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GROUP ACCIDENT CERTIFICATE OF INSURANCE

Policyholder: SEIU LOCAL 503, OREGON PUBLIC EMPLOYEES UNION
Policy Number: 50059083
Governing Jurisdiction: OREGON
Policy Effective Date: January 1, 2026
Policy Anniversary: January 1
Class Description: ALL ELIGIBLE MEMBERS OF THE POLICYHOLDER

This Certificate is a part of the Policy and replaces any other that We may have issued to the Policyholder. You are insured for the benefits described in this Certificate, subject to the provisions of this Certificate.

READ THE CERTIFICATE CAREFULLY. INSURANCE BENEFITS MAY BE SUBJECT TO CERTAIN REQUIREMENTS, REDUCTIONS, LIMITATIONS AND EXCLUSIONS.

If the terms and provisions of the Certificate differ from the Policy, the Policy will govern. Your coverage may be canceled or changed in whole or in part under the terms and provisions of the Policy but shall not be less than those stated in this Certificate. You may inspect a copy of the Policy upon request to Your Participating Employer.

The Policy is delivered in and is governed by the laws of the state of issue shown above, and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments.

Capitalization of a term which is not typically capitalized according to standard punctuation guidelines indicates a word or phrase that is a defined term in this Certificate or refers to a specific provision contained herein.

Signed for US Able Life at Little Rock, Arkansas on the Policy Effective Date.

Michelle W. Harding
Secretary

[Signature]
President

You have a 30-day right from the Effective Date of Coverage to examine this Certificate. If You are not satisfied, it may be returned to Us within 30 days from receipt of this Certificate. In that event, We will consider it void from its effective date and any premiums paid will be refunded. Any claims paid under the Policy during the initial 30-day period will be deducted from the refund.

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

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GROUP ACCIDENT INSURANCE OVERVIEW

Eligible Class	ALL ELIGIBLE MEMBERS OF THE POLICYHOLDER
Coverage Type	Employee only Employee + Spouse Employee + Children Family
Occupational Coverage Type	24 hour coverage
Annual Enrollment Date	January 1 of each year
Eligibility Waiting Period	Employees in an Eligible Class before January 1, 2026 Policy Effective Date. Employees in an Eligible Class after January 1, 2026 Date of hire.

Disclosure of Fees:

We may adjust premiums, rates, fees and/or other expenses for programs under the Policy.

Disclosure of Services:

In addition to the insurance coverage, We may offer non-insurance benefits and services to Employees.

SCHEDULE OF BENEFITS

This is a brief overview of Your benefits in the event of a Covered Loss. These benefits are described further in the Certificate, along with other important information about Your coverage.

Defined terms are capitalized when used throughout the Certificate and can be located in the Glossary section of the Certificate.

Benefit	Benefit Amount Plan 1
Injury Benefits	
Burns	<ul style="list-style-type: none"> • Third degree: \$2,000 • Second degree: \$500 • Skin graft: 100% of Burn benefit
Brain Injury	\$200
Coma	\$8,000
Dislocation (Non-Surgical Repair)	\$500
Eye Injury (Non-Surgical Repair)	\$300
Fracture (Non-Surgical Repair)	\$500
Lacerations	\$100
Treatment and Services Benefits	
Ambulance	<ul style="list-style-type: none"> • Ground ambulance: \$100 • Air ambulance: \$500
Blood Products	\$200 per day
Diagnostic Examination	\$50 per day
Emergency Dental Procedure	<ul style="list-style-type: none"> • Broken tooth repaired with crown: \$100 • Broken tooth repaired with extraction: \$50
Emergency Treatment	\$100 per visit
Follow-Up Physician Treatment	\$25 per visit
Medical Equipment	\$100
Physical Therapy	\$25 per visit
Physician Office and Urgent Care Treatment	\$25 per visit
Prosthetics	\$500
X-Ray	\$50 per day
Accidental Death, Functional Loss, and Paralysis Benefits	

