USAble Life

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CERTIFICATE OF INSURANCE

Group Hospital Confinement

Policyholder: MARION SCHOOL DISTRICT

Class: 001 - ALL FULL TIME ACTIVE CERTIFIED EMPLOYEES

State of Residence: ARKANSAS

Effective Date: October 1, 2013

This is to certify that USAble Life has issued and delivered the Group Hospital Confinement 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.

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 that USAble Life may have issued to the Policyholder to give to You under the Group Insurance Policy specified herein.

Signed for USAble Life:

Secretary

President

Please read Your Certificate carefully.

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Schedule of Insurance

Policyholder:	MARION SCHOOL DISTRICT
Group Policy Number:	50001086
Policy Effective Date:	October 1, 2013 *This Certificate replaces any Certificate issued before the date shown.
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 001 ALL FULL TIME ACTIVE CERTIFIED EMPLOYEES

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:	October 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 – Hospital Care	3 Units	4 Units	6 Units
Module 2 – Surgical	0 Units	2 Units	2 Units
Module 3 – Treatment	0 Units	0 Units	2 Units
Module 4 – Wellness	2 Units	4 Units	6 Units

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.

Ambulatory Surgical Center means a place which:

1. is equipped for Surgery 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.

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

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.

Burn Unit means a Hospital unit that:

1. has beds committed solely to burn care;
2. has a multi-specialty / trauma and nursing staff that rotate in this service; and
3. provides electrocardiograph, oscilloscope, defibrillation, cardiac output monitoring, physical therapy, hydrotherapy and occupational therapy.

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.

Cardiac Care Unit (CCU) means a separate, clearly designated service area in a Hospital and which meets all of the following tests:

1. it is solely for the treatment of patients who require special medical attention because of their critical condition;
2. it provides constant special nursing care and observation not available in the regular rooms and wards of the Hospital;
3. it provides special life-saving equipment available at all times for patients in the CCU;
4. it contains at least two beds for the accommodation of critically ill patients; and
5. it provides at least one registered nurse (R.N.) who continuously and constantly attends the patient Confined in such area on a 24 hour a day basis.

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 Policy holder.

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.

Emergency Treatment means medical attention provided after the acute onset of symptoms relating to Illness or Injury, including severe pain, which symptoms are severe enough that the lack of immediate medical attention could reasonably be expected to result in any of the following:

1. health would be placed in serious jeopardy;
2. bodily function would be seriously impaired; or
3. there would be serious dysfunction of a bodily organ.

Emergency Treatment does not include care that is:

1. elective;
2. preventive; or
3. well care.

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 addition, 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.

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

General Anesthesia means the induction of a balanced state of unconsciousness, accompanied by the absence of pain sensation and the paralysis of skeletal muscle over the entire body.

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. a Hospital 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.

Observation Unit means a specified area within a Hospital, apart from the Emergency Room, where a patient can be monitored following outpatient Surgery or treatment in the Emergency Room by a Physician and which:
1. is under the direct supervision of a Physician or registered nurse (R.N.);
2. is staffed by nurses assigned specifically to that unit; and
3. provides care seven days per week, 24 hours per day.

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.

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 an Immediate 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 group 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.

Preoperative Visit means a visit with a Physician by a Covered Person the purpose of which is preparation and management prior to Surgery.

Pre-Existing Condition means a pregnancy existing on the effective date of coverage; or any condition for which You have done any of the following at any time during the 12 months just prior to Your Effective Date of coverage:

1. received medical treatment or consultation;
2. taken or were prescribed drugs or medicine; or
3. received care or services, including diagnostic measures, whether or not that condition is diagnosed at all or is misdiagnosed during that period of time.

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.

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.

Second Surgical Opinion means another opinion on a Surgery which opinion is rendered by a Physician who is not:

1. the Physician who originally recommended the Surgery;
2. a partner in practice with the Physician who originally recommended the Surgery; or
3. the Physician who will perform the Surgery.

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, or civil union partner if legally recognized in the governing jurisdiction or as otherwise agreed upon between the Policyholder and the company.

