

**CALCASIEU PARISH SCHOOL BOARD**  
**Basic Life, Optional Life, and Dependent Life Benefits**

**TRUSTMARK LIFE INSURANCE COMPANY**  
400 Field Drive  
Lake Forest, Illinois 60045  
(847) 615-1500  
(Herein We, Us, and Our)

**Life, Dependent Life Benefits**

**Policyholder:** **CALCASIEU PARISH SCHOOL BOARD**  
**Policyholder Effective Date:** **May 1, 2026**  
**Certificate Effective Date:** **May 1, 2026 This Certificate automatically supersedes any other Certificate We previously issued to You**  
**Group ID:** **JH395**

This booklet is Your Individual Certificate of Insurance (Certificate) while You are insured. It briefly explains the rights and benefits that are determined by the Master Policy (Policy). The Policy is a contract between the Policyholder and Us.

The Policy alone constitutes the agreement under which payments are made. We will pay the benefits set forth in the Policy. Benefit payment is governed by all the terms, conditions, and limitations of the Policy. The Policy may be amended at any time without Your consent or notice to You. Any such amendment will not affect any charge Incurred before the amendment takes effect.

The Policy may be inspected at Our office by any Policyholder, Covered Person, or beneficiary during regular business hours.

This Certificate was issued on the basis that the information on Your employee enrollment form was correct and complete. **If any of the information on the enrollment form was not correct or complete, write to Us within 10 days of receipt of this Certificate. An error or omission may result in loss of coverage as of its effective date.**

This Certificate automatically supersedes any other Certificate We previously issued to You.

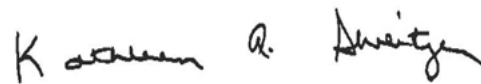
**Please read this Certificate carefully.**

**TRUSTMARK LIFE INSURANCE COMPANY**



**Randall H. Weinstock**

**President**



**Kathleen A. Sweitzer**

**Secretary**

This privacy notice (“Notice”) is provided on behalf of the following insuring companies (collectively “Trustmark” “us”, “our”, “we”):

**Trustmark Insurance Company**  
**Trustmark Life Insurance Company**  
**Trustmark Life Insurance Company of New York**

## NOTICE OF PRIVACY PRACTICES

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THIS NOTICE DESCRIBES OUR INSURANCE INFORMATION PRIVACY PRACTICES AND YOUR PRIVACY RIGHTS AND CHOICES. IT DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

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### **Our Privacy Commitment**

We understand that when you share personal information with us, you expect it to be protected. That’s a responsibility we take seriously. This Notice explains what we collect, how we use it, how we keep it safe, and the choices available to you.

### **What Information This Notice Covers**

This Notice applies to the personal information (PI) we collect and maintain in connection with providing insurance products and services. PI includes non-public information that identifies you. Depending on your coverage, PI may also include protected health information (PHI), which is subject to additional privacy protections.

### **The PI We Collect About You**

The types of PI we collect depend on the insurance product or service you have with us. We may collect PI from a variety of sources, including:

- **Information you provide to us.** You may provide us with your PI, such as your name, address, Social Security number, health information, employment details, income, or payment information when you apply for coverage, make changes to your policy, pay premiums, or file a claim.
- **Information we receive from others.** With your permission when required, we may obtain PI from consumer reporting agencies for underwriting purposes. We may also receive PI from your employer or plan sponsor to determine your eligibility or premium rates.

### **Uses and Disclosures of Your PI**

Except as described in this Notice, or as required or permitted by law, we will not use or disclose your PI without your written authorization. You have the right to

revoke that authorization in writing unless we have taken any action in reliance on the authorization.

We may use or disclose PI, limited to the minimum necessary, without your prior authorization in the following circumstances:

- To effect, administer, or enforce a transaction in connection with your insurance product or service, such as underwriting, policy administration, premium billing and collection, claims processing, or fraud prevention.
- For treatment, payment, or healthcare operations, as permitted by law.
- To non-affiliated third parties or business associates who provide contracted services on our behalf, such as brokers or agents, actuaries, underwriting support providers, legal and audit professionals, enrollment and billing service providers, collection agencies, claims payment administrators, reinsurers, and IT service or system providers.
- To an employer or plan sponsor, but only as permitted by law. For example, to confirm enrollment or disenrollment, determine eligibility, or to provide summary health information for plan management purposes. We do not disclose PHI to an employer for employment-related decisions without your written authorization.
- To regulatory, law enforcement, or other government authorities, including for the detection or prevention of criminal activity, fraud, material misrepresentation or nondisclosure in connection with an insurance matter.
- For judicial or administrative proceedings, such as in response to a court order, subpoena, or discovery request.
- For health oversight activities, such as audits,

investigations, or inspections by government health agencies.

- To support actuarial analysis or research.
- As otherwise required or permitted by law.

**In addition to the above, we:**

- Do not sell your PI.
- Do not use or disclose your PHI for marketing purposes without your written authorization.
- Do not disclose your PHI related to reproductive health care except as permitted or required by applicable law.
- Do not use genetic information for underwriting purposes.
- Do not disclose substance use disorder records without your written consent, except as permitted by law after notice and an opportunity to be heard.
- Do not disclose psychotherapy notes without obtaining your written authorization.
- Retain records containing your PI for the duration required or allowable by law.

**Protecting Your PI**

We maintain physical, technical, and administrative safeguards designed to protect the confidentiality, integrity, and availability of your PI. These safeguards are designed to prevent unauthorized access, use, or disclosure of your PI. We also require third parties who receive PI from us to implement appropriate protections. Access to PI is limited to individuals who need it to perform their job responsibilities in connection with providing our products or services.

**Your Privacy Rights**

Depending on your state of residence and the type of product you have with us, you may have rights related to your PI. We honor these rights in accordance with applicable laws. If we are unable to fulfill your request, we will explain the reason for the denial. You may:

- Request access to certain PI we maintain about you. We may charge a reasonable fee for the costs of copying or mailing documents.
- Request correction, amendment, or deletion of PI. We will review your request and make changes where appropriate. We cannot change the information provided to us by other parties, such as credit agencies.

**Additional Rights for Health Insurance Customers**

If you have a health insurance product with us, or we manage your health-related benefits, you may also:

- Request an accounting of certain disclosures of your PHI made within the past six years.
- Request restrictions on how your PHI is used or disclosed for payment and healthcare operations. While we are not required to agree to all requests, we will review them in accordance with applicable law.

- Request confidential communications, such as receiving mail at an alternative address or by alternative means.
- Receive notification in the event of a breach involving your unsecured PHI.

To exercise any of these rights, please send us a written request at the address listed at the end of this Notice. Include your full name, mailing address, policy or member number, a description of the request, and your signature. We will not retaliate against you for exercising your rights.

**Complaints**

If you believe your privacy rights have been violated, you may file a written complaint with:

- Us, at the address listed at the end of the Notice
- Your state insurance department, if the issue relates to your insurance product
- The U.S. Department of Health and Human Services, if your concern involves a health insurance product or PHI. You may mail your complaint to:

Office for Civil Rights  
U.S. DHHS  
200 Independence Avenue, S.W.  
Washington, D.C. 20201  
Phone: 1-877-696-6775

**Information Collected Through Digital Channels**

This Notice governs information that you provide to us or that we otherwise receive when you apply for or receive insurance related products or services. Depending upon the nature of your relationship with us, or how you interact with us, such as through our websites or online platforms, we may collect additional information from you. Details about how we protect and use this information, including privacy rights that may be available to you, are found on our Privacy page at [www.trustmarkbenefits.com](http://www.trustmarkbenefits.com).

