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CERTIFICATE OF INSURANCE

Group Accident

Policyholder: GLEN ROSE SCHOOL DISTRICT

Class: 0001 - ALL FULL TIME ACTIVE EMPLOYEES WORKING 20 HOURS OR MORE

State of Residence: ARKANSAS

Effective Date: February 1, 2016

This is to certify that US Able Life has issued and delivered the Group Accident Insurance Policy to the Policyholder.

The Policy insures the Employees and their Dependents, if elected, of the Policyholder who:

1. are eligible for the insurance;
2. become insured; and
3. continue to be insured;

according to the terms of the Policy.

The terms of the Policy that affect Your insurance are contained in the following pages.

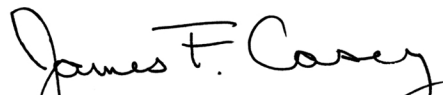
Important Note: Benefits are payable for on and off-the-job Accidental bodily Injuries that occur as the result of an Accident and where expenses are incurred. The Accident must occur while the Covered Person is Insured under the Policy, subject to the provisions of the Certificate.

The benefits for Dependents described in this Certificate will be applicable to each of Your Dependents if You have applied for Dependent coverage and only if You are insured under the Policy.

This Certificate of Insurance is a part of the Policy. This Certificate replaces any other Certificate that US Able Life may have issued to the Policyholder to give to You under the Group Insurance Policy specified herein.

Signed for US Able Life:


Secretary


President

Please read Your Certificate carefully.

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Schedule of Insurance

Policyholder: GLEN ROSE SCHOOL DISTRICT
Group Policy Number: 50010848
Policy Effective Date: February 1, 2016
 *This Certificate replaces any Certificate issued before the date shown.

Accident Type: On & Off-the-Job

Issue Age: Employee 16 through 64
 Spouse 16 through 64
 Child 15 days through 26 years

Beneficiary: As Named on the Employee application

Eligible Class: Class 0001 ALL FULL TIME ACTIVE EMPLOYEES WORKING 20 HOURS OR MORE

Waiting Period: You will be eligible for coverage on first of the policy month following completion of the following period of continuous Active Work:

1. If You are working for the Employer on the Policy Effective Date – 0 days
2. If You start working for the Employer after the Policy Effective Date – 30 days

Annual Enrollment Date: February 1 of each year

Full-time Employment: 20 hours weekly

Type of Coverage: Employee, Employee and Spouse, Single Parent, Family.

Premium Mode: Monthly

Benefits amounts available for eligible Employees shall be determined in accordance with the following schedule as elected on the Employee application:

Benefits	Number of Units		
	Basic	Select	Ultra
Module 1 – Accident Treatment	5 Units	6 Units	9 Units
Module 2 – Hospital Care	5 Units	6 Units	8 Units
Module 3 – Follow-Up Care	5 Units	7 Units	8 Units
Module 4 – Transportation Lodging	4 Units	6 Units	7 Units

Assistance

Module 5 – Surgery Benefits 5 Units 6 Units 8 Units

Module 6 – Wellness Benefit 4 Units 5 Units 7 Units

Accidental Only Hospital and ICU Daily Benefit Rider

Hospital Confinement 10 Units/\$250 10 Units/\$250 10Units/\$250

Hospital ICU 10 Units/\$500 10 Units/\$500 10 Units/\$500

Elimination Rider

If applicable, Elimination Rider was provided at time of enrollment.

Definitions

The terms listed, if used, will have these meanings.

Accident or Injury is an unforeseen occurrence which results in the Accidental Bodily Injury and occurs while this Certificate is in force and is not excluded in the Certificate.

Accidental Bodily Injury means an Injury or Injuries for which Necessary Treatment is received and benefits are provided. The Injury or Injuries must be sustained by a Covered Person and must be the direct cause of the loss, independent of disease or bodily infirmity. All such Injuries, with any complications and any recurrences of complications arising from any one Accident, will be deemed to be a single Injury. Such Injury or Injuries must occur while the Certificate is in force.

Active Work or Actively at Work means the expenditure of time and energy for the Policyholder or an Associated Company at Your usual place of business on a Full-time basis. If You are not working on a day Your coverage would otherwise take effect, You will be considered to be at Active Work on that day only if:

1. when that work day begins, it would be reasonable to expect that You would be physically and mentally able to complete a Full-time week of work in Your Regular Occupation; and
2. You are not disabled; and
3. Your contract of employment, if applicable, remains active; and
4. You are not on an unapproved, administrative or disciplinary leave; and
5. You return to work at the end of a paid break or vacation period.

Amendment, Endorsement, or Rider means a form issued by Us which adds, modifies, changes, or deletes any Policy or Certificate provisions or benefits.

Ambulatory Surgical Center means a place which:

1. is equipped for surgical procedures performed by qualified Physicians;
2. provides anesthesia administered by a licensed anesthesiologist or licensed nurse anesthetist; and
3. has written agreements with local Hospitals to immediately accept patients who develop complications.

Annual Enrollment Period means the 60 days prior to and the 30 days immediately following the annual enrollment date shown in the Schedule of Insurance.

Associated Company means any company shown in the application which is owned by or affiliated with the Policyholder.

Beneficiary means the person or entity You choose to receive Your amount of insurance at Your death.

Calendar Year means the period from January 1 through December 31 of the same year. Thereafter, it is the period beginning on January 1 and ending on December 31 of each following year.

Certificate means this document that describes Your insurance coverage.

Confined or Confinement means medically necessary care as a resident bed patient in a Hospital because of an Accident or Sickness. It must be for at least 18 hours in the same facility. A Physician must recommend and supervise the Confinement. Confinement does not mean care as an outpatient or in an emergency or observation room.

Covered Person means an eligible Employee or the Employee's Dependents whose insurance has become and remains effective under all the conditions and provisions of the Policy. Covered Persons do not include contract, temporary, seasonal, or Part-time workers.

Dependent means an Eligible Person who is:

1. Your Spouse if not legally separated from You
2. any child less than age 26 and is:
 - a. a natural child; or
 - b. a legally adopted child or a child who has been placed for adoption with You; or
 - c. a stepchild, grandchild, or foster child; or
 - d. a child for whom You have been appointed legal guardian; or
 - e. a child not living with You, but to whom You are legally required to provide support.

If a Dependent child has reached age 26, but is a handicapped child as defined in the Continuation of Insurance for a Handicapped Child section, We will continue the child's coverage under the following conditions:

1. The child must be incapacitated;
2. We must receive proof of incapacity;
3. We may require additional proof of such incapacity from time to time, but not more than once a year after the child attains age 26; and
4. Your coverage must remain in force.

Effective Date means the date coverage is in force as shown on the Schedule of Insurance. The Effective Date will start at 12:01 a.m. at the main place of business of the Policyholder.

Eligible Class means a class of persons eligible for insurance under the Policy. This class is based on employment or membership in a group.

Eligible Person means a person who:

1. is a citizen of the United States of America (U.S.) or Canada, who either:
 - a. resides in the U.S. or Canada; or
 - b. is stationed outside the U.S. or Canada for a period of less than 6 months; or
2. is a foreign national residing in the U.S. and meets all of the following requirements:
 - a. has a valid permanent residency visa;
 - b. participates in U.S. Social Security; and
 - c. is covered by Workers' Compensation.

Emergency Room means a specified area within a Hospital which is designated for the emergency care of Accidental Injuries or Sicknesses. This area must:

1. be staffed and equipped to handle trauma;
2. be supervised and provide treatment by Physicians; and
3. provide care seven days per week, 24 hours per day.

Employee means an Eligible Person who is:

1. directly employed in the normal business of the Employer; and
2. paid for services by the Employer; and
3. Actively at Work for the Policyholder or an Associated Company; or
4. a Retiree, if listed as eligible in the Certificate.

No director, officer, consultant or other person not Actively at Work on behalf of the Employer will be considered an Employee unless he meets the above conditions.

Employer means the Policyholder.

Evidence of Insurability means a signed health and medical history form provided by Us, a medical examination, if requested, and any additional information and attending Physicians' statements that We may require.

Extended Care Facility means part of an institution that:

1. is licensed or accredited to provide nursing or rehabilitative care under the supervision of a Physician or a registered nurse;
2. provides 24-hour skilled nursing service; and
3. maintains daily medical records on each patient.

It does not include institutions or parts of institutions which are primarily for the care and treatment of drug addiction, alcoholism, or the aged.

Family Member means a person who is a parent, Spouse, child, sibling, grandparent, grandchild, step-child, step-parent, step-sister, step-brother, father-in-law, or mother-in-law of the Covered Person; or Spouses, as applicable, of any of these.

Free Standing or Standalone Emergency Center means a facility physically separate from a Hospital, which uses in its title or in its advertising, the words "emergency", "urgent care", or parts of those words or other language of symbols which imply or indicate to the public that immediate medical treatment is available to individuals suffering from a life-threatening medical condition. The facility rendering such care is capable of treating all medical emergencies that have life-threatening potential.

Full-time means working at least the number of hours indicated in the schedule of insurance for Full-time employment.

Group Application means the form completed and signed to apply or enroll for this insurance coverage.

Home Office means the principal office of USAble Life in Little Rock, Arkansas.

Hospital means a licensed institution that has on its premises or in facilities available to the Hospital on a contractually prearranged basis and under the supervision of a staff of one or more duly licensed Physicians:

1. Laboratory, X-ray equipment, and operating rooms where major surgical operations may be performed by licensed Physicians;
2. Permanent and full-time facilities for the care of overnight resident bed patients under the supervision of a licensed Physician;
3. 24-hour-a-day nursing service by or under the supervision of graduate registered nurses; and
4. A patient's written history and medical records.

We will consider a Government or Charity Hospital as any other Hospital.