Surgery means the cutting into the skin or other organ to accomplish any of the following goals:

1. take a biopsy of a suspicious lump that results in a diagnosis of Cancer (internal or invasive) or Carcinoma In Situ;
2. further explore the condition for the purpose of diagnosis;
3. remove diseased tissues or organs;
4. remove an obstruction;
5. reposition structures to their normal position;
6. redirect channels;
7. transplant tissue or whole organs;
8. implant mechanical or electronic devices;
9. reconstruct anatomic defects that result from treatment of Cancer (internal or invasive) or Carcinoma In Situ; or
10. restore proper function.

The following will not be considered a Surgery for the purposes of this Certificate:

1. venipuncture (drawing blood);
2. lumbar puncture;
3. epidural steroid injections;
4. removal of skin tags;
5. catherization; or
6. endoscopic procedures not requiring biopsy or removal of tissue.

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.

Urgent Care Facility means a licensed facility that:

1. sees walk-in patients without appointment;
2. has emergency facilities;
3. is supervised by a medical staff, including registered nurses (R.N.s);
4. has an agreement with a nearby Hospital for immediate acceptance of patients who require Hospitalization;
5. is not a private office or clinic of one or more Physicians;
6. is not a Hospital or Emergency Room; and
7. does not provide for overnight stays.

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** mean 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 in 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 in the Schedule of Insurance which immediately follows the date noted in items 2, 3, or 4 above.

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 policy 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 the redetermination date. If You are not, Your coverage amount will not change until the date You return to Active Work.

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 Exclusion 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 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;
4. the date the Policy terminates; or
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 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 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, deems 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
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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 enrollment form, 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 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, USAble 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 Numbers.

   Give Us updates of such records as needed.
3. 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.
4. 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.
3. Provide any other official documents to review the loss such as a certified death certificate, investigating officer's report, or medical records.
4. Allow release of medical and income data needed to adjudicate Your claim.
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 Hospital Confinement 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 children'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 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 Hospital Confinement 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 Hospital Confinement 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 Hospital Confinement 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

Pre-Existing Conditions - Limitations for Certain Conditions:
Benefits will not be paid for loss caused by Pre-Existing Conditions during the first 12 months following the Effective Date of Your coverage and Your loss is caused by, contributed to by, or the result of a Pre-Existing Condition. After this 12 month period, however, loss due to such Pre-Existing Conditions will be payable unless specifically excluded from coverage.

Exclusions - What We Will Not Pay For:

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

1. Being exposed to war or any act of war, declared or undeclared, actively participating in a riot or insurrection, or serving in any of the armed forces.
2. Intentionally self-inflicting bodily Injury or attempting suicide, while sane or insane.
3. Participating in any form of flight aviation other than as a fare-paying passenger in a fully licensed/passenger-carrying aircraft.
4. 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.
5. Receiving treatment for any mental, nervous or emotional disorder without demonstrable organic disease.
6. Receiving treatment for alcoholism or drug addiction, or the use of alcohol or drugs (unless administered by a Physician and taken according to the Physician's instructions) or voluntarily taking, administering, absorbing, or inhaling poison, gas, or fumes.
7. Participating in any activity or event, including the operation of a vehicle, while under the influence of a narcotic (unless administered 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.
8. 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.
9. Having dental or cosmetic Surgery or other elective procedures that are not medically necessary, or having dental treatment except as a result of Injury or congenital defect of a newborn child (including adopted children as defined).
10. Receiving treatment for hernia, tonsils or adenoids during the first six months of coverage unless treated on an emergency basis.
11. A newborn child's routine nursing or routine well baby care during the initial hospital confinement.
12. Receiving routine eye examinations, eye glasses or the fitting thereof.
13. Receiving hearing aids or the fitting thereof.
14. Receiving reversal of a tubal ligation or vasectomy.
15. Receiving artificial insemination, in vitro fertilization, and test tube fertilization, including any related testing, medications or physician services, unless required by law.
16. 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.
17. Riding in or driving any motor-driven vehicle in a race, stunt show or speed test.
18. Childbirth occurring within the first 10 months of the Covered Person's effective date of coverage (complications of pregnancy are covered to the same extent as a Sickness).

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

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. See Your Schedule of Insurance/application for the number of units of coverage You have in force for each module.