**Changes to This Notice**

We reserve the right to change the terms of this Notice in the future. If we do amend our Notice, a copy of the new Notice will be posted on our website and/or sent to you when required by law.

**How to Contact Us**

Trustmark Companies  
Privacy Request  
Attn: Privacy Team  
P.O. Box 7961  
Lake Forest, IL 60045-7961  
1-847-615-1500 option 9  
[PrivacyTeam@trustmarkbenefits.com](mailto:PrivacyTeam@trustmarkbenefits.com).

**Notice Effective Date: October 1, 2025**

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TCLATC00401

## SCHEDULE OF BENEFITS

The Insurance Classes for each Benefit Section are as follows:

Class	Description
I	Active Employees who are employed as Administrators, Supervisors, Assistant Supervisors, Coordinators, Directors, Psychologists, Principals, Assistant Principals, Nurses, Maintenance Foremen, Data Processing Managers, active School Board Members, and Programmers
II	Retired Employees who were employed as Administrators, Supervisors, Assistant Supervisors, Coordinators, Directors, Psychologists, Principals, Assistant Principals, Nurses, Maintenance Foremen, Data Processing Managers, retired School Board Members, and Programmers
III	Active Employees who are employed as Maintenance and Warehouse Personnel, Media Specialists, and Electronic Technicians
IV	Retired Employees who were employed as Maintenance and Warehouse Personnel, Media Specialists, and Electronic Technicians
V	Active Employees who are employed as Central Office Personnel Staff (other than those in Class I), Unclassified Employees, Lunchroom Managers, and Assistant Lunchroom Managers
VI	Retired Employees who were employed as Central Office Personnel Staff (other than those in Class I), Unclassified Employees, Lunchroom Managers, and Assistant Lunchroom Managers
VII	Active Employees who are employed as Teachers, Counselors, Librarians, Coaches, Secretaries, Clerks, Resource Specialists, Strategists, Teacher's Aides, Tutors, Consultants, Assessment Teachers, Consultant Strategists, Social Workers and Evaluation Personnel
VIII	Retired Employees who were employed as Teachers, Counselors, Librarians, Coaches, Secretaries, Clerks, Resource Specialists, Strategists, Teacher's Aides, Tutors, Consultants, Assessment Teachers, Consultant Strategists, Social Workers and Evaluation Personnel
IX	Active Employees who are employed as Bus Drivers and Bus Driver Aides
X	Retired Employees who were employed as Bus Drivers and Bus Driver Aides
XI	Active Employees who are employed as Cafeteria Workers and Janitors
XII	Retired Employees who were employed as Cafeteria Workers and Janitors

XIII

Dependents of Employees and Retirees of Calcasieu Parish School Board, who are not eligible for Personal Life Insurance due to a late application or failure to provide satisfactory proof of good health

## MAXIMUM BENEFITS FOR EMPLOYEE INSURANCE

<b>Class Insurance</b>	<b>Basic Amount of Life Insurance</b>	<b>Optional Amount of Life Insurance</b>
I	\$30,000	\$20,000
II	\$30,000	\$20,000
III	\$20,000	\$15,000
IV	\$20,000	\$15,000
V	\$10,000	\$10,000
VI	\$10,000	\$10,000
VII	\$10,000	\$15,000
VIII	\$10,000	\$15,000
IX	\$5,000	\$5,000
X	\$5,000	\$5,000
XI	\$5,000	\$2,000
XII	\$5,000	\$2,000
XIII	None	None

### REDUCTION IN LIFE INSURANCE

If you are or become age 65, all Life Insurance amounts (including Optional, if any) will be 75% of the amounts shown on this schedule for your class. At age 70 these amounts will be 50% of the amounts shown.

The new amounts will be effective on the later of:

1. the July 1st which falls on or next follows each of those birthdays; or
2. the date your insurance becomes effective.

If the amounts shown on this schedule for your class later change due to a change in coverage or class, the same reductions will apply to those amounts.

### NOTE:

Benefits for Voluntary Life Insurance are described in a separate policy. Please see Your Employer for further information regarding the Voluntary Life Insurance Benefit.

MAXIMUM BENEFITS FOR DEPENDENT INSURANCE

**Classes I – XII:**

Class(es)	Dependent Spouse	Dependent Child	
		Age	Benefit Amount
I - XII	\$1,000	From birth to 6 months	\$100
		6 months and over	\$1,000

**CHANGES IN THE DEPENDENT LIFE AMOUNT**

A change in the amount of Dependent Life Insurance because of:

1. an amount change within your class; or
2. your change from one class to another; will become effective on the date your amount changes.

No Dependent Life Insurance amount may be more than 50% of your insurance. Therefore, Dependent Life Insurance amounts will be adjusted for any reductions in your coverage.

**DEPENDENT LIFE INSURANCE for Class XIII:**

Class(es)	Dependent Spouse	Dependent Child	
		Age	Benefit Amount
XIII	\$1,000	From birth to 6 months	\$100
		6 months and over	\$1,000

**Proof of good health**, satisfactory to the Company and without expense to the Company, must be provided on any amount of Dependent Life Insurance.

TCLASB40003

## LIFE BENEFIT

A Life Benefit will be paid in the event You die while covered by this Benefit. The amount of coverage is shown on the Schedule of Benefits by Insurance Class. Your Life Benefit reduces with advancing age, as shown on the Schedule of Benefits.

TCXXLI40500

### INSTALLMENT SETTLEMENT OPTION

The Life Benefit is usually paid in one sum. All or part of any such benefit may, instead, be paid to the beneficiary in equal monthly payments. You must make a written request for this option. Payments may not extend for more than a 10 year period. If the monthly payment will be less than \$25, this option may not be used.

The first payment is due upon Your death. Each payment shall include interest of at least 3.5% per year compound interest on the unpaid balance. The Table of Monthly Payments is based on such interest rate. Additional interest may be authorized by Our Board of Directors. Any additional interest will be paid to the beneficiary. Any monthly payments unpaid at the death of the beneficiary will be discounted at 3.5% per year compound interest and paid in a single sum. This sum will be paid to the estate of the beneficiary, unless You specify otherwise.

We may agree to any other settlement option requested during Your lifetime. If no option is in effect at Your death, We may agree upon a settlement option with the beneficiary. The option must be one that would have been available to You at the time of death.

<b>Number of Years</b>	<b>Monthly Installments Per \$1,000 Payable Under this Option</b>
1	\$ 84.65
2	\$ 43.05
3	\$ 29.19
4	\$ 22.27
5	\$ 18.12
6	\$ 15.35
7	\$ 13.38
8	\$ 11.70
9	\$ 10.75
10	\$ 9.83

TCXXLI41000

## **PARTICIPATION AND DIVIDENDS (if applicable)**

Our Board of Directors shall declare annually what portion of any divisible surplus accrues upon this Life Benefit as a dividend. Any dividends will be credited on the succeeding Policy Anniversary if such coverage remains in force. Policyholder may choose to have dividends:

- paid in cash; or
- applied toward premiums.

If no option is chosen at least 30 days before the date a dividend is to be credited, the dividend will be paid in cash. Any dividend paid or applied toward premium shall fully discharge Our liability for such dividend. A dividend paid or applied on a Policyholder's anniversary may exceed the Policyholder's cost for this coverage during the prior year. Policyholder shall apply any such excess for the benefit of the Covered Persons.