The term Hospital does not include an institution or that part of an institution operated as:

1. A place for rehabilitation;
2. A place for rest or for the aged;
3. A nursing or convalescent home;
4. A long-term nursing unit or geriatrics ward; or
5. An Extended Care Facility for the care of convalescent, rehabilitative, or ambulatory patients.

Hospital Confined and Hospital Confinement means staying in a Hospital as a registered inpatient for 18 hours a day.

Hospital Sub-Acute Intensive Care Unit means a place which:

1. Is a specifically designated area of the Hospital that provides a level of medical care below intensive care, but above a regular private or semi-private room or ward;
2. Is separate and apart from the surgical recovery room and from, beds and wards customarily used for patient confinement;
3. Is permanently equipped with special lifesaving equipment for the care of the critically ill or injured; and
4. Is under constant and continuous observation by a specially trained nursing staff.

A Hospital Sub-Acute Intensive Care Unit may be referred to by other names such as progressive care, intermediate care, or a step-down unit, but is not a regular private or semi-private room, or a ward with or without monitoring equipment.

Immediate Family Member means You, Your Spouse, child, mother, father, brother, sister, or other close Family Member of the Covered Person.

Insured, You, Your and Yours means an Employee of the Policyholder or an Associated Company who has met all the eligibility requirements for coverage, and is:

1. directly employed in the normal business of the Employer; and
2. paid for services by the Employer; and
3. Actively at Work for the Employer, or Associated Company covered under the Policy; or
4. a Retiree, if listed as eligible in the Policy.

Intensive Care Unit (ICU) means a place which:

1. is a specifically designated area of the Hospital that provides the highest level of medical care and is restricted to patients who are critically ill or injured and who require intensive comprehensive observation and care;
2. is separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient confinement;
3. is permanently equipped with special lifesaving equipment for the care of the critically ill or injured;
4. is under constant and continuous observation by a specially trained nursing staff assigned exclusively to the unit on a twenty-four hour basis; and
5. has a Physician assigned to the unit on a full-time basis.

Notwithstanding the above, an Intensive Care Unit is not any of the following step down units:

1. a progressive care unit;
2. an intermediate care unit;
3. a private monitored room;
4. Sub-Acute Intensive Care Unit;
5. an observation unit;
6. a telemetry unit, or
7. any facility not meeting the definition of a Hospital Intensive Care Unit as defined above.

Material Duty or Material Duties mean the sets of tasks or skills required generally by Employers from those engaged in an Occupation.

Necessary Treatment means the medical treatment which is consistent with currently accepted medical practice. Any confinement, operation, treatment, or service which is not a valid course of treatment recognized by an established medical society in the United States is not considered Necessary Treatment. No treatment, service, or expense which is experimental in nature is considered Necessary Treatment.

We may use other professional medical opinions to determine if health care services are:

1. medically necessary;

2. consistent with professionally recognized standards of care with respect to quality, frequency, and duration; and
3. provided in the most economical and medically appropriate site for treatment.

Expenses related to such services will not be considered Necessary Treatment if services are not considered to be:

1. medically necessary; or
2. consistent with professionally recognized standards of care with respect to quality, frequency, or duration.

Occupation means a group of jobs:

1. in which a common set of tasks is performed; or
2. which are related in terms of similar objectives and methodologies, and which may be related in terms of materials, products, worker actions, or worker characteristics.

Off-the-Job Accident means an Accidental Bodily Injury which does not occur while the Covered Person is in the workplace or during the course of any employment for pay, benefit, or profit.

Outpatient means a Covered Person who receives medical tests, treatment, or services from a Hospital, Ambulatory Surgical Center, medical clinic, or Physician's office and is not charged for room and board.

Physician means a person acting within the scope of his or her license to practice medicine, prescribe drugs or perform surgery. This includes a person whom We are required to recognize as a Physician by the laws or regulations of the governing jurisdiction. However, neither You nor a Family Member will be considered a Physician.

Plan means the Policy and Certificates of Insurance provided for Covered Persons.

Plan Administrator means the Employer that sponsors the Plan for the benefit of its Employees and eligible Dependents.

Policy means the Policy issued by Us to the Policyholder that describes the benefits for which You may be eligible.

Policyholder means the entity to which the Policy is issued.

Regular Care means You personally visit a Physician as often as is medically required to effectively manage and treat Your disabling condition(s), according to generally accepted medical standards; and You are receiving appropriate treatment and care, according to generally accepted medical standards. Treatment and care for the Sickness or Injury causing Your disability must be given by a Physician whose specialty or experience is appropriate.

Regular Occupation means the Occupation in which You were working immediately prior to becoming disabled.

Rehabilitation Unit means an appropriately licensed facility that provides rehabilitation care services on an inpatient basis. Rehabilitation care services consist of the combined use of medical, social, educational, and vocational services to enable patients disabled by Accidental Injury to achieve the highest possible functional ability. Services are provided by or under the supervision of an organized staff of Physicians. The Rehabilitation Unit may be part of a Hospital or freestanding facility.

A Rehabilitation Unit is not:

1. a nursing home;
2. an Extended Care Facility;
3. a skilled nursing facility;

4. a rest home or home for the aged;
5. a hospice care facility;
6. a place for alcoholics or drug addicts; or
7. an assisted living facility.

Retired, Retiree or Retirement means You begin receiving Retirement benefits from either:

1. a retirement plan sponsored by Your Employer, the Policyholder, or an Associated Company, or
2. a government Plan.

Sickness means a disease or illness, including pregnancy.

Spouse as named in the application, includes Your legally married Spouse (not legally separated), Your common law Spouse, domestic partner, or civil union partner if legally recognized in the governing jurisdiction or as otherwise agreed upon between the Policyholder and the company.

Type of Coverage means insurance coverage selected for this Certificate is shown on the schedule of insurance/Your application. The types of coverage available are:

1. Employee – Coverage on the Insured only.
2. Employee and Spouse – Coverage on the Insured and Spouse only.
3. Single Parent – Coverage on the Insured and any Dependent child.
4. Family – Coverage on the Insured, the Insured's Spouse, and any Dependent child.

United States of America means the fifty (50) states of the United States and the District of Columbia. It does not include territories of the United States.

Waiting Period is the number of continuous days of service during which You must be an active, Full-time Employee in a class eligible for insurance before You become eligible for coverage.

We, Us, and Our means USAble Life.

Eligibility and Effective Date Provisions

Policyholder coverage will start on the Effective Date shown on the schedule of insurance. Coverage will start on that date at 12:01 a.m. at the main place of business of the Policyholder.

Eligible Employee

If You are working on a Full-time basis for the Employer, You are eligible for insurance after completion of the required Waiting Period, provided You are in a class of Employees who are included.

Employee Eligibility Date

If You are working for Your Employer in an Eligible Class, the date You are eligible for coverage is the latest of the following dates:

1. the Policy Effective Date;
2. the day after You complete any Waiting Period shown on the Schedule of Insurance by continuous service with the Policyholder or an Associated Company;
3. the date the Policy is changed to include Your class; or
4. the date You become a member of a class eligible for insurance.

If You do not apply when You are first eligible, You will again be eligible on the first annual enrollment date as shown on the schedule of insurance which immediately follows the date noted in items 2, 3, or 4 above.

Rehires: If You were insured under this Policy and Your insurance terminated due to termination of employment or eligibility, and You again become an eligible Employee within 12 months, there is no Waiting Period.

Effective Date of Employee Insurance

You must use forms approved by Us when applying for insurance.

For Benefit Amounts Not Requiring Evidence of Insurability:

1. When Your Employer pays 100% of the cost of Your coverage under the Policy, You will be covered at 12:01 a.m. at Your Employer's address on Your eligibility date.
2. When You and Your Employer share the cost of Your coverage under the Policy or when You pay 100% of the cost Yourself, You will be covered at 12:01 a.m. at Your Employer's address on the latest of the following dates:
 - a. on Your eligibility date, if You enroll for insurance within 31 days after the date You first become eligible for coverage; or
 - b. on the first day of the Policy month following the date We approve Your application if You do not apply for insurance within 31 days after Your eligibility date; or
 - c. on the annual enrollment date as shown on the Schedule of Insurance if You enroll during the Annual Enrollment Period. If You do not apply for coverage during the first Annual Enrollment Period following Your eligibility date, You will be required to submit satisfactory Evidence of Insurability.

For Benefit Amounts Requiring Satisfactory Evidence of Insurability, Your coverage will be effective on the first day of the Policy month following the date We approve Your application on the annual enrollment date as shown on the Schedule of Insurance if You enroll during the Annual Enrollment Period.

Delayed Effective Date

If You are not Actively at Work on the date Your insurance or any increase in insurance is scheduled to take effect, it will take effect on the day You return to Active Work. If Your insurance is scheduled to take effect on a non-working day, Your Active Work status will be based on the last working day before the scheduled Effective Date of Your insurance.

Dependent Eligibility

Dependents are eligible for insurance on the latest of the following dates:

1. the date You become eligible for Dependent insurance;
2. the date a person becomes a Dependent; or
3. the date the Policy is amended to include Your class as being eligible for Dependent insurance.

If You do not apply when You are first eligible for Dependent coverage, You will again be eligible on the first Annual Enrollment Date as shown in the Schedule of Insurance which immediately follows the date noted in items 1, 2, or 3 above.

Effective Date of Dependent Insurance

You must use forms approved by Us when applying for Dependent insurance.

Dependents will not be insured until You are insured.

For Benefit Amounts Not Requiring Evidence of Insurability:

1. When Your Employer pays 100% of the cost of Your Dependent coverage under the Policy, Your Dependents will be covered at 12:01 a.m. at Your Employer's address on Your Dependent's eligibility date.
2. When You and Your Employer share the cost of Your Dependent coverage under the Policy or when You pay 100% of the cost Yourself, Your Dependents will be covered at 12:01 a.m. at Your Employer's address on the latest of the following dates:
 - a. on Your Dependent's eligibility date, if You enroll for Dependent coverage within 31 days after the date Your Dependent first becomes eligible for coverage; or
 - b. on the first day of the Policy month following the date We approve Your application for Dependent coverage if You do not apply for Dependent coverage within 31 days after Your Dependent's eligibility date; or
 - c. On the Annual Enrollment Date as shown in the Schedule of Insurance if You enroll during the Annual Enrollment Period. If You do not apply for Dependent coverage during the first Annual Enrollment Period following Your Dependent's eligibility date, You will be required to submit satisfactory Evidence of Insurability.