Accidental Death	<ul style="list-style-type: none"> • Basic accidental death: \$10,000 • Common carrier accidental death: \$20,000 <p>Benefit amounts for a covered child are 50% of the Covered Employee Benefit amount.</p>
Functional Loss	<ul style="list-style-type: none"> • Loss of both hands, loss of both feet, or loss of entire sight of both eyes: \$10,000 • Loss of speech and loss of hearing: \$10,000 • Loss of one hand, loss of one foot, loss of entire sight of one eye or loss of hearing: \$5,000 • Loss of multiple fingers or loss of multiple toes: \$1,000 <p>Benefit amounts for a covered child are 50% of the Covered Employee Benefit amount.</p>
Paralysis	<ul style="list-style-type: none"> • Hemiplegia: \$10,000 • Paraplegia: \$10,000 • Quadriplegia: \$20,000 <p>Benefit amounts for a covered child are 50% of the Covered Employee Benefit amount.</p>
Rider Benefits	
Accident Care Rider	See Rider Schedule of Benefits

ELIGIBILITY AND EFFECTIVE DATE

Eligibility for Coverage

Coverage Eligibility Date

As an Employee, You are eligible for coverage on the later of:

- a. the Policy Effective Date; or
- b. the date You become a member of an Eligible Class; or
- c. the date You complete any applicable Eligibility Waiting Period.

If You elect coverage for Yourself, Your Dependent is eligible for coverage on the later of:

- a. the date You are eligible for coverage; or
- b. the date the person becomes a Dependent.

Dual Coverage Restriction

Your Spouse or Child will not be eligible for Dependent insurance if either is insured under the Policy as an Employee.

If both You and Your Spouse are insured as Employees, Your eligible Children may be insured as Dependents of only one of You.

Other Insurance With Us

If You are covered under more than one Policy of this type with Us, only one Policy, chosen by You or Your estate, will be effective (this includes coverage for any insured 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.

Enrolling for Coverage

Initial Enrollment

Contributory Coverage

You may apply for any coverage available for You, Your Spouse and Children within 31 days of a Covered Person's Coverage Eligibility Date.

You may also apply for any coverage available for You, Your Spouse and Children during the Annual Enrollment Period.

Late Enrollment

Contributory Coverage

If You did not apply for coverage during the Initial Enrollment Period or You voluntarily cancelled coverage for any Covered Person and are re-applying, You may apply for coverage during the Annual Enrollment Period, or within 31 days of the date they become eligible for coverage.

Effective Date of Coverage

Contributory Coverage

Coverage for a Covered Person will begin on the latest to occur of:

1. the first day of the month following the date an Employee or Dependent becomes eligible as described in the Eligibility for Coverage provision, if enrolled on or before that date;
2. an Annual Enrollment Period, if an Employee or Dependent is enrolled during an Annual Enrollment Period;
3. the first day of the month following an Additional Enrollment Event, if an Employee or Dependent is enrolled during an Additional Enrollment Event; or
4. the first day of the month following the date an Employee or Dependent is enrolled, if enrolled after becoming eligible as described in the Eligibility for Coverage provision.

In no event will Dependent insurance become effective before an Employee becomes insured. An initial period of coverage for a new Dependent may be available under the New Dependent Enrollment provision.

The Effective Date of Coverage for any Employee or Dependent is subject to the Deferred Coverage Effective Date provision.

Deferred Effective Date of Coverage

Deferred Effective Date due to Not Actively at Work

All effective dates of coverage, Changes in Coverage effective dates and Reinstatement of Coverage effective dates for an Employee and any Dependent(s) will be deferred if an Employee is not Actively at Work on the day coverage would otherwise begin. If deferred, coverage will become effective on the day the Employee returns to Active Work.

Deferred Effective Date due to Confinement

All effective dates of coverage, Changes in Coverage effective dates, and New Dependent Enrollment effective dates for a Dependent will also be deferred if on the date the Dependent is to become covered, he or she is Confined. Such coverage will not start until the day the Dependent is no longer Confined.