TCLALI41500

## **ABSOLUTE ASSIGNMENT OF LIFE BENEFITS**

You may make an absolute assignment of all benefits and rights under Your life coverage. Consent of any revocable beneficiary is not required. You must file such assignment with Us on an approved form. We will furnish an acknowledgement for Your records. Such assignment takes effect when signed by You. You need not be living when We record the assignment. We shall not be held liable for any payment or other action taken by Us before We record the assignment. We will not be responsible for deciding if any assignment is valid or sufficient. An assignment, when filed, shall affect the Claim Payment Provisions as they apply to Life Benefits as follows:

- the Life Benefits provision will be void. If no beneficiary designated by the assignee is living at Your death, benefits will be payable to the assignee, if living. Otherwise, benefits will be payable to the estate of the assignee; and
- only the assignee shall have the right to name or change the beneficiary. All beneficiary designations made by You prior to the date of the assignment will be void.

An assignment, when filed, shall affect the Life Benefit as follows:

- under the Life Benefit Conversion Privilege provision in the Coverage After Termination, only the assignee will have the right to request conversion for You; and
- under the Installment Settlement Option provision, only the assignee shall have the right to elect a settlement option. Any such option elected prior to the date of assignment, or specified in the plan of coverage, will be void.

An assignment shall not affect any Dependent Life coverage.

The rights of the assignee shall accrue to, and his obligations shall be binding on, his heirs, assigns, executors and administrators.

TCXXLI42500

## ACCELERATED LIFE BENEFIT

If it is determined that You have a life expectancy of 6 months or less, a portion of Your Life Benefit may be received in advance of Your death.

Your Physician must state in writing that You have a life expectancy of 6 months or less. The prognosis must be confirmed by a Physician appointed by Us.

The amount available will be 25% of Your Life Benefit up to a maximum of \$35,000. You and any assignee or irrevocable beneficiary must give prior written approval of the accelerated benefit payment. The Life Benefit otherwise payable at the time of Your death will be reduced by the amount paid in advance.

The following is an example of payment of an Accelerated Life Benefit and the effect of the payment on the remaining amount of Life Insurance:

\$10,000	Original Life Benefit amount;
\$ 2,500	The Accelerated Life Benefit (25% of the original Life Benefit);
\$ 7,500	The amount of Life Insurance remaining after payment of the Accelerated Life Benefit. This is the amount of Life Insurance that will be paid to the beneficiary upon Your death provided coverage under this Certificate remains in effect.

The receipt of the Accelerated Life Benefit may be taxable. Assistance should be sought from a personal tax advisor.

Premium for Life coverage shall remain payable until the date of death as if an Accelerated Life Benefit had not been paid, unless waived under the Life Benefit Waiver of Premium provision.

TCXXLI43000

## **DEPENDENT LIFE BENEFIT**

### **BENEFIT**

A Life Benefit will be paid in the event a Dependent dies while covered by the Dependent Life Benefit. A Dependent may be covered by the benefit only while You are covered by the Life Benefit of this Certificate. The amount of coverage is shown on the Schedule of Benefits by Insurance Class.

### **ASSIGNABILITY**

A Dependent's Life coverage and benefits are not assignable.  
TCXXDL40500

## CONDITIONS OF INSURANCE

### DEFINITIONS

**Actively at Work (Active Work):** Performing services for Policyholder, at the location at which such services are normally performed, for 30 or more hours per week earning W-2 wages from the Policyholder which are the equivalent of at least the Federal Minimum Wage. Except that an employee whose full time occupation normally requires less than 30 hours per week shall also be considered a full time employee. In no event shall any person appointed on a temporary basis be considered a full time employee.

TCLACI00100/CPSB

**Contributory Coverage:** Coverage for which You pay premium.

**Covered Person:** An Eligible Person or a Dependent whose coverage herein has become effective.

TCXXCI00500

**Dependent:** A person qualifies as a Dependent if he is Your:

- spouse;
- child under 21 years of age;
- unmarried grandchildren under 21 years of age who are in the legal custody of and residing with the grandparent;
- child from his 21st birthday to his 24th birthday if he is a full time student at an accredited educational institution\*;
- child who, because of a handicap condition that occurred before the attainment of the limiting age, is incapable of self-sustaining employment and is dependent on his parents or other care providers for lifetime care and supervision. All other requirements for Dependents must be met. We will require proof of incapacity and dependency. Such proof may be given at any time within 31 days after the date the limiting age is reached, and will not be required earlier than 60 days before the limiting age is reached. We may also request proof of continuing incapacity and dependency, but no more than once each Year after initial proof is given. If proof is not given within 60 days of a request, coverage for the Dependent will end 60 days after the request was made.

\* **NOTE:** Educational institution includes college, university, vocational or technical school or secondary school.

The term child refers to Your unmarried:

- natural child;
- step-child who resides in Your home for more than 6 months in a Year;
- adopted child, including a child being adopted by You, from the earlier of the date the child is placed with You, or the time You are legally and partially or totally financially responsible for the child, if earlier; and
- child pursuant to a court issued qualified medical child support order;
- grandchild who is in your legal custody and residing with you; and
- any other children for whom the Employee has legal custody, who live in the household of the Employee, and who are or will be included as a Dependent on Employee's federal income tax return for the current or next tax year (if filing is required).

Dependent does not include:

- a foster child;
- a child or spouse who permanently resides outside of the United States of America; or
- any person eligible for coverage as an Eligible Person.

TCLACI00701

**Eligible Earnings:** The Eligible Person's regular salary or wages as last reported in writing by the Policyholder. Overtime, bonuses, commissions and other special pay are excluded from the calculation of Eligible Earnings.

TCLACI00850

**Eligible Person:** means a full-time Employee as defined by a Participant Employer in accordance with state law. No person appointed on a temporary appointment will be considered an Employee.

A person who permanently resides outside of the United States for more than 90 days per calendar year is not considered an Eligible Person.

TCXXCI00901/CSPB

**Eligible Retired Person:** means an employee who was a Covered Employee, as defined by the terms of this certificate, immediately prior to the date of retirement and who, upon retirement;

- a. immediately received retirement benefits from an approved state or state governmental agency defined benefit plan; or
- b. was not eligible for participation in such a plan or had legally opted to not participate in such a plan, and;
  - (1) was employed prior to September 16, 1979, has 10 years of continuous state service and has reached the age of 65; or
  - (2) was employed after September 16, 1979, has 10 years of continuous state service and has reached the age of 70; or
  - (3) was employed after July 8, 1992, has ten years of continuous state service, had a credit for at least forty quarters in the Social Security system at the time of employment, and has reached the age of 65; or
  - (4) maintained continuous coverage with the Program as an eligible Dependent until such time as he/she became eligible as a former state employee to receive a retirement benefit from an approved state governmental agency defined benefit plan, or
- c. immediately received retirement benefits from a state-approved or state governmental agency-approved defined contribution plan and has accumulated the total number of years of creditable service which would have entitled him to receive a retirement allowance from the defined benefit plan of the retirement system for which the employee would have otherwise been eligible. The appropriate state governmental agency or retirement system responsible for administration of the defined contribution plan shall be responsible for certification of eligibility hereunder to the State Employees Group Benefits Program.
- d. An employee retired from one Participant Employer may be covered as an active employee of another Participant Employer or as a Retiree of the Agency from which he retired, but not both. In order to retain eligibility, upon termination of employment from the later Participant Employer, such employee shall return to the retirement group of his original Participant Employer within 30 days. In no event shall any person at any time be covered by more than one Participant Employer.

TCXXCI01101/CPSB

**Eligibility Period:** Specified period of Active Work for Policyholder which an Employee must complete before becoming eligible for coverage. The length of the Eligibility Period is chosen by Policyholder and may differ for each benefit section or Insurance Class. Refer to the Effective Date of Individual Coverage section to determine the date Your Insurance will start.

TCLACI01302

**Evidence of Insurability:** Medical evidence, satisfactory to Us, that the person is insurable.

TCXXCI01500

**Health Factors:** Any of the following health-status related factors:

- health status;
- medical condition;
- receipt of health care;
- disability.