For Benefit Amounts Requiring Satisfactory Evidence of Insurability, Your Dependent's coverage is effective on the first day of the Policy month following the date We approve Your application for Dependent coverage on the annual enrollment date as shown on the Schedule of Insurance if You enroll during the Annual Enrollment Period.

You must furnish satisfactory evidence of the Dependent's insurability at Your own expense if You have previously terminated Dependent coverage while in an Eligible Class.

Newborn Child Coverage (including children placed for adoption)

Any child of Yours born while You are a Covered Person will be immediately covered as a Dependent from the moment of birth for 90 days. Any newly adopted child or child placed for adoption age 15 days or older will be immediately covered from the moment of placement for 90 days. In order for coverage to continue beyond 90 days We must receive: (1) written notice of the birth of the newborn child or the date of placement for adoption; and (2) payment of any

required additional premium within 31 days of Our notifying the Policyholder of the amount. Additional premium, if any, will begin on the premium due date following the child's date of birth or date of placement, if later.

Written notice should include the child's name, date of birth, and, if applicable, date placed for adoption. We must receive this notice by the end of the 90-day period following the date of birth or adoption placement. Notice is NOT required if You are already paying the premium for children's coverage.

If the required written notice is not received by Us during the 90-day period, a newborn child or child placed for adoption may be covered after this date only if the following conditions are met:

1. Your written application for coverage is approved by Us; and
2. the payment of any required premium is made.

Delayed Effective Date

Coverage for a Dependent, other than a newborn child, who is confined in a Hospital on the day Dependent insurance or an increase in insurance is scheduled to take effect will not become effective until the 10th day following final discharge from the Hospital.

Changes in Coverage Provisions

When Coverage Amounts Change (Redetermination Date)

The Policy redetermines Your amount of insurance on the anniversary date. Changes to a Covered Person's earnings are subject to any proof of insurability requirements of the Policy.

Delayed Effective Date of Change

You must be Actively at Work on a Full-time basis on the redetermination date. If You are not, Your coverage amount will not change until the date You return to Active Work on a Full-time basis.

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

Changes to the Policy

Any increase or decrease in coverage because of a change in the Plan of insurance will become effective on the date of the change. The Delayed Effective Date provision and the Pre-existing Condition Limitation provision will apply to an increase.

Termination Provisions

Termination of Employee Insurance

Your insurance will terminate at 12:00 midnight on the earliest of the following dates:

1. the last day of the period for which a premium payment is made, if the next payment is not made;
2. the date the Policy terminates, or the date a specified benefit terminates;
3. the date You cease to be a member of a class eligible for insurance;
4. the date You cease to be Actively at Work;
5. if Your coverage is continued under the Waiver of Premium provision, the date specified under "Termination of the Waiver of Premium Benefit."

Continuation of Insurance

If You are unable to perform Active Work for a reason shown below, the Policyholder may continue Your insurance, on a premium-paying basis provided You remain in other respects a member of an Eligible Class. The continuance cannot be more than the maximum continuance shown below. The Employer must act so as not to discriminate unfairly among Employees in similar situations.

The maximum continuance for insurance is the longest applicable period described below:

1. three months following the date Active Work stopped due to lay-off or approved leave of absence, or
2. twelve months following the date Active Work stopped due to Your Total Disability.

Total Disability for Continuation of Insurance means that You are under the Regular Care of a Physician, and prevented by Injury or Sickness from performing all of the Material Duties of Your Regular Occupation.

Termination of Dependent Insurance

Insurance on a Dependent will terminate at 12:00 midnight on the earliest of the following dates:

1. the date he or she ceases to be a Dependent as defined in the Definitions section;
2. the date You cease to be an Employee or a member of a class eligible for Dependent insurance;
3. the last day of the period for which a required Dependent premium payment is made, if the next payment is not made; or
4. the date the Policy terminates,
5. the date Your insurance under the Policy terminates.

Continuation of Insurance for a Handicapped Dependent Child

If an unmarried Dependent child is not capable of self-sustaining employment due to mental or physical handicap, his or her insurance will not terminate at age 26. The insurance will continue as long as the child remains handicapped, unless coverage terminates as described in the Termination of Dependent Insurance section, if You give Us proof that the child is:

1. incapable of self-sustaining employment; and
2. chiefly dependent on You for support and maintenance.

To keep this coverage in force, We may require proof at Our expense of the child's incapacity and dependence. We may require proof from time to time, but not more than once a year after the two years that follow the date the child reaches age 26.

Claim Provisions

Notice of Loss

Written notice of claim must be given to Us at Our Home Office within 30 days after a loss occurs or begins, or as soon after the loss as is reasonably possible to do so, but not later than one (1) year from the time notice is required. The notice should identify the Covered Person and the nature of the loss.

Within 15 days after the date of Your notice, We will send You claim forms. The forms must be completed and sent to Our Home Office. If You do not receive the claim forms within 15 days, We will accept a written description of the exact nature and extent of the loss.

Proof of Loss

For any loss for which the Policy provides periodic payment contingent upon continuing loss, written proof of loss must be given to Us within 90 days after the termination of the period for which We are liable. For any other loss covered by the Policy, written proof of loss must be given to Us within 90 days after the date of such loss. Failure to furnish proof within such time shall not invalidate nor reduce any claim if it was not reasonably possible to furnish proof within such time. Such proof must be furnished as soon as reasonably possible, and in no event, except in the absence of legal capacity of the claimant, later than one (1) year from the time proof was otherwise required.

Physical Examination and Autopsy

We have the right to have a Physician of Our choice examine the Covered Person as often as necessary while the claim is pending. We may also have an autopsy made in case of death, unless not allowed by law. We will pay the cost of the exam and autopsy.

Payment of Claims

All benefits will be paid to You. Any benefits unpaid at Your death will be paid to the designated Beneficiary. If the Beneficiary dies on the same day the primary Insured dies, benefits will be paid as if that Beneficiary had died before the primary Insured. If there is no named Beneficiary living at Your death, We may pay, at Our discretion, any amount due to one of the following classes of survivors:

1. Your Spouse;
2. Your surviving children in equal shares;
3. Your mother and/or father;
4. Your brother and/or sister; or
5. Your estate.

At Our option, an amount up to the maximum allowable by the state laws of the insured person's state of residence may be paid to any person who incurred funeral or other expenses related to the last illness or death of the Insured person.

Beneficiary

Your Beneficiary will be the person(s) You name in writing to receive any amount of insurance payable due to Your death. The Beneficiary's name is on record in Our Home Office, or in the Policyholder's office if the group is self-administered. You are the Beneficiary of the Dependent Accidental Death Benefit Rider if You are living. If You and Your Dependent die in the same Accident, the Dependent benefit will be paid to Your estate.

You may name or change a Beneficiary by giving Us written notice at Our Home Office (or by giving the Policyholder written notice if the group is self-administered) on a form acceptable to Us. When We receive the notice, it will be effective on the date made, subject to any payment We may have made before We receive it.

Assignment

You may transfer Your rights to name or change the Beneficiary to someone else by assignment. An assignment will affect Us only if it is in writing on a form acceptable to Us, and is received at Our Home Office. When We record it, the assignment will take effect as of the date You made it. The assignment will be subject to any action We may have taken before We record it. We take no responsibility for the validity of any assignment.

Claims of Creditors: To the extent allowed by law, proceeds will not be subject to any claims of a Beneficiary's creditors.

Authority

The Policyholder delegates to Us and agrees that We have the sole discretionary authority to determine eligibility for participation or benefits and to interpret the terms of the Policy.

We decide:

1. if a Covered Person is eligible for this insurance;
2. if a Covered Person meets the requirements for benefits to be paid; and
3. what benefits are to be paid by the Policy.

We also interpret how the Policy is to be administered. What We pay and the terms for payment are explained in this Certificate.

Limit on Legal Action

No action at law or in equity may be brought against the Policy until at least 60 days after You file proof of loss. No action can be brought after the statute of limitations has expired, but, in any case, not after three (3) years from the date of loss.

Review Procedure

You must request, in writing, a review of a denial of Your claim within 180 days after You receive notice of denial.

You have the right to review, upon request and free of charge, copies of all documents, records, and other information relevant to Your claim for benefits, and You may submit written comments, documents, records and other information relating to Your claim for benefits.

We will review Your claim after receiving Your request and send You a notice of Our decision within 45 days after We receive Your request, or within 90 days if special circumstances require an extension. We will state the reasons for Our decision and refer You to the relevant provisions of the Policy. We will also advise You of Your further appeal rights, if any.

Subrogation and Right of Reimbursement

The Plan assumes and is subrogated to Your legal rights to recover any payments the Plan makes for benefits, when a Sickness or Injury resulted from the action or fault of a third party. The Plan's subrogation rights include the right to recover the amount of benefits paid to You.

The Plan has the right to recover any and all amounts equal to the Plan's payments from:

1. the insurance of the injured party;
2. the person, company (or combination thereof) that caused the Sickness or Injury, or any insurance company; or

3. any other source, including disability benefit coverage.

This right of recovery under this provision will apply whether recovery was obtained by suit, settlement, mediation, arbitration, or otherwise. The Plan's recovery will not be reduced by Your negligence, nor by attorney fees and costs You incur.