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 – Hospital Care

Hospital Admission

We will pay $250 per unit of coverage if the Covered Person incurs charges for and is Confined to a Hospital, Hospital Intensive Care Unit or a Hospital Sub-Acute Intensive Care Unit as a resident bed patient for a period of 18 hours due to an Accident or Sickness. The Confinement to a Hospital must begin while the Certificate is in force.

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

We will pay this benefit a maximum of 10 times per Covered Person per Calendar Year. If a Covered Person is Confined and is discharged and Confined again for the same or related condition within 90 days of discharge, We will treat this later Confinement as a continuation of the previous Confinement. If more than 90 days have passed between the periods of Hospital Confinement, We will treat this later Confinement as a new and separate Confinement.

Hospital Confinement

We will pay $50 a day per unit of coverage if any Covered Person incurs charges for and is Confined to a Hospital as a resident bed patient for 18 hours due to:

1. Accidental Bodily Injury, directly and with no other cause, while this policy is in force; or
2. Sickness, disease, or complications of pregnancy; or
3. Pregnancy without complications, subject to the Pre-Existing Condition provision; or
4. Newborn child care, including a maximum of 5 days routine nursery care.

The Confinement to a Hospital must begin while the Certificate is in force. Benefits are also payable for Confinement in Hospitals operated by or for the United States government.

We will pay the unit amount for each day the Covered Person is Confined to a Hospital per day for up to 180 days per Confinement. We will not pay the Hospital Confinement and Intensive Care benefit for the same periods of Confinement. We will not pay this benefit for an Observation Unit, Emergency Room treatment or outpatient treatment.

We will pay this benefit a maximum of 10 times per Covered Person per Calendar Year. If a Covered Person is Confined and is discharged and Confined again for the same or related condition within 90 days of discharge, We will treat this later Confinement as a continuation of the previous Confinement. If more than 90 days have passed between the periods of Hospital Confinement, We will treat this later Confinement as a new and separate Confinement.

Intensive Care Benefit

We will pay $75 a day per unit of coverage if any Covered Person incurs charges for and is Confined to a Hospital Intensive Care Unit as a resident bed patient for 18 hours due to an Accident or Sickness. The Confinement to a Hospital must begin while the Certificate is in force. Benefits are also payable for Confinement in Hospitals operated by or for the United States government.

We will pay the unit amount for each day the Covered Person is Confined to a Hospital Intensive Care Unit per day for up to 15 days per Confinement. This benefit is in addition to the Hospital Confinement benefit. We will not pay the Hospital Confinement and Intensive Care benefit for the same periods of Confinement.

This benefit will be paid when the Covered Person is Confined to one of the following Intensive Care Units:

1. Intensive Care Unit;
2. Cardiac Care Unit; or
3. Burn Unit.

Some Hospitals may classify and bill for intensive care in Hospital Sub-Acute Intensive Care, intermediate or step-down units which are not covered under this benefit.

We will pay this benefit a maximum of 1 time per Covered Person per Calendar Year. If a Covered Person is Confined and is discharged and Confined again for the same or related condition within 90 days of discharge, We will treat this later Confinement as a continuation of the previous Confinement. If more than 90 days have passed between the periods of Hospital Confinement, We will treat this later Confinement as a new and separate Confinement.

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 or Sickness. The ground ambulance transportation must be between 0 to 30 days of the Accident or Sickness. The air ambulance transportation must be within 72 hours of the Accident or Sickness. We will pay the ground or air ambulance, but not both, once per Accident or Sickness, per Covered Person.

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

We will pay this benefit a maximum of 3 times per Covered Person per Calendar Year.

Module 2 – Surgical

Surgery Benefit

We will pay the benefit shown in the following Surgical Benefit Schedule, per unit of coverage, for a Surgery, in or out of a Hospital, when Surgery is due to an Accident or Sickness. Each unit of coverage is subject to a maximum surgical benefit of $1,000 per Surgery. The Surgery must be performed by a Physician in a Hospital or Ambulatory Surgical Center.

For Surgeries not listed, We will pay You an amount comparable to the amount shown in the following schedule for the Surgeries most nearly similar in severity and gravity. Surgeries

performed through the same incision or in the same body opening will be considered one Surgery. We will pay the amount shown in the Surgical Benefit Schedule for the one procedure with the largest benefit. The following schedule is for one unit of coverage.