**Injury:** Nonoccupational accidental damage to the body which causes a covered loss while the person is covered herein. Such damage must be the direct cause of the loss, independent of disease, bodily infirmity or other cause. A chewing Injury is not considered to be an accidental Injury.

TCLACI01700

**Insured:** An Eligible Person whose coverage herein has become effective.

TCXXCI01900

**Late Enrollee:** An Eligible Person or Dependent who requests coverage more than 30 days after the date the person was first eligible to enroll.

TCLACI02102

**Leave of Absence:** Any absence from Active Work granted by Policyholder. Leave of Absence does not include a medical leave.

TCLACI02300

**Newborn Child:** Infants from the time of birth until the later of age one month, or until such time as the infant is well enough to be discharged from a Hospital or neonatal special care unit to his home.

**Noncontributory Coverage:** Coverage for which You pay no premium.

TCLACI02700

**Nonoccupational:** Not resulting from a person's particular work or occupation.

TCXXCI02900

**Participant/Covered Person:** Any Employee or former Employee of a Member Employer who is or may become eligible to receive a benefit of any type from an Employee benefit plan which covers Employees of such Employer or members or whose beneficiaries may be eligible to receive any such benefit.

**Physician:** A duly licensed Physician or surgeon who is acting within the scope of his license. Physician also means the following practitioners: podiatrist, optometrist, psychologist, dentist, and chiropractor, providing such practitioner is acting within the scope of his license.

TCLACI03300

**Sickness:** Nonoccupational illness or disease or Complications of Pregnancy which causes a covered loss while the person is covered herein; and congenital defects, birth abnormalities and prematurity of a covered newborn child.

TCXXCI03700

**Sick Leave Day(s):** means any day for which the Employer continues your salary, either in whole or in part, on account of your injury or sickness and You are deemed to be an active full-time Employee.

**Temporary Employee:** means an appointment to any position for a period of 120 consecutive calendar days or less

**Year:** The period from January 1st through December 31st of the same calendar Year.

TCXXCI03900/CPSB

**Waiting Period:** The period that must pass with respect to the individual before the individual is eligible to be covered under the terms of the plan.

**You, Your:** An Eligible Person or an Eligible Retired Person whose coverage herein has become effective.  
TCLACI04100

**Note:** All masculine pronouns in the Policy also include the feminine.  
TCXXCI04300

## **ELIGIBILITY**

For purposes of this section, Participant Employer or Participating Employer means a school board or a state political subdivision authorized by state law to participate in the State Employees Group Benefit Program pursuant to Act 1044.

To be eligible for Personal Insurance, a person must be employed full time by the Policyholder. Only eligible persons within a class shown on the Schedule of Benefits will be covered.

### **1. Effective Dates of Coverage**

Each employee who makes a written request to his Participant Employer for Employee Coverage by completing the applicable enrollment forms, and agrees to make the required payroll contributions to his Participant Employer is to be effective for Employee Coverage on the first day of the month coinciding with, or next following the completion of one calendar month's service, provided, however, that no Employee Coverage shall in any event become effective unless the employee makes such request within 30 days after date of employment. Any such request for coverage after 30 days of employment will be subject to Proof of Good Health for Life Insurance.

An employee's (or eligible dependent's) coverage will become effective on the first day of the month following the date of receipt by the company of all required forms, if such forms are received by the company prior to the 15th of the month, or the first day of the second month following the date of the receipt by the company of all required forms, if such forms are received by the company on or after the 15th of the month, provided the employee (or dependent) is actively at work. **IN NO EVENT MAY A PERSON BE ENROLLED SIMULTANEOUSLY AS AN EMPLOYEE AND AS A DEPENDENT UNDER THE PLAN, NOR MAY A DEPENDENT BE COVERED BY MORE THAN ONE EMPLOYEE.** If a covered spouse chooses at a later date to be covered separately, and is eligible for coverage as an Employee, that person will be a covered Employee effective the first day of the month after such election. In no event shall this change in coverage increase benefits, as set forth in the Schedule of Benefits, to the employee or dependent.

If you are a Special Enrollee you become eligible for insurance on the date following termination or expiration of other insurance; or on the date of marriage, birth of your child, your adoption of a child, or the date of a child's placement for adoption with you.

### **2. Employee Deferral Rule**

In any instance in which an employee is confined at home, in a hospital, nursing home, or elsewhere, by reason of disease, illness, accident, or injury on the date the employee would otherwise become covered under this Policy, the effective date of the employee's coverage under this policy shall be deferred until the date such employee returns to active work for one full day at his customary duties and place of employment. This provision does not apply to Health Insurance.

Notwithstanding any provisions of the preceding paragraph to the contrary, the return to active work requirement shall not serve to defer an employee's effective date of coverage in the event that the individual's normal place of employment is not open on the day he would

otherwise have returned to work. If an employee is on an approved leave of absence on the day he would normally have returned to work, coverage will become effective on the day he would normally have returned to active work.

### 3. Re-enrollment, Previous Employment

An application for coverage by an employee of a participating employer whose employment is terminated while covered or eligible for coverage under the Policy and who is re-employed by the same or another participating employer within 12 months of the effective date of termination shall be considered a re-enrollment, previous employment application. A re-enrollment, previous employment applicant will be eligible for only that classification of coverage in force on the effective date of termination, subject to all modifications of eligible expenses, benefits, and/or premiums which became effective in the interim.

## Special Enrollment

If You are declining enrolment for Yourself, or Your Dependents (including Your spouse) because of other Health Insurance Coverage, You may, in the future, be able to enroll Yourself or Your Dependents in this plan, provided that You request enrollment within 30 days after Your other coverage ends. In addition, if You have a new Dependent as a result of:

1. marriage;
2. birth;
3. adoption; or
4. placement for adoption;

You may be able to enroll Yourself and Your Dependents, provided that You request enrollment within 30 days after the date of one of the events shown above.

## Retiree Coverage

### 1. Eligibility (Effective DECEMBER 9, 1993)

Each Retiree of a Participant Employer shall be eligible for retiree coverage under this policy.

Retiree means an employee who was a Covered Employee, as defined by the terms of this certificate, immediately prior to the date of retirement and who, upon retirement;

- a. immediately received retirement benefits from an approved state or state governmental agency defined benefit plan; or
- b. was not eligible for participation in such a plan or had legally opted to not participate in such a plan, and;
  - (1) was employed prior to September 16, 1979, has 10 years of continuous state service and has reached the age of 65; or
  - (2) was employed after September 16, 1979, has 10 years of continuous state service and has reached the age of 70; or
  - (3) was employed after July 8, 1992, has ten years of continuous state service, had a credit for at least forty quarters in the Social Security system at the time of employment, and has reached the age of 65; or
  - (4) maintained continuous coverage with the Program as an eligible Dependent until such time as he/she became eligible as a former state employee to receive a retirement benefit from an approved state governmental agency defined benefit plan, or
- c. immediately received retirement benefits from a state-approved or state governmental agency-approved defined contribution plan and has accumulated the total number of years of creditable service which would have entitled him to receive a retirement allowance from the defined benefit plan of the retirement system for which the employee would have otherwise been eligible. The appropriate state governmental agency or retirement system responsible for administration of the defined contribution plan shall be

responsible for certification of eligibility hereunder to the State Employees Group Benefits Program.