Priority Right of Reimbursement

Separate and apart from the Plan's right of subrogation, the Plan shall have first lien and right to reimbursement. This priority right of reimbursement supersedes Your right to be made whole from any recovery, whether full or partial. You agree to reimburse the Plan 100% first for any and all benefits provided through the Plan, and for any costs of recovering such amounts from those third parties from any and all amounts recovered through:

1. any settlement, mediation, arbitration, judgment, suit, or otherwise, or settlement from Your own insurance and/or from the third party (or their insurance);
2. any auto or recreational vehicle insurance coverage or benefits including, but not limited to disability benefit coverage; and
3. business and homeowner disability insurance coverage or payments.

The Plan may notify those parties of its lien and right to reimbursement without notice to or consent from any Covered Person.

This priority right of reimbursement will not be reduced by attorney fees and costs You incur.

The Plan may enforce its rights of subrogation and recovery against, without limitation, any tortfeasors, other responsible third parties or against available disability insurance coverages. Such actions may be based in tort, contract or other cause of action to the fullest extent permitted by law.

Notice and Cooperation

You are required to notify Us promptly if You are involved in an incident that gives rise to such subrogation rights and/or priority right of reimbursement, to enable Us to protect the Plan's rights under this section. You are also required to cooperate with Us and to execute any documents that We, acting on behalf of the Policyholder, deem necessary to protect the Plan's rights under this section.

You shall not do anything to hinder, delay, impede or jeopardize the Plan's subrogation rights and/or priority right of reimbursement. Failure to cooperate or to comply with this provision shall entitle the Plan to withhold any and all benefits due You under the Plan. This is in addition to any and all other rights that the Plan has pursuant to the provisions of the Plan's subrogation rights and/or priority right of reimbursement.

If the Plan has to file suit, or otherwise litigate to enforce its subrogation rights and/or priority right of reimbursement, You are responsible for paying any and all costs, including attorneys' fees, the Plan incurs in addition to the amounts recovered through the subrogation rights and/or priority right of reimbursement.

Legal Action and Costs

If a Covered Person settles any claim or action against any third party, that Covered Person shall be deemed to have been made whole by the settlement and the Plan shall be entitled to collect the present value of its rights as the first priority claim from the settlement fund immediately. The Covered Person shall hold any such proceeds of settlement or judgment in

trust for the benefit of the Plan. The Plan shall also be entitled to recover reasonable attorneys' fees incurred in collecting proceeds held by the Covered Person in such circumstances.

Additionally, the Plan has the right to sue on the Covered Person's behalf, against any person or entity considered responsible for any condition resulting in benefits paid or to be paid by the Plan.

Settlement or Other Compromise

The Covered Person must notify the Plan prior to settlement, resolution, court approval, or anything that may hinder, delay, impede or jeopardize the Plan's rights so that the Plan may be present and protect its subrogation rights and/or priority right of reimbursement.

The Plan's subrogation rights and priority right of reimbursement attach to any funds held, and do not create personal liability against the Covered Person.

The right of subrogation and the right of reimbursement are based on the Plan language in effect at the time of judgment, payment, or settlement.

The Plan, or its representative, may enforce the subrogation and priority right of reimbursement.

Alternate Dispute Resolution Procedures

This dispute resolution procedure ("procedure") is intended to provide a fair, quick and inexpensive method of resolving any and all disputes with Us. Such disputes include any matters that cause You to be dissatisfied with any aspect of Your relationship with Us, including any claim, controversy, or potential cause of action You may have against Us. Please contact the Dispute Resolution office at (800) 648-0271 if You have any questions about this section of the Certificate or to begin the dispute resolution process.

The following terms are applicable to all disputes:

1. This procedure is the exclusive method of resolving any disputes.
2. The procedure can only resolve disputes that are subject to Our control.
3. This procedure will be governed by the Employee Retirement Income Security Act of 1974 ("ERISA"); Rules and Regulations for Administration and Enforcement; Claims Procedure (the "Claims Regulation"). That includes the definition of an adverse benefit determination, which is defined as any denial, reduction, termination or failure to provide or make payment for what You believe should be a covered benefit.
4. You may request a form from Our dispute resolution office to authorize another person to act on Your behalf concerning a dispute.
5. We may elect to skip one or more of the steps of this procedure if it is determined that step will not help to resolve the dispute.
6. Any dispute will be resolved in accordance with the terms of this Certificate, applicable state or Federal laws and regulations.
7. You must begin the dispute process within 180 days from the date You receive notice of an adverse benefit determination. If You do not initiate the dispute process within that 180 day period, You give up the right to take any action based on that dispute.

Description of the Procedure

Inquiry

You should contact Our Dispute Resolution office to discuss and attempt to resolve any issues regarding a dispute. We hope that this informal process will resolve Your questions or concerns.

Appeals

If You are not satisfied with the response to Your inquiry, You may submit a written request (an “appeal”) to the Office of the Appeals Coordinator, USAbLe Life, PO Box 1650, Little Rock AR 72203-1650, asking that We reconsider an adverse benefit determination. Please contact the Dispute Resolution office if You have any questions about how to submit an appeal to Us. You are not required to use a specific form, but You may request that the Dispute Resolution office send You a blank appeal form to ensure that You provide the information that will be needed to review Your appeal.

We will assign a coordinator to review Your appeal. The appeal coordinator is an individual with appropriate expertise who is neither the individual who made the adverse benefit determination, nor a subordinate of that individual.

The appeal coordinator may request that You submit additional information concerning Your grievance. The appeal coordinator will also consider information submitted by others, including information requested from other USAbLe Life representatives. The appeal coordinator will have full discretionary authority to make eligibility, benefit or claim determinations and construe the terms of the Policy. Such determinations shall be subject to the review standards applicable to ERISA Plans, even if the Policy is not governed by ERISA.

We will make a decision within 60 days after receiving Your appeal concerning a claim determination.

The appeal coordinator will send You a written decision concerning Your appeal. The appeal coordinator’s decision will include: a statement of the coordinator’s understanding of Your appeal; a statement explaining the basis of the decision; and a list of the documents or information upon which that decision was based. We will send You a copy of the listed documents, without charge, if You make a written request for such documents.

Post Appeal Procedure

If You are still not satisfied after completing the appeal procedure, You have the right to bring a civil action against Us to obtain the remedies available pursuant to Sec. 502(a) of ERISA (an “ERISA Action”) after completing the mandatory appeal process. Those ERISA remedies will apply to this Policy even if Your Plan is not otherwise governed by ERISA. If You agree to arbitrate a dispute, We agree to suspend (or toll) any time periods affecting Your right to bring an ERISA Action against Us related to that dispute, until the arbitration has been completed.

You may request that the dispute be submitted for resolution by arbitration. That arbitration request must be submitted, in writing, to USAbLe Life’s General Counsel within sixty (60) days after You receive the appeal coordinator’s decision.

The dispute will be submitted to arbitration in accordance with the rules of the American Arbitration Association, unless We both agree to use an alternative dispute resolution administrator or procedure. The arbitration will be conducted before a single arbitrator.

We will pay the filing fee charged by the administrator and the arbitrator. You will be solely responsible for any other costs that You incur to participate in the arbitration process, including

Your attorney's fees. The filing fee and arbitrator's fees may be reallocated as part of an arbitration award, in whole or in part, at the discretion of the arbitrator.

The arbitration will be conducted in a location where it is reasonably convenient for You to participate. If We cannot agree concerning a convenient location, the administrator or arbitrator, if appointed, shall have the discretion to decide where the arbitration will be conducted.

The arbitrator:

1. shall consider the dispute individually and shall not certify or consider multiple disputes as part of a class action;
2. shall be required to issue a reasoned written decision explaining the basis of his or her decision and the manner of calculating any award;
3. shall limit his or her decision to deciding if Our adverse benefit decision was arbitrary or capricious based on ERISA standards;
4. may not award punitive, extra-contractual, treble or exemplary damages unless permitted to do so by applicable statutes or regulations;
5. may not vary or disregard the terms of the Policy; and
6. shall be bound by controlling law; when issuing a decision concerning the dispute.

The arbitrator shall limit discovery to the extent possible consistent with the objective of completing the arbitration in a fair, prompt, and cost effective manner. Emergency relief such as injunctive relief may be awarded by the arbitrator.

Contact Information

General Counsel
USABLE Life
P.O. Box 1650
Little Rock, AR 72203-1650
Telephone: 1-800-648-0271
Email: AppealCoordinator@usablelife.com

Office of the Dispute Resolution Coordinator
P.O. Box 1650
Little Rock, AR 72203-1650
Telephone: 1-800-648-0271
Email: AppealCoordinator@usablelife.com

Office of the Appeal Coordinator
P.O. Box 1650
Little Rock, AR 72203-1650
Telephone: 1-800-648-0271
Email: AppealCoordinator@usablelife.com

General Provisions

Entire Contract

This Certificate is furnished in accordance with and subject to the terms of the Policy. The entire contract consists of the Policy, which includes the Group Application, any Amendments and addenda; this Certificate; Your application, if required; and any Riders or Endorsements.

No change in the Policy will be effective until approved by one of Our officers. This approval can only be in writing and must be noted on or attached to the Policy. No agent has authority to change the Policy or Certificate or to waive any of their provisions.

Any statement made by You or the Policyholder is considered a representation. It is not considered a warranty or guarantee. A statement will not be used in a dispute unless it is written and signed, and a copy is given to the Covered Person or the Beneficiary.

Errors

An error in keeping records will not cancel insurance that should continue nor continue insurance that should end. We will adjust the premium, if necessary. If the premium was overpaid, We will refund the difference. If the premium was underpaid, the difference must be paid to Us.

Misstatements

If any information about a Covered Person or the Policyholder's Plan is misstated or altered after the application is submitted, including information with respect to participation or who pays the premium and under what circumstances, the facts will determine whether insurance is in effect and in what amount. We will retroactively adjust the premium.