If a Covered Person receives a subsequent Surgery for the same Accident or same Sickness, We will pay an additional benefit only if the subsequent procedure was performed more than 30 days after the last covered procedure was performed.

SURGERY SCHEDULE	**Benefit Per Unit**
AMPUTATIONS	
Arm at shoulder joint	$380
Arm below shoulder joint	$200
Finger	$110
Leg at hip joint	$400
Leg above or below knee	$290
Toe	$62
ARTERIES	
Endarterectomies/stenting	$300
Carotid endarterectomy	$780
Excision and graft, abdominal aortic aneurysm	$530
Injection, varicose veins	$18
Thromboendarterectomy	$400
BREAST	
Biopsy	$70
Excision of chest wall tumor	$340
Excision of cyst of benign tumor	$100
Mastectomy, radical	$380
Mammoplasty, reconstructive	$360
Mastectomy, simple	$208
DIGESTIVE SYSTEM	
Appendectomy	$220
Aspiration biopsy of liver, pancreas or bile duct	$40
Cholecystectomy	$284
Cholecystotomy	$250
Colostomy	$240
Diverticulectomy	$240
Enterectomy	$352
Enterotomy	$354
Enterostomy	$180
Enterolysis	$292
Fissurectomy or hemorrhoidectomy	$80
Fistulotomy	$60
Gastrectomy, partial	$480
Gastrectomy, total	$560
Gastrorrhaphy	$280
Gastroscopy	$84
Gastrostomy	$230
Gastrotomy	$270
Herniotomy	$210
Laparotomy	$170
Pancreatectomy, partial	$350
Pancreatectomy, total	$700

SURGERY SCHEDULE	Benefit Per Unit
Proctectomy	$560
Proctoplasty	$200
Proctosigmoidoscopy	$14
Removal of external hemorrhoids	$50
Sphincterotomy	$24
DISLOCATIONS	
Ankle	$54
Collar bone (requiring reduction)	$48
Fingers or toes	$10
Hip or knee	$155
Jaw	$40
Shoulder (humerus with anesthesia) or elbow	$27
Wrist	$30
EAR	
Drainage of abscess	$20
Labyrinthotomy or labyrinthectomy	$560
Mastoidectomy, simple	$300
Myringotomy	$20
Tympanoplasty	$620
ENDOCRINE SYSTEM	
Adrenalectomy	$390
Fine Needle Aspiration (FNA)	$18
Local excision of thyroid cyst or adenoma	$200
Thyroidectomy or parathyroidectomy	$520
EYE	
Excision of lacrimal glad or sac	$260
Excision of pterygium	$140
Extraction of lens (including cataract extraction)	$560
Iridectomy	$440
Strabismus	$380
Reattachment of retina	$820
Removal of eye	$250
Sclerotomy, anterior or posterior	$200
FRACTURES	
Ankle	$130
Collar bone	$70
Fingers	$30
Foot	$64
Hand	$50
Jaw	$160
Lower arm (radius)	$86
Lower arm (ulna)	$66
Lower leg (fibula)	$80
Lower leg (tibia)	$60
Nose	$30
Pelvis	$225
Shoulder blade (scapula)	$230
Skull	$360
Toes	$22

SURGERY SCHEDULE	Benefit Per Unit
Upper arm	$100
Upper leg	$200
Vertebrae, one or more	$200
Wrist	$50
GENITAL SYSTEM – MALE	
Biopsy, prostate	$40
Circumcision	$20
Excision of epididymis, hydrocele, varicocele	$160
Orchiectomy	$126
Prostatectomy, partial	$440
Prostatectomy – radical	$520
Reduction of torsion of testis	$200
Vasectomy	$90
GENITAL SYSTEM – FEMALE	
Amniocentesis	$20
Biopsy or removal of cervical lesion or polyp	$16
Dilation and curettage	$80
Cesarean section	$290
Hysterectomy, radical for cancer including lymph nodes	$480
Hysterectomy, vaginal or abdominal	$380
Myomectomy	$240
Obstetrical delivery	$210
Repair of cystocele or rectocele	$140
Repair of uterine suspension	$242
Salpingo-oophorectomy	$340
Tubal ligation	$200
HEART –CARDIOVASCULAR SYSTEM	
Angioplasty, percutaneous	$460
Catheterization of heart	$230
Coronary bypass, single or multiple	$1,000
Heart transplant	$1,000
Pervenous or transvenous insertion of pacemaker	$390
Repair of myocardial aneurysm	$760
Repair of septal defect	$780
Suture of heart wound or Injury	$480
Valvotomy, aortic and pulmonic valve	$740
Valvotomy, mitral valve	$860
Valvuloplasty or replacement aortic and mitral, pulmonary, or tricuspid valve	$1,000
HEMIC & LYMPHATIC SYSTEMS	
Biopsy of lymph node	$30
Radical lymphadenectomy	$420
Splenectomy	$320
JOINTS	
Ankle, arthrotomy	$240
Ankle, arthroplasty	$400
Hammertoe	$96
Hip, arthrotomy	$282
Hip, arthroplasty	$650