In no event will Dependent insurance become effective before an Employee becomes insured.

This provision does not apply to:

1. any newborn Dependent Child, regardless of Confinement; or
2. any disabled child who qualifies under the definition of Dependent Child(ren).

Changes in Coverage

An Employee may elect, drop, increase, decrease or otherwise change coverage:

1. during an Annual Enrollment Period; or
2. within 31 days of a Change in Family Status.

Any change in coverage requested by an Employee will become effective on the later of:

1. an Annual Enrollment Period, if the change is requested during such period;
2. the first day of the month following an Additional Enrollment Event, if the change is requested during such event; or
3. the first day of the month following the date on which the change is requested following a Change in Family Status;

subject to the Deferred Effective Date of Coverage provision.

An initial period of coverage for a new Dependent may be available under the New Dependent Enrollment provision.

Any change in coverage requested by the Policyholder or as a result of a change in the terms of the Policy will become effective on the first day of the month following the approval date of the request or change.

New Dependent Enrollment

Your newborn or newly adopted Children will automatically be covered for 31 days from their Coverage Eligibility Date if You are insured, subject to the Deferred Coverage Effective Date provision.

If You wish to continue Child coverage, You must notify Us on or before the end of the 31 day period and pay any additional premium.

If You already have coverage for Your Children, then all eligible Children will be covered and You do not need to notify Us or pay any additional premium for the newly eligible Child.

BENEFITS

If, while this Certificate is in force, a Covered Person incurs an Injury resulting in the losses described in the Benefits provision, and diagnosis is made by or treatment is prescribed by a Physician, We will pay the following benefits for such loss. The Injury must be initially diagnosed within 30 days of the Accident, unless otherwise stated. Benefits will not be paid for losses or medical expenses for an Injury incurred prior to the Effective Date of Coverage.

Injury Benefits

Burns: We will pay the Benefit Amount shown in the Schedule of Benefits if a Covered Person, as a result of an Accident, sustains a Second or Third Degree Burn.

Benefit Conditions:

1. Diagnosis must be made within 30 days of the Accident.
2. Third Degree Burns must cover at least 18 square inches of the Covered Person's body.
3. Second Degree Burns must cover at least 34% of the Covered Person's body.
4. Skin graft must be due to a covered Burn.

Benefit Limitations:

1. We will pay this benefit a maximum of 1 time per Covered Person per Accident.

Brain Injury: We will pay the Benefit Amount shown in the Schedule of Benefits if a Covered Person, as a result of an Accident, incurs a Brain Injury.

Benefit Conditions:

1. Diagnosis must be made within 30 days of the Accident.

Benefit Limitations:

1. We will pay this benefit a maximum of 1 time per Covered Person per Accident.
2. We will not pay the Brain Injury and Coma benefits concurrently. We will pay whichever is greater.

Coma: We will pay the Benefit Amount shown in the Schedule of Benefits if a Covered Person, as a result of an Accident, is diagnosed with a Coma.

Benefit Conditions:

1. Diagnosis must be made within 30 days of the Accident.

Benefit Limitations:

1. We will pay this benefit a maximum of 1 time per Covered Person per Accident.
2. We will not pay the Brain Injury and Coma benefits concurrently. We will pay whichever is greater.

Dislocation (Non-Surgical Repair): We will pay the Benefit Amount shown in the Schedule of Benefits if a Covered Person, as a result of an Accident, sustains a dislocation that requires non-surgical repair.

Benefit Conditions:

1. Diagnosis must be made within 30 days of the Accident.

Benefit Limitations:

1. We will pay this benefit a maximum of 1 time per Covered Person per Accident.
2. We will pay 50% of the Dislocation (Non-Surgical Repair) Benefit if a Covered Person sustains an Incomplete Dislocation.

An Incomplete Dislocation is a dislocation in which the joint is not completely separated.

Eye Injury (Non-Surgical Repair): We will pay the Benefit Amount shown in the Schedule of Benefits if a Covered Person, as a result of an Accident, sustains an eye Injury that requires non-surgical repair.