Other Insurance With Us

If You are covered under more than one Policy of this form or like form with Us, only one Policy, chosen by You or Your estate, will be effective (this includes coverage for any Covered Person). We will refund all premiums paid for all other policies from the date of duplication less any benefits paid under these policies from such date.

Incontestability

Unless the premiums have not been paid, the validity of the Policy cannot be contested after it has been in force for two years.

Any statement made by the Policyholder or a Covered Person will be considered a representation. It is not considered a warranty or guarantee. A statement will not be used in a dispute unless it is written and signed, and a copy is given to the Covered Person or the Beneficiary.

No statement, except fraudulent misstatement, made by a Covered Person about insurability will be used to deny a claim for a loss incurred or disability starting after coverage has been in effect for two years.

No claim for loss starting two or more years after the Covered Person's Effective Date may be reduced or denied because a disease or physical condition existed before the person's Effective Date, unless the condition was specifically excluded by a provision in effect on the date of loss.

Agency

Neither the Policyholder, any Employer, any Associated Company, nor any administrator appointed by the foregoing is Our agent. We are not liable for any of their acts or omissions.

Unpaid Premium

We may deduct any unpaid premium then due from the payment of a claim under this Certificate.

Refund of Premium

On the death of the Covered Person, proceeds payable hereunder shall include the amount of unearned premium paid beyond the end of the Policy month in which death occurred. Payment shall be made in one lump sum no later than 30 days after proof of the Covered Person's death has been furnished to Us.

Conformity with State Statutes

If the provisions of this Certificate do not conform with the applicable laws of the state in which You reside on the Certificate Effective Date, they are hereby amended to conform with the minimum requirements of the statutes of that state.

Policy Management

Efficient management of the Policy requires the joint efforts of the Policyholder, US Able Life, and each Covered Person. Each party has certain duties to bring about the effective administration of the Policy.

Duties of the Policyholder

The Policyholder's primary duties under the Policy are listed below.

1. Give Us prompt, written notice of any change in business of the Policyholder and Employer. This includes, but is not limited to:
 - a. the type of business;
 - b. addition or deletion of an Associated Company; or
 - c. financial status due to bankruptcy; merger; acquisition; or dissolution.
2. Give Us pertinent records for all Covered Persons. This includes, but is not limited to:
 - a. hire dates;
 - b. eligibility dates;
 - c. salaries;
 - d. Occupations;
 - e. birth dates; and
 - f. Social Security Number.
3. Give Us updates of such records as needed.
4. Give Us prompt notice of a covered Employee's disability. This notice should be given as soon as possible after the date of Injury or start of Sickness. The most effective time for such notice is when the Employee has not been able to perform Active Work for 30 days.
5. Give Us occupational data for all disabled Employees. This includes, but is not limited to:
 - a. job descriptions and analyses; and
 - b. environmental factors.

Duties of Covered Persons and Beneficiaries

You and Your Beneficiary's primary duties under the Policy are listed below:

1. Give notice and proof of loss as soon as possible after the date of Your Injury or Sickness, or the date of Your death, or the death of a covered Dependent, if applicable.
2. Give a complete account of the details of Your Injury or Sickness or the death on a form approved by Us. This will include:
 - a. the cause of Your disability, if known;
 - b. a description of Your Sickness or the Accident that caused Your Injury; and
 - c. a list of all Physicians, Hospitals, or other facilities where You have been treated for the cause of Your disability;
 - d. any other official documents to review the loss such as a certified death certificate, investigating officer's report, or medical records.
3. Allow release of medical and income data needed to adjudicate Your claim.
4. Give periodic medical updates as required by the Policy.
5. Provide evidence of the Regular Care of a Physician, if necessary.
6. Promptly report to Us any changes in Your status such as Your address or telephone number, or if You return to work or are no longer disabled.
7. If benefits are overpaid, reimburse such overpayment within 60 days of the date benefits were overpaid.
8. Provide proof of Your earnings for the period prior to a loss.

Fraud

It is unlawful to knowingly provide false, incomplete or misleading facts or information with the intent of defrauding Us. An application for insurance or statement of claim containing any materially false or misleading information may lead to reduction, denial or termination of benefits or coverage under the Policy and recovery of any amounts We have paid.

Portability Privilege

You may continue Your and Your Spouse's and children's Accident coverage if employment terminates and You meet the following requirements on the date employment terminates:

1. Not disabled; and
2. Either:
 - a. are not Retired and are under age 70; or
 - b. Retired and are under age 65.

Coverage will be continued under the Policy if You elect continuation of coverage under this Portability provision. Portability is not available upon Policy cancellation.

Your Spouse's and dependent's coverage may not be continued if Your coverage is not continued.

Application and Premium Payment

You must apply for portability in writing to USABLE Life within 31 days after the date employment ends.

You must pay the required premium monthly, quarterly, semi-annually, or annually directly to USABLE Life. The premium rate will be determined by Us. The first premium payment must be made no later than 31 days after the date the insurance would otherwise terminate under the Policy.

Amount of Insurance

The amount of insurance that You and the Spouse or children may continue is the amount in effect on the date employment terminates. The reduction and termination provisions stated in the Certificate will apply to insurance continued under this provision.

When Portability Ends

The continued coverage under this provision will end automatically on the earliest of the following:

1. the date the last period ends for which You made a premium payment;
2. the premium due date following attainment of age 70;
3. if coverage continued due to Retirement prior to age 65, on the premium due date following Your attainment of age 70;
4. the date You become a full-time member of the armed forces of any country; or
5. Spouse or child coverage will end on the premium due date following the date the Spouse or child ceases to be a Dependent as defined in the Policy, or
6. Spouse coverage will end on the premium due date following the Spouse's attainment of age 70.

Coverage continued under the Portability provision is in lieu of all other benefits under the Policy. If You return to work with the Employer and again become eligible for Accident coverage under the Policy, continued coverage under the Portability provision will cancel on the date coverage is resumed under the Policy.

Other Policy Provisions

With respect to any notice You are required to provide to the Employer under other provisions of the Policy, You must provide such notice to USABLE Life while the insurance is continued under the Portability provision.

Termination of the Policy

Portability coverage may continue beyond the termination date of the Policy, subject to the timely payment of premiums. Benefits, terms and conditions for portability coverage will be determined as if the Policy had remained in full force and effect.

Continuity of Coverage

Definitions

Prior Plan means the Policyholder's Plan of Group Accident insurance, if any, under which You were insured on the day before the Effective Date of this Policy.

Prior Plan Benefits mean the benefits, if any, that would have been paid to You under the Prior Plan had it remained in effect, and had You continued to be insured under the Prior Plan.

If You were Insured by the Prior Plan for Group Accident benefits just before You became eligible for coverage under this Plan; and You are in active employment; and You are insured under this Plan, then You may be eligible for coverage if Your Accident or Sickness is due to a pre-existing condition.

In order to receive payments from Us, You must satisfy the pre-existing condition limitation of:

1. this Plan; or
2. the Prior Plan, had the Plan stayed in effect.

We will consider the total amount of time You were continuously insured under both the Prior Plan and this Plan to determine if You satisfy the pre-existing condition limitation. If You cannot satisfy the pre-existing condition limitation of either Plan then We will not pay You for Your Accident or Sickness.

We will determine Our payment to You using the provisions of Your coverage with Us with respect to eligibility, Elimination Period, benefit amount and maximum benefit duration.

Exclusions and Limitations

What We Will Not Pay For:

This Policy pays only for loss resulting from an Accident as defined in this Policy. It DOES NOT cover Injury incurred as a result of the Covered Person:

1. Being exposed to War or any act of War, declared or undeclared, or serving in any of the armed forces.
2. Actively participating in a Riot or insurrection.
3. Intentionally self-inflicting bodily Injury or attempting suicide, while sane or insane.
4. Participating in any form of flight aviation other than as a fare-paying passenger in a fully licensed/passenger-carrying aircraft.
5. Participating in, or attempting to participate in, an illegal activity that is defined as a felony as defined by the law of the jurisdiction in which the activity takes place, whether charged or not; or being incarcerated in any type of penal institution.
6. Participating in any activity or event, including the operation of a vehicle, while under the influence of a narcotic (unless prescribed by a Physician and taken according to the Physician's instructions) or while intoxicated. "Intoxicated" means that condition as defined by the laws of the jurisdiction in which the Accident occurred. Conviction is not necessary for a determination of being intoxicated.
7. Voluntarily taking, administering, absorbing, or inhaling poison, gas, or fumes.

8. Driving any commercial passenger-carrying vehicle, except school buses, for wage, compensation or profit.
9. Engaging in hazardous avocations. Engaging in bungee jumping, sail gliding, parasailing, parakiting, mountaineering using ropes and/or other equipment, parachuting or hang gliding, or jumping, parachuting or falling from any aircraft or hot air balloon, including those which are not motor driven.
10. Having cosmetic surgery or other elective procedures that are not medically necessary, or having dental treatment except as a result of Injury.
11. Practicing for or participating in any semi-professional or professional competitive athletic contest for which any type of compensation or remuneration is received. sport or activity for wage, compensation or profit.
12. Riding in or driving any motor-driven vehicle in a race, stunt show or speed test.
13. Having any Sickness or declining process caused by a Sickness, including physical or mental infirmity or infection (except bacterial infection from a Accidental Injury).
14. Benefits are not payable for services rendered by an Immediate Family Member.

Participation in a riot shall include promoting, inciting, conspiring to promote or incite, aiding, abetting, and all forms of taking part in, but shall not include actions taken in defense of public or private property, or actions taken in Your own defense, if such actions of defense are not taken against persons seeking to maintain or restore law and order including but not limited to police officers and firemen.

Riot shall include all forms of public violence, disorder, or disturbance of the public peace, by three or more persons assembled together; whether or not acting with common intent and whether or not damage to persons or property or unlawful act or acts is the intent or the consequence of such disorder.

War means declared or undeclared war or a conflict involving the armed forces of any country, group of countries, governments, or international organization.