Retiree coverage will be effective on the first of the month following the date of retirement, provided the employee and employer have agreed to make and are making the required contributions. **RETIREEES SHALL NOT BE ELIGIBLE FOR COVERAGE AS LATE APPLICANTS.**

2. Active employment by a Participant Employer following retirement from a Participant Employer.

An employee retired from one Participant Employer may be covered as an active employee of another Participant Employer or as a Retiree of the Agency from which he retired, but not both. In order to retain eligibility, upon termination of employment from the later Participant Employer, such employee shall return to the retirement group of his original Participant Employer within 30 days. In no event shall any person at any time be covered by more than one Participant Employer.

TCXXCI42901/CPSB

#### **ENROLLMENT FOR COVERAGE**

An Eligible Person must apply for coverage, or a change in coverage, for himself and his Dependents, if any (except a decrease in amount due to a change in Insurance Class) within 30 days of the date he first becomes eligible. All applications must be made to Policyholder on a form approved by Us. Dependents may not become insured for Dependent coverage unless You are insured for employee coverage.

TCLACI41901

#### **EFFECTIVE DATE OF INDIVIDUAL COVERAGE AND ACTIVELY AT WORK REQUIREMENTS**

If an Eligible Person is not Actively at Work due to Health Factors, this paragraph does not apply to Comprehensive Medical or Dental coverage.

An Eligible Person must be Actively at Work for his coverage, any coverage on Dependents, or any increase in coverage, to become effective. If his Effective Date is a holiday or a day he is not scheduled to work, he shall be considered Actively at Work if he is not disabled on such day and was at work on his last scheduled work day. If, due to disability, Leave of Absence, temporary layoff, or by other arrangement he is not at work on his Effective Date, his coverage shall be delayed until the first day he is Actively at Work. An Eligible Person is considered Actively at Work, if he is absent from work in accordance with the Family Medical Leave Act of 1993.

#### **EFFECTIVE DATE OF INDIVIDUAL COVERAGE AND ACTIVELY AT WORK REQUIREMENTS FOR THE FIRST DAY OF WORK**

If due to Health Factors, Leave of Absence, temporary layoff, or by other arrangement, a person is not at work on his Effective Date, and has not been Actively at Work for the Policyholder prior to his Effective Date, his coverage shall be delayed until the first day he is Actively at Work.

TCLACI42101

If an Eligible Retiree is not Actively at Work due to Health Factors, this paragraph does not apply to Comprehensive Medical or Dental coverage. An Eligible Retired Person's change in benefits or increase in benefit amounts including changes to or addition of Dependent coverage will become effective on the date of such change in coverage, unless he is Hospital confined on that date. In such case, the change in coverage or increase in benefits will take effect on the day he is discharged from the Hospital.

TCLACI42500

Notwithstanding the above, a person's coverage shall become effective as follows:

- if he applies for coverage on or before the date he is eligible, his Effective Date shall be the first day of the month coinciding with or next following the date he becomes eligible;
- if he applies for coverage during the first 30 days after the date he is eligible, his Effective Date shall be the first day of the month coinciding with or next following the date he applies;
- if he applies for coverage more than 30 days after the date he is eligible, he is a Late Enrollee and must furnish Evidence of Insurability for Life Coverages. His Effective Date shall then be the first day of the month coinciding with or next following the date We accept the evidence as satisfactory.
- if he applies for coverage after prior termination due to unpaid premium or due to a prior request to terminate, he must furnish Evidence of Insurability. His Effective Date shall then be the first day of the month coinciding with or next following the date We accept the evidence as satisfactory.

TCXXCI42901

## **CHANGE IN INSURANCE CLASS**

Your Policyholder shall notify You when Your Insurance Class changes. If Your Insurance Class changes, You may be eligible for a different amount of coverage.

**For Noncontributory Coverage:** The new amount shall become effective on the first day of the month coinciding with or next following the date of the change in Insurance Class.

### **For Contributory Coverage:**

- any decrease in coverage will become effective on the date of the change in Insurance Class.
- You must apply for any increase in coverage for which You become eligible. The increased amount will become effective on the date of such increase.

TCLACI43100

## **TERMINATION OF INDIVIDUAL COVERAGE**

Your coverage under a benefit section shall terminate at the earliest of the following:

- at the start of the period for which You do not pay, when due, any required contributory premium;
- at the end of the period for which premium has been paid for You;
- on the date You become a member of any military, naval or air force on active duty;
- on the date any continuation of coverage ends;
- on the date Your Policyholder terminates coverage under a Benefit Section;
- on the date the Policy terminates;
- at the end of the month in which You are no longer in an Insurance Class shown on the Schedule of Benefits;
- on the date coverage is terminated for Your Insurance Class;
- at the end of the month in which Your Active Work terminates. This provision does not apply to an Eligible Retired Person.

Dependent's coverage under a benefit section shall terminate at the earliest of the following:

- at the start of the period for which You do not pay, when due, any required contributory premium for the coverage;
- at the end of the period for which premium has been paid for the Dependent;
- on the date the Dependent becomes a member of any military, naval or air force on active duty;
- at the end of the month in which status as a Dependent ends;
- on the date Dependent's coverage terminates for the Insurance Class of the Dependent;
- on the date Your Policyholder terminates coverage under a Benefit Section;
- on the date the Policy terminates.

**Louisiana Health Insurance Association**  
**Upon losing group coverage, contact the Louisiana Health Insurance Association.**

TCLACI43302

## **RESUMPTION OF INDIVIDUAL COVERAGE**

If Your coverage has terminated due to Leave of Absence or temporary layoff of not more than 3 months, You may resume coverage on the first day of the month coinciding with or next following the date You are again Actively at Work. Two additional conditions must also be met. You must otherwise be eligible for coverage and Your premium must be paid. If You are not at work, or are Disabled, on the date coverage would resume, the resumption of coverage will be delayed as provided in the Effective Date of Individual Coverage. If a Dependent is confined in a Hospital or unable to do his normal activities on the date coverage would resume, the resumption of his coverage will also be so delayed.

If You start Active Work after Leave of Absence or layoff of more than 3 months, You must apply in writing for coverage. You must also complete the Eligibility Period, if any. Coverage shall become effective as provided in the provision titled Effective Date of Individual Coverage.

TCXXCI43701

## **CONTINUATION OF COVERAGE**

### **LIFE BENEFIT WAIVER OF PREMIUM**

If You are disabled, Your Life Coverage may be continued as follows:

For the purposes of this provision, You are disabled if: due to Sickness or Injury, You are continuously unable to do any work for which You are, or become, qualified by reason of education, training or experience. Disability will not exist if You are doing any work for wage or profit. Disability must begin:

- before age 60;
- before retirement; and
- while You are covered by the Life Benefit.

Your premium will be waived for the period during which coverage is continued for disability, as shown below.

If You incur disability and are eligible for coverage on the date of the disability, Your Life Coverage will continue for up to 1 year under the Standard Continuation provision. If You die during that year, We will pay the Life Benefit upon receipt of due proof of such disability and death.

If You incur disability which is expected to continue for longer than 1 year, Your Life Coverage will continue, provided You complete a waiver of premium claim form, You are eligible for coverage and proof of permanent disability is furnished to Us after 9 months and before 1 year after the date disability begins. Upon acceptance of such proof by Us, coverage will be extended for another year. Additional 1 year extensions of coverage will be made if You furnish Us, annually, proof of continuance of disability. Such proof must be furnished within 3 months before the end of each 1-year extension. The waiver of premium will end if any proof is not furnished within such time durations. If You die during continuation due to disability, We will pay the Life Benefit upon receipt of due proof of death.

Once proof of permanent disability is furnished, as stated above, and waiver of premium is approved, the waiver of premium is effective the date permanent disability was Incurred.

Written proof of death during disability must be given within 1 year after death. Otherwise, We will not be liable for the Benefit.