Benefit Conditions:

1. Diagnosis must be made within 30 days of the Accident.

Benefit Limitations:

1. We will pay this benefit a maximum of 1 time per Covered Person per Accident.

Fracture (Non-Surgical Repair): We will pay the Benefit Amount shown in the Schedule of Benefits if a Covered Person, as a result of an Accident, sustains a fracture that requires non-surgical repair.

Benefit Conditions:

1. Diagnosis must be made within 30 days of the Accident.

Benefit Limitations:

1. We will pay this benefit a maximum of 1 time per Covered Person per Accident.
2. We will not pay this benefit for a stress fracture.
3. We will pay 50% of the Fracture (Non-Surgical Repair) Benefit if a Covered Person sustains a Chip Fracture.

A Chip Fracture is a fracture in which a piece of the bone is broken off near a joint at a place where a ligament is usually attached.

Lacerations: We will pay the Benefit Amount shown in the Schedule of Benefits if a Covered Person, as a result of an Accident, sustains a Laceration.

Benefit Conditions:

1. Laceration repair must occur within 3 days of the Accident.
2. Laceration repair must require sutures, staples, or glue.

Benefit Limitations:

1. We will pay this benefit a maximum of 1 time per Covered Person per Accident.

Treatment and Services Benefits

Ambulance: We will pay the Benefit Amount shown in the Schedule of Benefits if a Covered Person, as a result of an Accident, receives transport by a licensed ambulance company to or from a Hospital or between medical facilities where treatment is received as a result of an Accident.

Benefit Conditions:

1. Ground ambulance transportation must occur within 30 days of the Accident.
2. Air ambulance transportation must occur within 3 days of the Accident.

Benefit Limitations:

1. We will pay this benefit a maximum of 1 time per Covered Person per Accident.

Blood Products: We will pay the Benefit Amount shown in the Schedule of Benefits if a Covered Person, as a result of an Accident, receives blood, plasma, or platelets.

Benefit Conditions:

1. Blood products must be prescribed within 30 days of the Accident.

Benefit Limitations:

1. We will pay this benefit a maximum of 1 time per Covered Person per Accident.
2. This benefit is not payable for immunoglobulins.

Diagnostic Examination: We will pay the Benefit Amount shown in the Schedule of Benefits if a Covered Person, as a result of an Accident, receives a Diagnostic Examination.

Benefit Conditions:

1. Examination must occur within 180 days of the Accident.

Benefit Limitations:

1. We will pay this benefit a maximum of 1 time per Covered Person per Accident.

Emergency Dental Procedure: We will pay the Benefit Amount shown in the Schedule of Benefits if a Covered Person, as a result of an Accident, receives dental services.

Benefit Conditions:

1. Dental procedure must occur within 30 days of the Accident.

Benefit Limitations:

1. We will pay this benefit a maximum of 2 times per Covered Person per Accident.

Emergency Treatment: We will pay the Benefit Amount shown in the Schedule of Benefits if a Covered Person, as a result of an Accident, receives an examination or treatment in an Emergency Room.

Benefit Conditions:

1. Treatment must start within 3 days of the Accident.

Benefit Limitations:

1. We will pay this benefit a maximum of 1 time per Covered Person per Accident.
2. We will not pay the Hospital Confinement or Emergency Treatment benefits concurrently.

Follow-Up Physician Treatment: We will pay the Benefit Amount shown in the Schedule of Benefits if a Covered Person, as a result of an Accident, receives Follow-Up Physician Treatment.

Benefit Conditions:

1. Treatment is by a Physician or a medical professional in the Physician's office.
2. Initial treatment must occur within 30 days of the Accident.
3. Follow-Up Physician Treatment must be completed within 365 days of the Accident.
4. Follow-Up Physician Treatment must be for the same or related Injury.

