase a service, and each year while you are a customer, or when significant or legal changes require a revision. Please review the privacy policy posted on our website, <a href="http://ZurichNA.com">ZurichNA.com</a> . It contains additional information about our practices.
<b>Why do you collect my NPI?</b>	We collect NPI when you apply for insurance or file an insurance claim to help us provide you with our insurance products and services, and determine your insurability or other eligibility. We may also ask you and others for information to help us verify your identity in order to prevent money laundering and terrorism. Information in a report prepared by an insurance support organization may be retained by that organization and provided to others.
<b>What NPI do we share?</b>	We may provide to affiliates and/or nonaffiliated third parties the same NPI listed above in the section entitled, "What types of information do we collect?"
<b>How do you safeguard my NPI?</b>	Employees who have access to your NPI are required to maintain and protect the confidentiality of that information. Access to your personal information may be needed to conduct business on your behalf or to service your insurance coverage. In addition, we maintain physical, electronic and procedural measures to protect your personal information in compliance with applicable laws and regulatory standards.

**FOR RESIDENTS OF ARIZONA, CALIFORNIA, CONNECTICUT, GEORGIA, ILLINOIS, MAINE, MASSACHUSETTS, MINNESOTA, MONTANA, NEW JERSEY, NEVADA, NORTH CAROLINA, OHIO, OREGON, OR VIRGINIA:**

**You have the following individual rights under state law:**

Except for certain documents related to claims and lawsuits, you have the right to access the recorded personal information that we have collected about you which we reasonably can locate and retrieve. To access your recorded personal information, you must submit a request using our online form on our website, ZurichNA.com, or calling our toll-free number at 1-800-382-2150. You may also reasonably describe the information you seek in writing and send your written request to the Privacy Office via mail (Zurich – Privacy Office, 1299 Zurich Way, Schaumburg, IL 60196) or via email at [privacy.office@zurichna.com](mailto:privacy.office@zurichna.com). If you would like a copy of your recorded personal information that we reasonably can locate and retrieve, we may charge you a reasonable fee to cover the costs incurred in providing you a copy of the recorded information if it is permitted by law. If you request medical records, we may elect to supply that information to you through your designated medical professional for security purposes. We may also direct you to a consumer reporting agency to obtain certain consumer report information.

Generally, most of the recorded nonpublic personal information we collect about you and have in our possession is from policy applications or enrollment forms you submit to obtain our products and services, and is reflected in your statements and other documentation you receive from us. If you believe that the personal information we have about you in our records is incomplete or inaccurate, please let us know at once through any of the above methods, and we will investigate and correct any errors we find.

You also have the right to request the correction, amendment, or deletion of recorded personal information about you that we have in our possession. You may make your request using any of the above methods.

Residents of California and Nevada have additional rights over their non-public personal information if it is not governed by the Gramm-Leach-Bliley Act. For more information about these rights, please consult our online privacy policy posted on our website, ZurichNA.com.

**FOR RESIDENTS OF MASSACHUSETTS ONLY WHO ARE ZNA P&C CUSTOMERS:** You may ask in writing for the specific reasons for an adverse underwriting decision. An adverse underwriting decision is where we decline your application for insurance, offer to insure you at a higher than standard rate or terminate your coverage.

<b>Key words and phrases</b>	<b>TERMS YOU SHOULD KNOW</b>
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Definitions	
<b>Everyday business purposes</b>	The actions necessary for financial companies like the Company to conduct business and manage customer accounts, such as: <ul style="list-style-type: none"> <li>Processing transactions, mailing and auditing services;</li> <li>Administering insurance coverage, product, services or claims;</li> <li>Providing information to credit bureaus;</li> <li>Protecting against fraud;</li> <li>Responding to court/governmental orders or subpoenas and legal investigations; and</li> <li>Responding to insurance regulatory authorities.</li> </ul>
<b>Affiliates</b>	Financial or nonfinancial companies related by common ownership or control. <ul style="list-style-type: none"> <li><i>Company affiliates include insurance and non-insurance companies under common ownership with the Company and that provide insurance and non-insurance products or services.</i></li> </ul>
<b>Nonaffiliated Third Parties</b>	Financial or nonfinancial companies not related by common ownership or control. We may share your information with companies that we hire to perform marketing and business services for us, such as data processing, computer software maintenance and development, and transaction processing. When we share information with others to perform these services, they are required to take appropriate steps to protect this information and use it only for purposes of performing the services. <ul style="list-style-type: none"> <li><i>The Company does not share information with nonaffiliates to market their products to you.</i></li> </ul>

<b>Joint marketing</b>	<p>A formal agreement between nonaffiliated financial companies that together market financial products or services to you.</p> <ul style="list-style-type: none"> <li>• <i>The Company does not jointly market.</i></li> </ul>
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<b>Changes to this Privacy Notice; contact us</b>	<p>We may change the policies, standards and procedures described in this Notice at any time to comply with applicable laws and/or to conform to our current business practices. We will notify you of material changes.</p> <p>If you have any questions about your contract with us, you should contact your agent.</p> <p>If you have questions specific to our Privacy Notice, contact our Privacy Office via mail (Zurich – Privacy Office, 1299 Zurich Way, Schaumburg, IL 60196) or via email at <a href="mailto:privacy.office@zurichna.com">privacy.office@zurichna.com</a>.</p>
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This Privacy Notice is sent on behalf of the following affiliated companies, which are referred to in this Privacy Notice, in the aggregate, as the “Company:”

*American Guarantee and Liability Insurance Company, American Zurich Insurance Company, Colonial American Casualty and Surety Company, Empire Fire & Marine Insurance Company, Empire Indemnity Insurance Company, The Fidelity and Deposit Company of Maryland, Steadfast Insurance Company, Universal Underwriters Insurance Company, Universal Underwriters of Texas Insurance Company, Zurich American Insurance Company, Zurich American Insurance Company of Illinois, The Zurich Services Corporation (together, “the ZNA P&C Companies”), Zurich American Life Insurance Company, and Zurich American Life Insurance Company of New York.*