Geographic Limitation

We will not provide benefits for treatments received outside of Canada, the territorial limits of the United States or its possessions .

Benefits

If a Covered Person receives an Accidental Bodily Injury and expenses are incurred, We will pay the following benefits according to the Schedule of Insurance/Your application. Such Injury must be independent of disease or bodily infirmity other than an Accident, except for Wellness benefit if included. Such Accident must occur while coverage is in force.

Benefit payment will be made directly to You, unless You assign benefits. Proof of Loss must be submitted to Us for each incurred expense. Under no conditions will We pay any benefits for losses or medical expenses incurred prior to the Effective Date.

The benefits described below are for one unit of coverage. The number of units selected by the Policyholder for each benefit (module) is shown on the Schedule of Insurance. Your application identifies the Plan You selected for the number of units of coverage You have in force for each module.

Module 1 – Accident Treatment

Initial Physician Office Visit

We will pay \$25 per unit if a Covered Person receives treatment or advice in a Physician's office for an Injury within 30 days of an Accident. Treatment or advice is limited to a Physician's office which does not include treatment or advice in an Emergency Room. We will pay for such treatment or advice as follows:

1. Treatments must be furnished by a Physician in a Physician's office;
2. Such treatment or advice must begin within 30 days of the Accident;
3. This benefit is payable up to a maximum of 2 treatments or advice per Covered Person per year.

This benefit is not payable for the same visit that the Physical Therapy Benefit or Emergency Treatment Benefit is paid.

Emergency Treatment Benefit

We will pay \$25 per unit of coverage if a Covered Person receives Necessary Treatment for an Injury due to an Accident. This benefit is payable for treatment for X-rays, treatment received in an Emergency Room or Standalone Emergency Center. Necessary Treatment must be received within 72 hours of such Accident for benefits to be payable. This benefit is payable once per Accident, per Covered Person.

If the Covered Person has been treated in an Emergency Room or Standalone Emergency Center for a laceration that is repaired without stitches, staples, or glue, or for the removal of a foreign object from the eye; We will pay \$10 per unit of coverage under this benefit and the Follow-up Physician Visit benefit combined. This benefit and the Initial Physicians Office Visit benefit are not payable together.

Emergency Dental Work

We will pay the benefit shown below per unit of coverage if the Covered Person receives Necessary Treatment for Injuries sustained in an Accident. Treatment must begin within 30 days after the Accident. Payment is limited to one dental benefit per Covered Person per Accident.

Amount	Benefit per Unit
Broken tooth repaired with crown	\$50
Broken tooth resulting in extraction	\$20

Major Diagnostic Examinations Benefit

We will pay \$40 per unit, per Covered Person, for one major diagnostic examination per Accident. Such examination must be performed within 180 days due to Injuries sustained in an Accident. These exams must be performed in a Hospital, a Physician’s office, or an Ambulatory Surgical Center.

Major diagnostic examinations are limited to the following:

1. CT (computerized tomography) scan;
2. MRI (magnetic resonance imaging); and
3. EEG (electroencephalogram).

Lacerations

We will pay the benefit up to the incurred charges of \$90 per unit of coverage if the Covered Person receives Necessary Treatment for a laceration or a cut requiring sutures that is sustained in an Accident. The Injury must be repaired by a Physician within 72 hours of the Accident.

Lacerations not requiring stitches, staples or glue will be paid up to the incurred charges of \$20 per unit of coverage.

Burn

We will pay the indemnity benefit shown below per unit of coverage if the Covered Person receives Necessary Treatment for one or more burns as a result of an Accident. Treatment must begin within 72 hours after the Accident. We will pay the amount shown below only once per Covered Person per Accident.

Burn Benefit	Benefit per Unit
1. Second and third degree burns covering less than 15% of the total body surface	\$100
2. Second and third degree burns covering 15% or more of the total body surface	\$500

One or more skin grafts for a covered burn will be paid at 50% of the Burn benefit amount We paid for the burn involved.

Eye Injury

We will pay the benefit shown below per unit of coverage if the Covered Person receives Necessary Treatment for an eye Injury as the result of an Accident. The eye Injury must require surgery or the removal of a foreign object by a Physician within 30 days after the Accident. An examination with anesthesia will not be considered surgery.

Eye Injury Benefit	Benefit per Unit
1. With surgical repair	\$ 40
2. Non-surgical removal of foreign body by a Physician	\$ 7

We will pay the amount shown per Covered Person per Accident.

Brain Injury Diagnosis

We will pay \$100 per unit for a diagnosis of concussion, cerebral laceration, cerebral contusion, or intracranial hemorrhage by a Covered Person as the result of an Accident. Necessary Treatment must be received within 72 hours of such Accident.

Diagnosis of the covered traumatic brain Injury by computed tomography (CT) scan. Magnetic resonance imaging (MRI), electroencephalogram (EEG), positron emission, Tomography (PET) scan, or X-ray must occur within 30 days of the Injury. This benefit is payable once per Covered Person, per Accident.

Dislocation Benefit

We will pay the benefit shown below per unit of coverage for the treatment listed if the Covered Person receives Necessary Treatment for a dislocation sustained in an Accident. A dislocation is a completely separated joint. It must be diagnosed as a dislocation by a Physician within 30 days after the Accident. It can be corrected by open (surgical) or closed (non-surgical) reduction.

If a Physician diagnoses the dislocation as an incomplete dislocation, We will pay 25% of the amount shown for the joint involved. An incomplete dislocation is a dislocation in which the joint is not completely separated.

Dislocations which are reduced under general anesthesia are payable as follows:

1. If a Covered Person receives more than one dislocation in an Accident and requires open or closed reduction, We will pay 200% of the amount for the dislocation involved that has the highest benefit amount. No other amount will be paid under this benefit;
2. If a Covered Person receives a dislocation and a fracture in the same Accident, We will pay 200% of the amount for the dislocation or fracture involved that has the highest benefit amount. No other amount under this benefit or the Fracture benefit will be paid;
3. If a dislocation is reduced without general anesthesia by a Physician, We will pay 25% of the amount shown for the dislocation involved; and
4. Benefits are payable only for the first dislocation of a joint. If a Covered Person dislocates a joint and then dislocates the same joint again, the second same joint dislocation would not be covered.

Dislocation Benefit	Benefit Per Unit
Hip	
Open Reduction.....	\$550
Closed Reduction.....	\$150
Knee or Shoulder	
Open Reduction.....	\$120
Closed Reduction.....	\$50
Collar Bone	
Open Reduction.....	\$190
Closed Reduction.....	\$40
Ankle or Foot (excluding toes)	
Open Reduction.....	\$150
Closed Reduction.....	\$55
Lower Jaw	
Open Reduction.....	\$120
Closed Reduction.....	\$60
Wrist or Elbow	
Open Reduction.....	\$95

Closed Reduction.....	\$45
Toe or Finger	
Open Reduction	\$25
Closed Reduction.....	\$12

Fracture Benefit

We will pay the benefit as shown below per unit of coverage if the Covered Person receives Necessary Treatment for treatment of a fracture, a break in a bone which can be seen by X-ray, diagnosed by a Physician within 14 days after the Accident. The fracture must require open (surgical) or closed (non-surgical) reduction by a Physician.

If a Covered Person receives more than one fracture in an Accident and requires open or closed reduction, We will pay 200% of the amount for the fracture involved that has the highest benefit amount. No other amount will be paid under this benefit.

If a Covered Person receives a fracture and a dislocation in the same Accident, We will pay 200% of the amount for the fracture or dislocation involved that has the highest benefit amount. No other amount under this benefit or the dislocation benefit will be paid.

If a Physician diagnoses the fracture as a chip fracture, We will pay 25% of the amount shown for the bone involved. A chip fracture is a fracture in which a piece of the bone is broken off near a joint at a place where a ligament is usually attached.

Fracture Benefit	Benefit Per Unit
Hip	
Open Reduction.....	\$550
Closed Reduction.....	\$275
Leg	
Open Reduction	\$240
Closed Reduction.....	\$125
Skull	
Depressed.....	\$600
Simple.....	\$150
Hand (excluding fingers) Foot (excluding toes/heel), Wrist, Shoulder Blade, Forearm, Ankle, Elbow, Kneecap, Sternum or Lower Jaw	
Open Reduction.....	\$120
Closed Reduction.....	\$60
Vertebrae (body of), Pelvis (excluding coccyx)	
Open Reduction.....	\$240
Closed Reduction.....	\$120
Upper Jaw, Upper Arm or Face (excluding Nose), Collar Bone	
Open Reduction	\$140
Closed Reduction.....	\$70
Rib(s)	
Open Reduction.....	\$240
Closed Reduction.....	\$30
Nose, Heel or Finger(s)	
Open Reduction.....	\$120
Closed Reduction.....	\$30
Coccyx	
Open Reduction.....	\$50
Closed Reduction.....	\$30
Toe(s)	

Open Reduction.....	\$50
Closed Reduction.....	\$30
Vertebral Processes	
Open Reduction.....	\$240
Closed Reduction.....	\$40

Benefits are not payable for services rendered by an Immediate Family Member.

Module 2 – Hospital Care

Initial Hospitalization/Intensive Care Unit Benefit

We will pay \$200 per unit of coverage if a Covered Person is admitted for 18 hours or more and confined to a Hospital, Hospital Intensive Care Unit or a Sub-Acute Intensive Care Unit because of Injuries received in an Accident. The Covered Person must become confined as a resident bed patient to a Hospital within 30 days after the Accident. This benefit is payable once per Hospital Confinement and only once per Calendar Year per Covered Person.

We will not pay this benefit for confinement to an observation unit, for Emergency Room treatment or Outpatient treatment.

Surgery Benefit

We will pay \$250 per unit of coverage when a Covered Person undergoes abdominal or thoracic surgery within 48 hours of the Accident for an Injury. Surgery must be for repair of internal Injuries. For exploratory or other surgery without repair We will pay \$50 per unit of coverage. Hernia repair will not be covered under this benefit.