Benefit Limitations:

1. We will pay this benefit a maximum of 2 times per Covered Person per Accident.
2. Treatment does not include care that is elective, preventative, or diagnostic.
3. We will not pay the Chiropractic Therapy, Follow-Up Physician Treatment, Physician Office and Urgent Care Treatment, or Physical Therapy benefits concurrently. We will pay whichever is greater.

Medical Equipment: We will pay the Benefit Amount shown in the Schedule of Benefits if a Covered Person, as a result of an Accident, requires the use of Durable Medical Equipment.

Benefit Conditions:

1. Equipment must be prescribed within 180 days of the Accident.

Benefit Limitations:

1. We will pay this benefit a maximum of 1 time per Covered Person per Accident.

Physical Therapy: We will pay the Benefit Amount shown in the Schedule of Benefits if a Covered Person, as a result of an Accident, receives physical therapy.

Benefit Conditions:

1. Physical Therapy must be completed within 365 days of the Accident.

Benefit Limitations:

1. We will pay this benefit a maximum of 6 times per Covered Person per Accident.
2. Treatment does not include speech therapy or occupational therapy.

3. We will not pay the Chiropractic Therapy, Follow-Up Physician Treatment, Physical Therapy, or Physician Office and Urgent Care Treatment benefits concurrently. We will pay whichever is greater.

Physician Office and Urgent Care Treatment: We will pay the Benefit Amount shown in the Schedule of Benefits if a Covered Person, as a result of an Accident, receives an examination or treatment in a Physician office or Urgent Care Facility.

Benefit Conditions:

1. Treatment must start within 30 days of the Accident.

Benefit Limitations:

1. We will pay this benefit a maximum of 1 time per Covered Person per Accident.
2. Treatment does not include care that is elective, preventative, or diagnostic.
3. We will not pay the Chiropractic Therapy, Follow-Up Physician Treatment, Physical Therapy, or Physician Office and Urgent Care Treatment benefits concurrently. We will pay whichever is greater.

Prosthetics: We will pay the Benefit Amount shown in the Schedule of Benefits if a Covered Person, as a result of an Accident, requires the use of a prosthetic device.

Benefit Conditions:

1. Device must be prescribed within 180 days of the Accident.

Benefit Limitations:

1. We will pay this benefit a maximum of 2 times per Covered Person per Accident.
2. This benefit is not payable for hearing aids, wigs, or any dental aids including false teeth.

X-Ray: We will pay the Benefit Amount shown in the Schedule of Benefits if a Covered Person, as a result of an Accident, receives an x-ray.

Benefit Conditions:

1. X-ray must occur within 180 days of the Accident.

Benefit Limitations:

1. We will pay this benefit a maximum of 1 time per Covered Person per Accident.

Accidental Death, Functional Loss, and Paralysis Benefits

Accidental Death: We will pay the Benefit Amount shown in the Schedule of Benefits if a Covered Person, as a result of an Accident, suffers a loss of life.

Benefit Conditions:

1. The loss must be incurred within 180 days of the Accident and must be due to an Injury independent of all other causes.
2. Common Carrier benefits are payable if death results directly from an Accident sustained by the Covered Person while:
 - a. A fare paying passenger on a Common Carrier; or
 - b. A passenger on public transportation that is a Common Carrier, for which there is no fare.

Common Carrier means commercial airlines; passenger trains; inter-city bus lines; trolleys; or boats. It does not include intra-city bus lines, taxis, limousines or privately chartered vehicles.

Benefit Limitations:

1. Benefit amounts for a covered child are 50% of the Covered Employee Benefit amount.

Functional Loss: We will pay the Benefit Amount shown in the Schedule of Benefits if a Covered Person, as a result of an Accident, suffers a Functional Loss.

Benefit Conditions:

1. The loss must be incurred within 180 days of the Accident and must be due to an Injury independent of all other causes.

Benefit Limitations:

1. Benefit amounts for a covered child are 50% of the Covered Employee Benefit amount.

Paralysis: We will pay the Benefit Amount shown in the Schedule of Benefits if a Covered Person, as a result of an Accident, suffers a Paralysis.