SURGERY SCHEDULE	Benefit Per Unit
Knee, arthrotomy	$250
Knee, arthroplasty	$460
Shoulder or elbow, arthrotomy	$220
Shoulder or elbow, arthroplasty	$440
Wrist, arthrotomy	$160
Wrist, arthroplasty	$300
LARYNX	
Laryngectomy	$500
Laryngoscopy	$20
LUNGS	
Pneumocentesis	$30
Pneumonectomy, total	$600
Pneumonotomy	$280
Thoracentesis	$40
Thoracoscopy (including biopsy)	$140
Thoracotomy	$280
Wedge resection of lung, single or multiple	$380
MUSCULOSKELETAL SYSTEM BONE OR CARTILAGE GRAFT	
Spinal fusion	$360
Spinal fusion for scoliosis	$600
NERVOUS SYSTEM	
Burr holes	$200
Cranioplasty	$480
Craniotomy or craniectomy	$176
Laminectomy	$700
Median nerve decompression (carpal tunnel)	$168
Paravertebral block, lumbar, or thoracic nerve	$30
Spinal puncture	$40
NOSE	
Excision of nasal polyps	$48
Submucous resection, classic nasal sept	$220
SINUSES	
Frontal sinusotomy – radical	$250
Frontal sinusotomy – simple	$210
SKIN – INTEGUMENTARY SYSTEM	
Acne Surgery	$10
Biopsy	$20
ChemoSurgery – malignancies of skin	$92
Electro-surgical destruction of chemocautery	$18
Excision of benign tumor	$40
Excision of malignant tumor (trunk, arms or legs)	$30
Excision of malignant tumor (face, scalp, ears, neck, hands, feet, genitalia)	$60

SURGERY SCHEDULE	Benefit Per Unit
Excision of malignant tumor (eyelids, nose, lips, mucous membrane)	$60
Excision of nail	$76
Incision and drainage of cyst	$16
Repair, complex wounds (linear repair)	$35
Repair, skin grafts (multiple stage)	$70
Repair, skin grafts (single stage)	$35
Repair, simple wounds	$16
TENDONS	
Lengthening or shortening (e.g. Achilles tendon)	$160
Repair or suture	$60
TRACHEA & BRONCHI	
Bronchoscopy	$120
Closure of tracheotomy	$98
Tracheotomy	$20
URINARY SYSTEM	
Cystectomy, complete	$510
Cystectomy, partial	$245
Cystoplasty	$400
Cystotomy	$340
Dilation of urethra	$30
Kidney transplant	$600
Lithotripsy	$375
Nephrostomy	$400
Nephrectomy	$420
Nephrolithotomy	$400
Renal biopsy	$56
Urethroscopy or cystoscopy	$40

Anesthesia Benefit

We will pay 5% of the Surgery Benefit if any Covered Person requires General Anesthesia during a covered Surgery. Payment of this Benefit will not increase any other Benefit of the Policy.

Preoperative Visit Benefit

We will pay 1.5% of the Surgery benefit for a Preoperative Visit for a Covered Person.

The Preoperative Visit must:

1. take place while Your Certificate is in force;
2. be in connection with Surgery covered by the Policy; and
3. take place within 30 days prior to the date of Surgery.

This Benefit is limited to 2 Preoperative Visits per proposed Surgery.

Second Surgical Opinion Benefit

We will pay 1.5% of the Surgery benefit for a Second Surgical Opinion given to a Covered Person.