The amount which will be payable as a Life Benefit during disability is the lesser of:

- the amount in force for You on Your last day of Active Work; or
- the amount that would be in force for You on the date of death were You not disabled; or
- when You reach the age for normal retirement, the amount available on retirement, if any.

Your waiver of premium ends at the earliest of the following:

- Your disability ends;
- You do not take a medical examination required by Us;
- You fail to furnish proof of continuing disability;
- You reach age 70 or the limiting age on the Schedule of Benefits, if earlier; or
- You retire, if no Benefits are provided for retirees, or any other date Your coverage would end if You were not disabled.

We have the right, at Our own expense, to require You to be examined by a Physician of Our choice while premium is being waived. This may be required at reasonable intervals. After coverage has been extended for 2 years, We will not require examinations more than once a year.

If You return to Active Work for Policyholder, Your waiver of premium ends, and Your regular coverage under this Life Benefit resumes. If Your disability ends and You do not return to such work, You are entitled to Your rights under the Life Conversion Privilege.

TCXXCI44301

## **DEPENDENT LIFE WAIVER OF PREMIUM**

Premiums will be waived for Dependent Life Benefit if the premium for Your Life Benefit is being waived. Any waiver under the Dependent Life Benefit:

- applies only to those Dependents covered at the time Your waiver starts;
- applies only to those Dependents who continue to be eligible for this Dependents Life Benefit; and
- is in effect only while Policyholder's coverage under this benefit section is in force.

TCLACI44500

## **FAMILY AND MEDICAL LEAVE ACT CONTINUATION**

This provision applies if Your Policyholder is subject to the provisions of the Family and Medical Leave Act of 1993, as amended.

If You are on Leave of Absence from work with Policyholder under the FMLA, coverage may be continued as if You were Active at Work.

FMLA Continuation will end on the earliest of:

- the end of any 12 weeks which occur within 12 months of the date Your FMLA absence began;
- the end of the period for which premium is paid;
- the date Policyholder terminates coverage with Us for any reason; or
- the date the Policy terminates.

TCLACI44700

## **STANDARD CONTINUATION**

Your Policyholder may, at his option, choose to continue Life coverage for You and Your Dependents, if Your Active Work has ended due to:

- change to part-time status;
- approved Leave of Absence;
- temporary layoff; or
- Disability leave.

Your Policyholder must:

- act without individual selection between Covered Persons; and
- continue making premium payments for those Covered Persons.

The amount of Life coverage that may be continued shall be the lesser of:

- the amount in force on Your last day of Active Work;
- the amount that would be in force if You were Actively at Work;
- when You reach normal retirement age, the amount available on retirement, if any.

Standard Continuation will end on the earliest of:

- the end of the period for which premium is paid;
- the end of a 12 month period which began on the date Your Active Work terminated, except if the Covered Person has not exhausted all accumulated Sick Leave Days. If the Covered Person has such Sick Days available, coverage will continue until the Policyholder reports to Us that the Covered Person has exhausted all accumulated Sick Leave Days. During such continuation, the Covered Person shall be entitled to all benefits, rights, and privileges available to his Insurance Class, subject to all applicable terms and conditions of this Policy.
- as to any Dependent, the end of the month in which the Dependent ceases to qualify as a Dependent;
- the date Policyholder terminates coverage with Us for any reason; or
- the date the Policy terminates.

TCLACI45100

## LIFE CONVERSION PRIVILEGE

Your Life Benefit may be converted to an individual life insurance policy if coverage ends because:

- Your employment terminates;
- Your waiver of premium under the Life Benefit waiver of premium provision ends; or
- any continuation of coverage ends and You do not return to Active Work for Policyholder.

Under the circumstances cited above, the individual policy will provide a benefit equal to that provided for You under the Life Benefit on the date Your coverage ended. Premiums received for Continuation of Coverage when Your Active Work terminated due to disability leave will only be refunded when the Life Benefit Waiver of Premium is approved.

If You have had continuous coverage under the Life Benefit section, and any it replaces, for at least 5 Years, conversion may also be made if:

- Your Insurance Class terminates; or
- Your Policyholder terminates Life coverage with Us.

Under these circumstances the individual policy benefit will be the lesser of:

- \$2,000; or
- the amount in force for You at termination reduced by any amount for which You become eligible, within 31 days after termination, under any group Life coverage issued by Us or any other insurer.

Conversion may also be made if Your coverage reduces due to a change in Insurance Class or attainment of a specified age. The individual policy will not provide a benefit greater than the amount of the reduction.

You will be given notice of the right to convert at least 15 days before the end of the 31 day period allowed for conversion. If such notice is not given within the time required, You shall have an additional period of time to apply for conversion. This extra period of time will be 15 days after notice is given, but not longer than 60 days after the 31 days otherwise allowed for conversion.

The individual policy will be issued as follows:

- it will be any form of life insurance policy, except term insurance or a policy with Disability benefits, We then have available for conversion;
- Evidence of Insurability will not be required;
- the premium for the individual policy will be based on Your age at the time of conversion, and the form and amount of coverage provided;
- the individual policy will take effect at the end of the 31 day period for conversion;
- the individual policy shall be in place of all coverage under the Life Benefit Section.

You must take the following steps to convert:

- make written application to Us at Our Home Office within 31 days after the date coverage under the Life Benefit section ends;
- pay, within such 31 days, the first premium for the individual policy.

You have coverage during the 31 day period for conversion. The amount of such coverage is the amount that can be converted. This amount will be paid as a Life Benefit if You die during this 31 day period less the premium that would have been due. Application for conversion need not have been made.

TCLACI45701

## **DEPENDENT LIFE CONVERSION PRIVILEGE**

Conversion to an individual life insurance policy may be made for a Dependent covered by the Dependent Life Benefit if:

- Your employment terminates;
- the person is no longer a Dependent as defined above; or
- You die while coverage is in force for the Dependent.

Under the circumstances cited above, the individual policy will not provide a benefit greater than that provided for the Dependent under the Dependent Life Benefit on the date such coverage ended.

If Your Dependent has had continuous coverage under the Dependents Life Benefit, and any it replaces, for at least 5 Years, conversion may also be made if:

- the Insurance Class of the Dependent terminates; or
- Your Policyholder terminates Life coverage with Us.

Under these circumstances the individual policy will be the lesser of:

- \$2,000; or
- the amount in force for the Dependent at termination reduced by any amount for which he becomes eligible, within 31 days after termination, under any group Life coverage issued by Us or any other insurer.

Conversion may also be made if a Dependent's coverage reduces due to a change in Insurance Class. The individual policy will not provide a benefit greater than the amount of the reduction.

The new policy will be issued as follows:

- it will be any type of life insurance policy, except term insurance or a policy with Disability benefits, We then have available for conversion;
- Evidence of Insurability will not be required;
- the premium for the individual policy will be based on the age of the Dependent at the time of conversion, and the form and amount of coverage provided;
- the individual policy will take effect at the end of the 31 day period for conversion; and
- the individual policy shall be in place of all coverage under the Dependent Life Benefit section.

You or Your Dependent must take the following steps to convert:

- make written application to Us at Our Home Office within 31 days after the date coverage under the Dependent Life Benefit Section ends; and
- pay, within such 31 days, the first premium for the individual policy.

A Dependent has coverage during the 31 day period for conversion. The amount of such coverage is the amount that can be converted. This amount will be paid as a Dependent Life Benefit if the Dependent dies during this 31 day period less the premium that would have been due. Application for conversion need not have been made.

TCLACI45901

## **CLAIM PAYMENT PROVISIONS**

### **CLAIM PAYMENT**

When we receive proof of your death, we will pay your surviving beneficiary(ies) the applicable amount shown in the Schedule of Benefits, less any Accelerated Benefit Amount you receive.