Benefit Conditions:

1. The loss must be incurred within 180 days of the Accident and must be due to an Injury independent of all other causes.

Benefit Limitations:

1. Benefit amounts for a covered child are 50% of the Covered Employee Benefit amount.

EXCLUSIONS AND LIMITATIONS

Exclusions

We will not pay benefits for a loss that is caused by, contributed to by, or occurs as a result of any of the following:

1. Receiving treatment for illness, disease, bodily or mental infirmity, bacterial or viral infection, or medical or surgical treatment.
2. Intentionally self-inflicting bodily injury or attempting suicide, whether sane or insane.
3. Being exposed to any act of war, declared or undeclared, or serving in any of the armed forces.
4. Being exposed to a nuclear, chemical, biological, or radiological event.
5. Participating in, or attempting to participate in commission of a felony; actively participating in a riot or insurrection; or that occurs while incarcerated in any type of penal institution.
6. the Covered Person being intoxicated as defined by the laws of the jurisdiction in which the loss occurred, unless taking narcotics as prescribed by a Physician.
7. Participating in any form of flight aviation other than as a fare-paying passenger in a fully licensed/passenger-carrying aircraft.
8. Engaging in bungee jumping, sail gliding, parachuting, parasailing, parakiting, hang gliding, mountain climbing, or jumping from any aircraft.
9. Participating in any organized sport in a professional or semi-professional capacity.
10. Riding in or driving any motor-driven vehicle in a race, stunt show or speed test.

We will not pay benefits for medical or receiving healthcare treatment, services, transportation, or for a Hospital stay in any medical facility outside the United States of America or Canada.

WHEN INSURANCE ENDS

Termination of Coverage

Coverage for You and any Dependent(s) will end on the earliest of the following:

1. the date You are no longer Actively at Work;
2. the date You become no longer eligible for insurance under any provision of the Policy;
3. the date You are no longer in an Eligible Class or the Policy no longer covers Your class;
4. the date You request We terminate coverage, subject to the Changes in Coverage provision;
5. the date the required premium is due but not paid, or
6. the date the Policy terminates or the Participating Employer ceases to participate in the Policy.

Coverage for a Dependent will also end on the date a Dependent no longer satisfies the definition of Spouse or Dependent Child(ren), except for a Dependent Child that reaches the age limit. Coverage for a Dependent Child that reaches the age limit will end the date the child attains the limiting age.

When coverage would otherwise end, You or an insured Spouse may be able to continue insurance for You and any Dependent Child(ren):

1. through a Continuation provision; or
2. through the Portability provision.

Termination of coverage has no effect on benefits payable for treatment that is received for a loss sustained while a Covered Person was insured under the Policy.

Continuation of Coverage

Continuation

You may be able to continue coverage for You and any Dependent(s) in certain circumstances when You are no longer Actively at Work. The Continuation Options are outlined below.

Any coverage continued under this provision through any of the Continuation Option(s) is subject to the following conditions:

1. We must continue to receive premium payment when due (premiums must be paid by You or paid on Your behalf); and
2. the Participating Employer must approve the continuation; and
3. if You are eligible for more than one Continuation Option:
 - a. the continuation time periods will not be applied consecutively; and
 - b. the longest applicable continuation time period from the date You were last Actively at Work will apply.

Coverage continued under this provision will end on the last day of the month following the earliest of the following dates:

1. the applicable continuation time period has expired, as described in the Continuation Options;
2. You return to Active Work for the Participating Employer; or
3. You begin full-time employment with a Participating Employer other than the Policyholder.

Continued coverage will also end in accordance with the Termination of Coverage provision. Coverage continued under this provision is subject to all other terms and provisions of the Policy.

Continuation Option(s)

Leave of Absence: If You are on a leave of absence approved by the Participating Employer due to any personal reason, coverage may be continued for up to 3 months from the date You ceased Active Work.