The Second Surgical Opinion must:

1. take place while the Certificate is in force;
2. be in connection with Surgery covered by the Policy; and
3. take place within 30 days prior to the date of Surgery.

This Benefit is limited to 2 Second Surgical Opinions per proposed Surgery.

Diagnostic Procedure Benefit

We will pay $50 per unit of coverage if any Covered Person incurs charges for and has one of the following diagnostic procedures while this Certificate is in force. The procedure must be required due to an Accident or Sickness and limited to one diagnostic procedure.

Breast

Biopsy (incisional, needle, sterotactic)

Cardiovascular

Angiogram

Arteriogram

EPS

Thallium Stress Test

Transesophageal Echocardiogram (TEE)

Digestive

Barium Enema/Lower GI series

Barium Swallow/Upper GI series

Esophagogastroduodenoscopy (EGD)

Ear/Nose/Throat/Mouth

Laryngoscopy

Gynecological

Amniocentesis

Cervical biopsy

Cone biopsy

Endometrial biopsy

Hysteroscopy

Loop Electrosurgical Excisional Procedure (LEEP)

Liver

Biopsy

Lymphatic

Biopsy

Diagnostic Radiology

Computerized Tomography Scan (CT Scan)

Electroencephalogram (EEG)

Magnetic Resonance Imaging (MRI)

Myelogram

Nuclear medicine test

Positron Emission Tomography Scan (PET Scan)

Miscellaneous

Bone marrow aspiration/biopsy

Renal

Biopsy

Nephrostomy

Respiratory

Biopsy

Bronchoscopy

Pulmonary Function Test (PFT)

Skin

Biopsy

Excision of lesion

Thyroid

Biopsy

Urinary

Cystoscopy

We will pay this benefit a maximum of 3 times per Covered Person per Calendar Year.

Module 3 – Treatment

Emergency Treatment Benefit

We will pay $50 per unit of coverage if a Covered Person incurs charges for and requires examination and Emergency Treatment by a Physician in a Emergency Room or Urgent Care Facility due to a Accident or Sickness while this Certificate is in force. Necessary Treatment due to a Accident must be received within 72 hours of such Accident for benefits to be payable. This benefit is payable once per Accident or Sickness, per Covered Person. Benefits will not be paid for services rendered by an Immediate Family Member.

We will pay the charges incurred, not to exceed $40 per unit of coverage, if the Covered Person is treated in an Urgent Care Facility.

We will pay this benefit a maximum of 3 times per Covered Person per Calendar Year.

Physician Office Visit Benefit

We will pay $25 per unit of coverage if the Covered Person incurs charges for and has a Physician's office visit. This benefit is not payable for services rendered by a Physician while a Covered Person is Confined to a Hospital or considered Emergency Treatment.

A covered Physician Office Visit is one that:

1. is not a Preoperative Visit;
2. is not a Second Surgical Opinion;
3. takes place while the Certificate is in force; and
4. is for the diagnosis or treatment of an Accident or Sickness.

We will pay the unit amount shown on the Schedule of Insurance per Physician Office Visit.

We will pay this benefit a maximum of 5 times per Covered Person per Calendar Year.

Module 4 – 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
Blood test for triglycerides
Bone marrow testing
Breast ultrasound
CA 125 (blood test for ovarian cancer)
CA 15-3 (blood test for breast cancer)
CEA (blood test for colon cancer)
Chest X-ray
Colonoscopy
Fasting blood glucose test
Flexible sigmoidoscopy
Hemocult stool analysis
Mammography
Pap test
PSA (prostate-specific antigen tests)
Serum cholesterol test to determine HDL/LDL level
Serum Protein Electrophoresis (blood test for myeloma)
Stress test on a bicycle or treadmill
Thermography

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.

USAble Life

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, USAble 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.

USAble 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.

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

- privacy law, we can 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.

USAble 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 USAble 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, USAble 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.