This benefit is payable once per Accident, per Covered Person.

Ambulance Benefit

We will pay for the per unit benefit amount shown below for ground or air ambulance transportation if a licensed professional ambulance company transports a Covered Person to or from a Hospital or between medical facilities where treatment is received for Injuries as a result of an Accident. The ground ambulance transportation must be between 0 to 30 days of the Accident. The air ambulance transportation must be within 72 hours of the Accident. We will pay the ground or air ambulance, but not both, once per Accident, per Covered Person.

Ambulance Benefit	Benefit per Unit
1. Ground Ambulance	\$ 40.00
2. Air Ambulance	\$250.00

Blood, Plasma, and Platelets

We will pay \$40 per unit of coverage if a Covered Person is injured in an Accident and requires any of the following within 30 days after the Accident as a result of the Injury:

1. transfusions of whole blood and blood products which are limited to red blood cells;
2. platelets;
3. fresh frozen plasma;
4. cryoprecipitate and leukocytes including the processing, typing, cross-matching, and administration of the blood or blood products.

We will pay this amount once per Accident, per Covered Person.

Module 3 – Follow-Up Care

Physician Follow-Up Treatment Benefit

We will pay \$10 per unit if a Covered Person first receives treatment for an Injury within 72 hours of an Accident and later requires additional treatment for the same Injury. We will pay for such follow-up treatment as follows:

1. This benefit is payable up to a maximum of six follow-up treatments per Accident, per Covered Person.
2. Such treatment must begin within 30 days of, and be completed within the six-month period following the later of the following dates:
 - a. the Accident;
 - b. discharge from the Hospital from a confinement; or
 - c. discharge from the Extended Care Facility; and
3. Treatments must be furnished by a Physician in a Physician's office or in a Hospital on an Outpatient basis.

This benefit is not payable for the same visit that the Physical Therapy benefit is paid or the Initial Physician Office Visit benefit is paid.

Rehabilitation Unit Confinement

We will pay \$25 per unit if a Covered Person incurs a charge for and is transferred to a Rehabilitation Unit immediately after a period of Hospital Confinement due to an Accident. We will pay this amount for each day of confinement in a Rehabilitation Unit, up to a maximum of 30 days per Covered Person per Accident but not to exceed 60 days per Calendar Year.

We will not pay both the Rehabilitation Unit Confinement and the Accident Hospital and ICU Daily Benefit Rider concurrently.

Physical Therapy Benefit

We will pay \$20 per visit per unit of coverage if a Covered Person requires physical therapy as a result of an Accident. We will pay this amount per visit with a maximum of six visits per Accident. The therapy must begin within 30 days after the Accident and must be completed within twelve months after the Accident. All services must be prescribed by a Physician and rendered by a licensed physical therapist and performed in an office or in a Hospital on an inpatient or Outpatient basis. This benefit is not payable for the same visit that the Physicians Follow-up Treatment benefit is paid.

Physical therapist is anyone, other than You or Your Immediate Family Member, who is licensed as a physical therapist and certified to treat physically disabled or handicapped persons with physical agents and methods such as massage, manipulation, therapeutic exercise, cold, heat, hydrotherapy, electrical simulation, and light to assist in rehabilitation.

Appliance

We will pay the per unit benefit amount of \$20 for a medical appliance recommended by a Physician as an aid in personal locomotion. Treatment of Injuries sustained in an Accident must be performed within 365 days of the Accident. Benefits include and are payable for such items as crutches, leg braces, wheelchairs, and walkers. This benefit is not payable for prosthetic devices.

Prosthetic Devices

Benefits are payable for one or more prosthetic devices. The prosthetic device(s) must be received within 30 days of the Accident. This benefit is not payable for hearing aids, dental aids (including false teeth), eye glasses, or for cosmetic prosthetic devices such as hair wigs. We will not pay for joint replacement, such as an artificial hip or knee.

Benefits are payable for eye Injury.

Prosthetic Device Benefit

1. Benefit for one prosthetic device; or
2. Benefit for two or more prosthetic devices

Benefit per Unit

\$ 75.00
\$150.00

Module 4 – Transportation/Lodging Assistance

Family Lodging

If the Covered Person is injured in an Accident that requires non-local Hospital Confinement, We will pay \$25 per unit of coverage for accommodations for a member of the immediate family to accompany the Covered Person. This benefit will be paid as follows:

1. Necessary Treatment for Injuries must be within 30 days of the Accident;
2. Accommodations will be for a room in a motel, hotel, or other accommodations acceptable to Us;
3. The Hospital and accommodations must be more than 100 miles from the permanent residence of the Covered Person; and
4. The accommodations will be for a period not to exceed 30 days.

The benefit is payable once per Accident, per Covered Person.

Transportation

We will pay the per unit benefit amount of \$100 per roundtrip to the Hospital if a Covered Person requires special treatment in a Hospital located more than 100 miles from the person's residence or site of the Accident for Injuries sustained within 30 days of the Accident. This benefit will be paid only for (a) the Covered Person for whom the treatment is prescribed, and (b) if the treatment is for a Dependent child and commercial travel is necessary, the Dependent child's parent or legal guardian who travels with the child. Only one person will be paid to travel with the Dependent child. The local attending Physician must prescribe the treatment, and the treatment must not be available locally. This benefit is not payable for transportation by ambulance or air ambulance to the Hospital. This benefit is payable for up to 5 trips per Calendar Year per person.

Post Accident Transportation

We will pay the per unit benefit amount of \$50 per trip for a Covered Person's transportation from the Hospital to the Covered Person's permanent residence. We will pay for such transportation under the following conditions:

1. The Covered Person is Hospital Confined and paid under the Accident Hospital and ICU Daily Benefit Rider for 10 consecutive days;
2. The Covered Person resides more than 200 miles from the Hospital in which the Covered Person is Hospital Confined; and
3. The transportation by the Covered Person from the Hospital to the Covered Person's permanent residence is by licensed common carrier for the transportation of passengers.

This benefit will be paid only for the Covered Person for whom the transportation is hired. This benefit is not payable for transportation by ambulance or air ambulance.

Module 5 – Surgery Benefits

Tendon/Ligament

We will pay \$100 per unit of coverage for each Accident if a Covered Person receives one or more injured tendons or ligaments within 30 days of the Accident. The tendon or ligament must be torn, ruptured or severed. A Physician must repair it through surgery within twelve months after the Accident.

If the Covered Person is in an Accident and receives a fracture or a dislocation and tears, ruptures, or severs a tendon or ligament, We will pay only one benefit. We will pay the larger of either the Tendon/Ligament benefit, the Fracture benefit, or the Dislocation benefit. If exploratory arthroscopic surgery is performed and no repair is done, We will only pay \$25 per unit of coverage.

Torn Knee Cartilage

We will pay the benefit shown below per unit of coverage for the treatment listed if a Covered Person receives treatment for a torn knee cartilage sustained in an Accident. It must be treated by a Physician within 30 days after the Accident. A Physician must repair it through surgery within twelve months after the Accident. Only one payment amount under this benefit will be paid per Covered Person per Accident.

Torn Knee Cartilage Benefit	Benefit per Unit
1. Exploratory surgery without repair or if the cartilage is shaved (debridement)	\$ 75
2. Surgical Repair	\$100

Ruptured Disc

We will pay \$100 per unit of coverage if a Covered Person receives treatment for a ruptured disc sustained in an Accident. A ruptured disc is a herniated, ruptured or prolapsed intervertebral disc that is diagnosed by myelography, computed tomography (CT) or magnetic resonance imaging (MRI). A Physician must treat it within 30 days after the Accident. It must be repaired through surgery by a Physician within twelve months after the Accident.

Only one payment amount under this benefit will be paid per Covered Person per Accident.

This benefit is not payable for the Surgery benefit.

Torn Rotator Cuff

We will pay \$100 per unit of coverage if a Covered Person receives treatment for one or two torn rotator cuffs sustained in an Accident. A Physician must repair the torn rotator cuff through surgery within 180 days after the Accident. It must be repaired through surgery by a Physician within six months after the Accident.

This benefit is not payable for the Surgery benefit.

Module 6 – Wellness Benefit

Waiting Period – Payments under this benefits will not be made for test performed within 30 days after the Effective Date of coverage.

After the Waiting Period, We will pay \$15 per unit, for each Covered Person when a charge is incurred for one of the below-listed health screening tests. This benefit is limited to one payment per Calendar Year per Covered Employee & Spouse and two payments per Calendar Year per covered children.

Health Screening Tests - The annual health screening tests payable under this benefit are listed as follows:

Biopsy	Flexible sigmoidoscopy
Blood test for triglycerides	Hemocult stool analysis
Bone marrow testing	Mammography
Breast ultrasound	Pap test
CA 125 (blood test for ovarian cancer)	PSA (prostate-specific antigen tests)
CA 15-3 (blood test for breast cancer)	Serum cholesterol test to determine HDL/LDL level
CEA (blood test for colon cancer)	Serum Protein Electrophoresis (blood test for myeloma)
Chest X-ray	Stress test on a bicycle or treadmill
Colonoscopy	Thermography
Fasting blood glucose test	

Health screening tests must be performed under the supervision of or recommended by a Physician, and a charge must be incurred. Satisfactory proof of the charges incurred for the health screening tests must be submitted with each new claim. Under no condition will We pay any benefits for losses incurred prior to the Effective Date.



ACCIDENT ONLY HOSPITAL AND ICU DAILY BENEFIT RIDER

This Rider is issued in consideration of the Application and payment of any required premium. Except as shown in this Rider, the provisions of the Certificate to which this Rider is attached will prevail.

This Rider is made part of the Certificate issued by US Able Life to which it is attached.

This Rider takes effect on February 1, 2016 and expires at the same time as the Policy or Certificate.