On receiving written proof that your Insured Dependent has died, we will pay the Life Insurance to you.

When you have named more than one beneficiary without stating amounts or order of payment, benefits will be equally divided. The share of any beneficiary who has died before you will go equally to the surviving beneficiary(ies).

If there is no named beneficiary at the time of your death, benefits will be paid equally to the members of the first surviving Class as follows:

1. your spouse;
2. your children;
3. your parents;
4. your brothers and sisters; otherwise
5. to your estate.

We may pay up to \$250 of the benefits to anyone who pays for expenses of your final illness or burial.

When no beneficiary has been named, any payment we have made in good faith under these sections will discharge our liability to the extent of the payment.

### **WAIVER OF PREMIUM BENEFITS**

#### **Notice of Claim**

Benefits will be considered when We receive due proof of disability. Written notice of claim should be given to Us after 9 months and before 1 Year after the date of disability begins. Failure to give notice within such time shall not invalidate or reduce any claim if it shall be shown not to have been reasonably possible to give such notice and that notice was provided as soon as was reasonably possible.

The claim form is available from Your Policyholder, 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.

Because provisions governing Waiver of Premium are different, it is not sufficient that You have filed a medical, disability or other claim under other coverage of the plan. You must notify Us immediately when You return to work in any capacity.

### **CHANGE OF BENEFICIARY**

If you have not assigned the right to do so, you may file a written change of beneficiary at any time. When recorded, the change will take effect as of the date it is signed, provided we receive it before benefits have been paid. The beneficiary records may be kept by us, the Policyholder or by a plan administrator.

## **METHOD OF PAYMENT**

A claim will be paid in one sum unless some other method of payment has been requested in writing and we have approved it.

### **Beneficiary Designation - Prior Group Insurers**

This provision applies if this Certificate replaces coverage of another insurer. We may, at the request of Policyholder, recognize beneficiaries in effect under such prior coverage as effective until a new designation is made.

### **Change of Beneficiary**

You may change the beneficiary at any time. The consent of the beneficiary is not required. Notice must be given to Us in writing on a form approved by Us. The new beneficiary designation will take effect on the date the notice is signed by You. We are discharged of Our liability to the extent of any payment made by Us before notice of the change is received at Our Home Office.

TCLACP41002

### **Payment Error**

Any benefit paid in error may be recovered from the person receiving the incorrect payment or from You. At Our option, We may offset the overpayment against future benefit payments. The acceptance of premium or paying other benefits shall not constitute a waiver of Our rights under this section. Recovery or offset shall be in addition to any other remedy available to Us at law or in equity.

TCLACP41502

### **Fraudulent Claim Submission**

If any Covered Person knowingly submits or participates in the submission of a claim for benefits which contains false or misleading information that would have the effect of increasing the benefit payable, We shall have the right to revoke that person's coverage to the date the fraud was perpetrated. Such rescission is without prejudice to any other right or remedy which might be available to Us at law or in equity.

### **Facility of Payment**

If benefits are payable to Your estate, We can pay up to \$1,000 of benefits to someone related to You by blood or marriage whom We deem to be entitled to the Benefits. If You, while living, are physically, mentally, or otherwise incapable of giving a valid release for any payment, We can pay up to \$1,000 of benefits to someone related to You by blood or marriage, or to any person or institution which has assumed financial responsibility for Your affairs.

TCXXCP42001

## **GENERAL PROVISIONS**

### **INCONTESTABILITY/TIME LIMIT ON CERTAIN DEFENSES**

All statements made by Policyholder or by a Covered Person are representations and not warranties. No such statement shall be used to contest the validity of coverage or reduce benefits unless it is in writing, signed by Policyholder or by the Covered Person. A copy of such statement, if contested, will be furnished to Policyholder, or the Covered Person or his beneficiary, whichever applies.

After coverage has been in force during a person's lifetime for two years from his effective date:

- any Life coverage for such person will be incontestable except as related to eligibility or nonpayment of contributory premium.

Any increase in coverage or reinstatement of coverage, as requested by application from the Covered Person, shall begin a new two year contestable period for the amount of the increase or reinstated coverage from the effective date of such coverage.

### **Entire Contract**

No agreement in conflict with, modifying, or extending the coverage of this Policy is valid unless it is in writing and physically made a part of the Policy or it is incorporated in the Policy by specific reference.

Any written agreement in conflict with, modifying, or extending the coverage of this Policy insurance will be deemed to be physically made a part of the Policy whenever such written agreement makes reference to the Policy and is sent to the Policyholder by United States mail, postage prepaid, at the Policyholder's last known address or is personally delivered to the Policyholder.

### **Expenses After Termination**

Except as otherwise stated in the Certificate, the Company is not liable for expenses for losses occurring subsequent to termination of coverage due to the Member Employee's failure to pay required premium, or for termination of coverage due to a change in Your eligibility for coverage.

TCLAGP40503

### **RECORDS, PHYSICAL EXAMINATIONS, AND AUTOPSY**

With written authorization, We may obtain a Covered Person's medical records. While a claim is pending, We have the right to have a Covered Person examined. The exam will be at Our expense and as often as reasonably necessary. We may also have an autopsy performed where allowed by law.

We have the right to require the Covered Person to provide Us information in addition to the proof of loss to determine benefits payable. Any cost associated with providing this information is the responsibility of the Covered Person.

### **LEGAL ACTION**

No legal action may be brought to recover on this Certificate within 60 days after written proof of loss has been given as required herein. No such action may be brought after 3 years from the time written proof is required to be given.

### **CONFORMITY WITH STATE STATUTES**

Any provision of this Policy which, on the date of issue, is in conflict with the statutes of the state in which the insured resides at the date of issue is understood to be amended to conform to such statutes.

### **STATE SERVICE CHARGE**

Service charges assessed pursuant to Louisiana law R.S. 22:239 as amended will always be covered in full. Such service charges are not payable to the Covered Person, and do not affect any Deductible, Copayment, Insured Percent, or Out-of-Pocket Maximum provisions of this coverage.

## **CLERICAL ERROR**

If a Clerical Error is made so that an otherwise Eligible Person's coverage does not become effective, coverage may be in effect if:

- the error is reported to Us within 60 days of the date the person's coverage would otherwise be effective;
- the person makes a written request for coverage on a form We approve; and
- any premium not paid because of the error is paid in full from the effective date of coverage.

If the error is reported to Us more than 60 days after the date the person's coverage would otherwise be effective:

- he must furnish evidence satisfactory to Us that he is insurable; and
- coverage shall become effective as provided in the provision Effective Date of Individual Coverage.

Clerical Error shall not prohibit Us from voiding coverage of a person not eligible. This includes errors in enrolling, recording or reporting for coverage purposes. Refund of premium paid for a non-Eligible Person will be limited to the premium paid for the 60 days immediately prior to the date the error is reported to Us. Interest will not be paid on returned premium. Policyholder shall reimburse Us for any claim overpayment made as a result of a Clerical Error. Any premium refund or credit due may, at Our option, be reduced by any payment made for claims.

TCLAGP41003

## MEDICAL NECESSITY AND APPEALS

We have developed a process to review your health services to determine whether the services are or were Medically Necessary. This review process is called Medical Necessity Determination. We will perform Medical Necessity Determinations as required by law. Medical Necessity Determination includes all review activities, whether they take place prior to the service being rendered (prospective), when the service is being rendered (concurrent) or after the service is rendered (retrospective).

### Prospective Review

Services described in the Pre-Certification provisions require our prior approval **before you receive treatment or service**. You or the attending Physician must call the telephone number for Pre-Certification shown on Your identification card. When these services are requested by You or Your provider they will be reviewed to determine if the service meets our guidelines.