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Internal Grievance Procedures

For claims governed by ERISA, there is a mandatory grievance (appeal) process, to which we adhere, and which an insured must follow. We also offer a similar appeal process to insureds under policies subject solely to state law, which appeal procedure is at the option of the insured. These procedures are as follows:

ERISA Claim Denials
Denial letters must be written in a manner calculated to be understood by the claimant and contain the following:

1. Specific reason(s) for the adverse determination.
2. A description of any additional information or material necessary for the claimant to perfect the claim and an explanation as to why such material is necessary.
3. A description of the claimant's required right to appeal, in accordance with the appeal procedures and applicable time limits described below, including a statement of the claimant's right to bring a civil lawsuit under ERISA following completion of the appellate review process established by the plan. If the plan offers a voluntary dispute resolution process, information about this process so the claimant may decide whether or not to submit to the process.
4. If the denial was based in whole or in part on the plan's internal rule(s), guideline(s), protocol(s) or similar guide(s), the plan must inform the claimant that such information has been relied upon for the decision. The plan may either set forth the content of the rule, guideline, etc. in the denial letter or state that a rule, guideline, etc. was relied upon for the decision (at least in part) and that a copy of the document will be provided to the claimant upon request.
5. After receiving an adverse benefit determination, upon the request of the claimant, the plan must provide to the claimant, free of charge, all relevant documents and information. "Relevant" is defined in the regulations and essentially requires production of the entire claim file, except for clearly privileged material such as attorney-client memos. The plan must also provide any information the plan generated or obtained in the process of ensuring or verifying that, in making the adverse determination, the plan complied with its own administrative processes.

ERISA Appeals
1. We will provide the claimant at least 180 days, following receipt of an adverse benefit determination notification, to file an appeal. This appeal is mandatory for an ERISA claim.
2. We will decide each appeal within 45 days after receipt of the appeal, and we shall consider all information, documents or other records submitted in connection with the claim and appeal. The time period starts when the appeal is filed without regard to whether all of the information necessary to decide the claim accompanies the filing.
3. The 45-day requirement may be extended by 45 days if the claim cannot be resolved (decided) for "special circumstances." The time it takes for the claimant to provide needed additional information does not count toward the extension time period.

4. Total allowable time to decide an appeal is 90 days, excluding the time it takes for the claimant to provide needed additional information.
5. A person or person(s) who is neither the individual who made the adverse benefit determination or a subordinate of such individual will conduct the appeal review.
6. If the adverse benefit determination was based in whole or in part on a medical judgment, the reviewer will consult with a health care professional that has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional will not be the same person who was consulted in connection with the original adverse benefit determination nor will he/she be a subordinate of that person.
7. A statement will be included in the appeal denial letter that: "You may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency.

Non-ERISA Claim Denials

Denial letters must be written in a manner calculated to be understood by the claimant and contain the following:

1. A description of the specific reason(s) for the adverse determination.
2. A description of any additional information or material necessary for the claimant to perfect the claim and an explanation as to why such material is necessary.
3. A description of the claimant's option to appeal this denial in accordance with the appeal procedures set forth for non-ERISA appeals below.
4. After receiving an adverse benefit determination, upon the request of the claimant, the carrier will provide to the claimant, free of charge, all relevant documents and information. "Relevant" is defined in the regulations and essentially requires production of the entire claim file, except for clearly privileged material such as attorney-client memos.

Non-ERISA Appeals

1. We will allow the claimant 180 days, following receipt of an adverse benefit determination notification, to file an appeal.
2. We will attempt to decide each appeal de novo within 60 days after receipt of the appeal, and we shall consider all information, documents or other records submitted in connection with the claim and appeal. The time period starts when the appeal is filed without regard to whether all of the information necessary to decide the claim accompanies the filing.
3. If, for good cause, we need additional time to complete our evaluation and decision on this appeal, we will advise the claimant in writing of the need for that extension. We will provide continuing written updates no later than every 30 days thereafter, until we complete the appeal evaluation and investigation, and notify the claimant in writing of our decision.
4. The claimant or claimant's representative shall have the opportunity to submit written comments, and review documents or records, and other information relating to the claim, without regard to whether these documents, records and other information were considered in making the initial adverse claim determination.
5. A person or person(s) who is neither the individual who made the adverse benefit determination or a subordinate of such individual will conduct the appeal review, and shall act as the appeal fiduciary.
6. If the adverse benefit determination was based in whole or in part on a medical judgment, the reviewer will consult with a health care professional that has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional will not be the same person who was consulted in connection with the original adverse benefit determination nor will he/she be a subordinate of that person.