This Rider only applies to Hospital Confinements which occur on or after this date.

DEFINITIONS

In addition to the definitions contained in the Policy and Certificate, the following definitions apply to this Rider:

Hospital Sub-Acute Intensive Care Unit means a place which:

1. Is a specifically designated area of the Hospital that provides a level of medical care below intensive care but above a regular private or semi-private room or ward;
2. Is separate and apart from the surgical recovery room and from rooms, beds, and wards customarily used for patient confinement;
3. Is permanently equipped with special lifesaving equipment for the care of the critically ill and injured; and
4. Is under constant and continuous observation by specially trained nursing staff.

A Hospital Sub-Acute Intensive Care Unit may be referred to by other names such as progressive care, intermediate care, or a step-down unit, but it is not a regular private or semi-private room, or a ward with or without monitoring equipment.

Hospital Confined and Hospital Confinement means staying in a Hospital as a confined bed patient for 18 hours a day.

Intensive Care Unit (ICU) - means a place which:

1. Is a specifically designated area of the Hospital that provides the highest level of medical care and is restricted to patients who are critically ill or injured and who require intensive comprehensive observation and care;
2. Is separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient confinement;
3. Is permanently equipped with special lifesaving equipment for the care of the critically ill or injured;
4. Is under constant and continuous observation by a specially trained nursing staff assigned exclusively to the unit on a twenty-four hour basis; and
5. Has a Physician assigned to the unit on a full-Time basis.

Notwithstanding the above, an Intensive Care Unit is not any of the following step-down units:

1. A progressive care unit;

2. An intermediate care unit;
3. A private monitored room;
4. A Sub-acute Intensive Care Unit;
5. An observation unit;
6. A telemetry unit; or
7. Any facility not meeting the definition of a Hospital Intensive Care Unit as defined above.

BENEFITS

The benefits described below are for one unit of coverage. The number of units selected by the Policyholder for this Rider is shown on the schedule of insurance. The number of units, or amount of coverage, selected by You is on Your application.

Accident Hospital Confinement Benefit - While this Rider is in force, if a Covered Person requires Hospital Confinement in a Hospital because of injuries received in an Accident, We will pay \$25 per unit, per day, of confinement. Confinement as a resident bed patient in a Hospital must start within 30 days of the Accident. We will pay this benefit up to 365 days per Accident and while the Covered Person is Hospital Confined. We will pay benefits for only one Hospital Confinement at a time even if the Hospital Confinement is caused by more than one Accident.

If the Covered Person is confined in a Hospital that does not meet the definition in this Policy of a Hospital We will not pay this benefit.

If the Covered Person is confined in a Hospital and is confined again within 90 days for the same Accident or related condition, We will treat this confinement as a continuation of the prior confinement. If more than 90 days have passed between the periods of Hospital Confinement, We will treat this confinement as a new confinement.

We will not pay this benefit for confinement to an observation unit, for Emergency Room treatment or for Outpatient treatment. We will not pay the Hospital Confinement benefit and the Hospital Intensive Care Unit Confinement benefit concurrently ; the larger benefit will be paid.

If the Covered Person is confined in a Hospital Intensive Care Unit for more than 15 days, the Hospital Confinement benefit will begin on the 16th day. The total amount payable per Accident will not exceed 365 days for Hospital Confinement and 15 days for Hospital Intensive Care Unit confinement.

Accident Hospital Intensive Care Confinement Benefit – While this Rider is in force, if a Covered Person requires Hospital Confinement in a Sub Acute ICU or an Intensive Care Unit because of injuries received in an Accident, We will pay \$50 per unit, per day of confinement.

The confinement in a Hospital Intensive Care Unit must begin within 30 days after the Accident. We will pay this amount per day up to 15 days per Accident and while the Covered Person is Hospital Confined. We will pay benefits for only one Hospital Confinement at a time even if is caused by more than one Accident.

If the Covered Person is confined in a Hospital that does not meet the definition in this Policy of an ICU unit, We will not pay this benefit.

If the Covered Person is confined in a Hospital Intensive Care Unit, and is confined again within 90 days for the same Accident or related condition, We will treat this confinement as a continuation of the prior confinement. If more than 90 days have passed between the periods of Hospital Confinement, We will treat this confinement as a new confinement.

We will not pay this benefit for confinement to an observation unit, for Emergency Room treatment or for Outpatient treatment. We will not pay the Hospital Confinement benefit and the Hospital Intensive Care Unit Confinement benefit concurrently; the larger benefit will be paid.

If the Covered Person is confined in a Hospital Intensive Care Unit for more than 15 days, the Hospital Confinement benefit will begin on the 16th day. The total amount payable per Accident will not exceed 365 days for Hospital Confinement and 15 days for Hospital Intensive Care Unit Confinement.

When Coverage Under This Rider Ends

Coverage under this Rider ends on the earliest of the following dates:

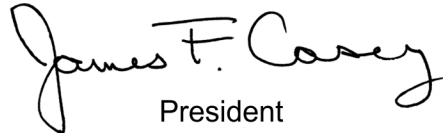
1. the date the Policy terminates;
2. the date Your coverage under the Policy ends;
3. the date Your Eligible Class is no longer covered for this Rider;
4. the last day of the period for which any required premium contributions for this Rider are made.

Termination of the Policy and/or Rider by Us will not affect any claim or loss which commenced while the Policy and/or Rider were in force.

This Rider is subject to all provisions of the Group Policy which are not inconsistent with the terms of this Rider.

Signed for USABLE Life at Little Rock, Arkansas, as of the Effective Date:


Secretary


President



P.O. Box 1650 • Little Rock, AR 72203-1650
(501) 375-7200 • (800) 648-0271

Health Insurance Portability and Accountability Act (HIPAA) Privacy Notice

By law, US Able Life is required to protect the privacy of your protected health information. We must also give you this notice to tell you how we may use and give out (“disclose”) your protected health information held by us.

US Able Life must use and give out your protected health information to provide information:

- To you or someone who has the legal right to act for you (your personal representative);
- To the Secretary of the Department of Health and Human Services, if necessary to make sure your privacy is protected; and
- Where required by law.

US Able Life has the right to use and give out your protected health information to perform business operations. For example:

- We can use your protected health information to pay or deny your claims or to collect your premiums.
- Members of our staff may use this information in an effort to continually improve the quality and effectiveness of the benefits and service we provide.
- We may disclose protected health information to your employer, if your employer arranges for your insurance. We may disclose de-identified protected health information to the appropriate areas so they can modify benefits, work to control overall plan costs, and improve service levels. This information may be in the form of routine reporting or special requests.
- We may disclose protected health information to others who are contracted to provide services on our behalf. Some services are provided in our organization through contracts with others. Examples may include claim investigation/management, medical record retrieval, reinsurance, and the copy service we use when making copies of your health record. Our contracts require these business associates to appropriately protect your information.
- Members of our staff, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person’s involvement in the payment of your claims or collection of your premiums. An example would be your spouse calling to verify a claim was paid or the amount paid on a claim.

US Able Life may use or give out your protected health information for the following purposes, under limited circumstances:

- To state agencies that have the legal right to receive US Able Life data (such as to make sure we are making proper payments);
- For public health activities (such as reporting disease outbreaks);
- For government oversight (such as fraud and abuse investigations);
- For judicial and administrative proceedings (such as in response to a subpoena or other court order);
- For law enforcement purposes (such as providing limited information to locate a missing person);
- To avoid a serious and imminent threat to health or safety;
- To contact you regarding new or changed benefits.

By law, US Able Life must have your written permission (an “authorization”) to use or give out your protected health information for any purpose other than payment or business operations or other limited exceptions outlined here or in the privacy regulation. You may take back (“revoke”) your written permission at any time, except it will not apply if we have already acted based on your permission.

Your Rights Regarding Medical Information About You

By law, you have the right to:

- See and get a copy of your protected health information that is contained in a designated record set that was used to make decisions about you.
- Have your protected health information amended if you believe that it is wrong, or if information is missing, and USABLE Life agrees. If USABLE Life disagrees, you may have a statement of your disagreement added to your protected health information record.
- Receive a listing of those getting your protected health information from USABLE Life. The listing will not cover your protected health information that was given out to you or your personal representative; that was given out for payment or business operations; that was given out based on an authorization signed by you; or that was given out for law enforcement purposes.
- Ask USABLE Life to communicate with you in a different manner or at a different place (for example, by sending your correspondence to a P.O. Box instead of your home address) if you are in danger of personal harm if the information is not kept confidential.
- Ask USABLE Life to limit how your protected health information is used and given out to pay your claims and perform business operations. Please note that USABLE Life may not be able to agree to your request.

To Exercise Your Rights

If you would like to contact USABLE Life for further information regarding this notice or the exercise of any of the rights described in this notice, you may do so by contacting our Privacy Office at the following telephone numbers:

USABLE Life
(501) 375-7200 (Little Rock) or (800) 648-0271 (toll-free)

Changes to This Notice

We are required by law to abide by the terms of this notice. We reserve the right to change this notice and make the revised or changed notice effective for medical information we already have about you as well as any future information we receive. When we make changes, we will notify you by sending a revised notice to the last known address we have for you.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with USABLE Life or with the Secretary of the Department of Health and Human Services. You may file a complaint with USABLE Life by writing to the following address:

USABLE Life
ATTN: Privacy Officer
P.O. Box 1650
Little Rock, AR 72203-1650

Or electronically to:
privacyoffice@usablelife.com

We will not penalize or in any way retaliate against you for filing a complaint with the Secretary or with us.

You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services. Complaints filed directly with the Secretary must: 1) be in writing; 2) contain the name of the entity against which the complaint is lodged; 3) describe the relevant problems; and 4) be filed within 180 days of the time you became or should have become aware of the problem.

Effective Date

The provisions of this notice become effective April 14, 2003.

Note: Unless you have questions regarding this notice, no reply is necessary.