Federal and/or State Laws: The federal Family and Medical Leave Act (FMLA) and Uniformed Services Employment and Reemployment Rights Act (USERRA) and any amendments thereto, as well as other applicable federal or state laws, may allow continuation of insurance in certain circumstances for medical leaves of absence, military leaves of absence, other leaves of absence, layoff or termination of employment.

If You are not Actively at Work and are eligible to continue insurance under one of these laws, coverage may be continued for up to the time period allowed by the law that enables the continuation. Contact the Participating Employer for additional information regarding continuation options that may be available through federal and/or state laws.

Illness or Injury: If You are not Actively at Work due to Illness or Injury, coverage may be continued for up to 12 months from the date You ceased Active Work.

Disability Insurance: If You are not Actively at Work and are approved for or are receiving benefits through a group disability insurance Policy or plan maintained or sponsored by the Policyholder and/or Participating Employer, coverage may be continued for up to 12 months from the date You ceased Active Work.

Portability

You and Your Dependents may continue coverage under a portability Policy when coverage ends under the Policy. The benefits, terms and conditions of the portability coverage will be the same as those provided under the Policy when the insurance terminated.

Portability coverage will be effective on the day after insurance under the Policy terminates.

Requirements for Portability

If You are age 79 or younger, You may request portability coverage for You and any insured Dependent(s) when:

1. You are no longer Actively at Work and are not eligible for coverage under any other Continuation provision in this Policy;
2. You are no longer employed by the Participating Employer, including retirement; or
3. the Policy terminates and the Policyholder does not obtain a replacement Policy with another insurance carrier within 31 days.

You must request portability coverage within 31 days of becoming eligible for portability coverage.

If You are eligible to request portability coverage, then You must elect insurance under the portability Policy in order for any Dependent(s) to be eligible for coverage under the portability Policy.

An insured Spouse who is age 79 or younger may request portability coverage for themselves and any insured Dependent Child(ren):

1. in the event of Your death;
2. in the event of divorce, dissolution of partnership or legal separation from You; or
3. when You enter active duty service or training in any military for a period of 31 days or more and are no longer eligible under the Policy as an Employee.

If an insured Spouse elects coverage under the portability Policy, the Spouse will become the primary insured under the portability Policy. Any Dependent Child(ren) may be covered under the Employee or the Spouse, but not both.

Portability Premiums

Premiums for portability coverage are due and payable in advance to Us at Our Home Office. Premium due dates are the first day of each calendar month. The portability premium rate may differ from the premium rate in effect for insureds who are still in eligible classes and may change on any premium due date. If You are on portability coverage, We will give You notice at least 31 days before a change to the portability coverage is to take effect.

Termination of Portability Coverage

Coverage under this portability provision ends on the earliest of:

1. The date You again become eligible for insurance under the Policy.
2. The last day for which premiums have been paid, if You fail to pay premiums when due, subject to the grace period.
3. With respect to insurance for dependents:
 - a. the date Your insurance terminates; or
 - b. the date the Dependent ceases to be an eligible Dependent, as defined.

CLAIMS

Notice of Claim

Notice of a claim may be provided in Writing, online at: usablelife.com/claims, or by contacting Us directly at 800-370-5856. Notice of a claim should be provided within 30 days from the date of the Covered Loss, or as soon as reasonably possible.

Filing a Claim

After receiving notice of a claim, We will send a claim form to You or Your authorized representative within 15 days from the date We receive the notice of a claim. Claim forms may also be available from Your Participating Employer, Policyholder or from Us online at: usablelife.com/claims.

When You or Your authorized representative receive the claim form, You or Your authorized representative must fill out Your own section of the claim form and provide the Covered Person's Physician with the applicable section of the claim form. The Covered Person's Physician should complete their section of the form and send it directly to Us.

If You or Your authorized representative do not receive a claim form from Us within 15 days after We receive notice of a claim, a Written statement from You or Your authorized representative as to the nature and extent of the Covered Loss will be deemed Proof of Loss, if sent to Us within the time limit stated in the Proof of Loss section below.