- At the time of the request You will be notified of all documentation required to make a determination of Medical Necessity.
- If additional information is required You or the attending Physician will be notified by telephone, within one day of the date the need for additional information is determined.
- Decisions as to Medical Necessity will typically be made within 2 days of the receipt of all necessary information, and will never be made more than 30 days after receipt of the necessary information, unless You or the attending Physician has agreed to an extension.
- The attending Physician will be notified within one working day of the date the decision as to Medical Necessity has been made. The attending Physician will receive documented confirmation of the decision within two working days of the date the decision is made.
- If You are dissatisfied with the decision, Your provider may request a reconsideration of the decision. The reconsideration shall occur within one working day of the request, and will be conducted between the provider and Our Physician, or Our Physician designee.

### Concurrent Review

- Hospital and other ongoing services, such as home care services, are reviewed concurrently to determine if the admission or home care treatment plan continues to be Medically Necessary.
- At the time of the request You will be notified of all documentation required to make a determination of Medical Necessity.
- If additional information is required You or the attending Physician will be notified by telephone, within one day of the date the need for additional information is determined.
- Decisions as to Medical Necessity will typically be made within 2 days of the receipt of all necessary information, and will never be made more than 30 days after receipt of the necessary information, unless You or the attending Physician has agreed to an extension.
- If ongoing treatment or a continued Hospital stay is determined to be Medically Necessary the attending Physician will be notified within one working day of the date of the decision. A confirmation of the decision will be provided within two working days and will include the number of intended days or the next review date, and the total number of days or services approved.
- If ongoing treatment or a continued Hospital stay is determined as not being Medically Necessary the attending Physician will be notified within one working day of the date of the decision. A confirmation of the decision will be provided within two working days to the Provider and You.
- If we determine that the ongoing treatment or continued stay is no longer Medically Necessary, we will not pay for any further treatment or any further days of such care.
- If You are dissatisfied with the decision, Your provider may request a reconsideration of the decision. The reconsideration shall occur within one working day of the request, and will be conducted between the provider and Our Physician, or Our Physician designee.

## **Standard Appeal**

Standard Appeal is available in the event You disagree with a Medical Necessity decision made during a Prospective or Concurrent Review. In addition, all services are subject to retrospective review to determine if they were Medically Necessary. If a service is determined as not Medically Necessary, the claim for that service will be denied. If you receive a claim denial which is based on Medical Necessity, You may request a Standard Appeal.

If You feel You cannot appeal Yourself, you can designate a representative to do so. You or Your designated representative may file a formal appeal by telephone or in writing. Please refer to your identification card for our address and telephone numbers.

- At the time of the request, You will be notified of all documentation required to make a determination of Medical Necessity.
- If additional information is required, You or the attending Physician will be notified by telephone within one day of the date of the need for additional information is determined.
- Decisions as to Medical Necessity will typically be made within 30 days of the receipt of all necessary information, and will never be made more than 180 days after receipt of the necessary information.
- If the treatment or service is determined not to be Medically Necessary, You and the attending Physician will be notified within five working day of the date the decision.

## **Expedited Appeal Procedures**

When the time frame for a Standard Appeal process would seriously jeopardize your life, health, or ability to regain maximum function, You or Your attending Physician may file a request for expedited appeal. All information necessary for the Appeal may be transmitted by phone, facsimile, or another expeditious method. Your request for expedited appeal will be reviewed within 1 working day after receipt of the request. A decision on the request will be made as quickly as possible, and in no event will it be made more than 72 hours after the appeal begins. Written notification of the decision will be provided within two working days of the decision.

## **Second Level Review**

You have the right to a second level review of any Medical Necessity decision appeal. A second level appeal gives You the right to attend the Second Level Review proceeding; to present information to the Review Panel; to submit supporting material prior to and at the Second Level Review meeting; and to ask questions of any of Our representatives. The Second Level Review will be evaluated by a Physician not involved in the original determination.

Within 45 days of receiving a request for Second Level Review, We will schedule and hold a Second Level Review meeting. The meeting will be held during regular business hours at a location that is reasonably accessible to You. You will be notified of the time and place of the meeting at least 15 working days in advance. On Your request, We will provide all relevant information that is not confidential, privileged, or which We may not otherwise provide by law.

A written decision will be provided to You within 5 working days of the completion of the Second Level Review meeting.

## **External Review**

An External Appeal is an independent review of a Medical Necessity determination by a third party known as an Independent Review Organization. You may request an External Review if Your attending Physician concurs that it is appropriate. You may only request External Review if You have exhausted the Second Level Appeal process described above, unless:

- You have an emergency medical condition; or
- We agree to waive the requirements for Standard and Second Level appeals.

You may have the right to an Expedited External Appeal if your attending Physician attests that a delay in providing the requested service would pose an imminent or serious threat to Your health. The time frames for Expedited External Appeals are shorter than the time frames for External Appeals.

You may request an External Appeal only if the requested service is a covered service under this Certificate and only if the prior appeal decisions indicate that the requested service is not Medically Necessary.

In order to make a request for External Appeal You must do the following:

- Within 60 days after the date of receipt of a decision on a Second Level Review You must, with the concurrence of Your attending Physician, file a request for an External Review with Us;
- Within 7 days after the date of receiving Your request, We will provide the documents and any information used in making the Second Level Review decision to our Independent Review Organization;
- Within 30 days of receipt of this information, the Independent Review Organization will provide notice of its decision to You, Your attending Physician and to Us. A longer time frame may be agreed to by all parties.

### **Expedited External Review**

You may request an Expedited External Review if You have an emergency medical condition; or Your attending Physician attests that a delay in providing the requested service would pose an imminent or serious threat to Your health.

When an Expedited External Review is granted, all information will be provided to the Independent Review Organization by phone, facsimile, or other expeditious method. Within 72 hours of receiving the information, the Independent Review Organization will make a Medical Necessity Determination, and notify You, Your attending Physician, and US of the decision.

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**Summary of the Louisiana Life and Health  
Insurance Guaranty Association Law and  
Notice Concerning Coverage  
Limitations and Exclusions**

Residents of Louisiana who purchase life insurance, annuities, or health insurance should know that the insurance companies licensed in this state to write these types of insurance are required by law to be members of the Louisiana Life and Health Insurance Guaranty Association (LLHIGA). The purpose of LLHIGA is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this happens, LLHIGA will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. However, the valuable extra protection provided by these insurers through LLHIGA is limited. As noted in the disclaimer below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

**Disclaimer**

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

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

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

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

**LLHIGA**

P.O. Box 3337  
Baton Rouge, Louisiana 70821

**Department of Insurance**

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

The state law that provides for this safety-net coverage is called the Louisiana Life and Health Insurance Guaranty Association Law (the Law), and is set forth at R.S. 22:2081 *et seq.* The following is a brief summary of this Law's coverages, exclusions and limits. This summary does not cover all provisions of the Law; nor does it in any way change any person's rights or obligations under the Law or the rights or obligations of LLHIGA.

**COVERAGE**

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

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## **EXCLUSIONS FROM COVERAGE**

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

- (1) He is eligible for protection under the laws of another state (This may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state.);
- (2) The insurer was not authorized to do business in this state;
- (3) His policy was issued by a profit or nonprofit hospital or medical service organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, an insurance exchange, an organization that issues charitable gift annuities as is defined in R.S. 22:952(A)(3), or any entity similar to any of these.

LLHIGA also does not provide coverage for:

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

## **LIMITS ON AMOUNT OF COVERAGE**

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

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

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

*Effective Date: August 2018*

**Certificate Effective Date: 05/01/26**