Completed claim forms may be submitted online or sent to Us by mail or fax:

Online:	usablelife.com/claims
Mailing Address:	USABLE Life P.O. Box 1650 Little Rock, Arkansas 72203
Fax:	501-235-8416

Proof of Loss

Proof of loss must be sent to Us within 90 days after the date of the loss. Proof of loss may not be given more than one year after the time proof is otherwise required, unless the claimant is legally incapacitated.

Physical Examination and Autopsy

We have the right, at Our expense, to have:

1. a Covered Person for whom a claim is made examined by a Physician or Medical Professional of Our choice during the pendency of a claim as often as reasonably required; and
2. an autopsy conducted for a Covered Person for whom a claim is made in case of death, where allowed by law.

Payment of Claims

Benefits payable under the Policy will be paid immediately upon receipt of due Proof of Loss.

All benefits are payable to You. Any benefits unpaid at the time of Your death will be paid in the following order:

1. Your designated beneficiary(ies);
2. Your Spouse;
3. Your surviving children in equal shares;
4. Your mother or father in equal shares, if paying both;
5. Your sisters and brothers in equal shares;
6. Your estate.

Beneficiary Designation

In the event of Your death, You should designate one or more beneficiaries to receive any benefits under the Policy that are unpaid at the time of Your death. Beneficiary records will be kept by the Policyholder, Plan Administrator or the office/system where beneficiary records for the Policy are kept.

Certain states are community property states. If You live in a community property state and designate someone other than Your Spouse as a beneficiary, state law may require that Your Spouse consent to such designation. If spousal consent to the designation is not obtained, then such designation may not be effective. Community property states as of the Policy Effective Date include: Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington and Wisconsin.

Change of Beneficiary

The beneficiary may be changed at any time by You or Your assignee (if You assigned this insurance). To make a change, a request should be provided to the Policyholder, Plan Administrator or to the office/system where beneficiary records for the Policy are kept. If it is not known where the records are kept, then the request may be provided to Us. When received by the Policyholder, Plan Administrator, office/system where beneficiary records for the Policy are kept or Us, the change will take effect as of the date the request is signed. The change will not apply to any payments or other action taken by Us before the request was received.

The right to change of beneficiary is reserved to You, and the consent of the beneficiary or beneficiaries shall not be requisite to any change in beneficiary, unless the current beneficiary designation is irrevocable.

Claim Denial

If a claim for benefits is wholly or partly denied, the claimant will be furnished with written notification of the decision. This written notification will:

1. give the specific reason(s) for the denial;
2. make specific reference to the Policy provisions on which the denial is based; and
3. provide a description of any additional information necessary to perfect a claim and an explanation of why it is necessary.

Appeals Process

On any claim, You or Your Beneficiary may request a review of the decision. To do so, You or Your Beneficiary:

1. must submit a written request for review within 180 days of receipt of the claim decision if the claim requires Us to make a determination of an Injury or other loss; and
2. may request copies of all documents, records, and other information relevant to the claim; and
3. may submit written comments, documents, records and other information relating to the claim.

We will review the claim and respond with a final determination within 45 days. If We need additional time to decide the appeal, We may extend the review by 45 days. If We need such an extension, We will inform You or Your Beneficiary in writing: (1) that We need an extension, (2) why We need the extension, (3) what additional information We may need to complete the review, and (4) when You or Your beneficiary can expect a decision. We will notify You or Your beneficiary of the extension before the expiration of the initial 45-day period. In no event will the total period for review of the appeal exceed 90 days.

Overpaid Claim

We have the right to recover any overpayments due to:

1. fraud;
2. misstatement of information; or
3. any error We make in processing a claim.

We must be reimbursed in full. If it is not possible for You to reimburse Us in a lump sum payment, We will develop a reasonable method of repayment. This may include reducing or withholding future payments.

We will not recover more money than the amount We paid You.

Unpaid Premium

Upon the approval of a claim, any premium then due and unpaid may be deducted from the claim payment.

GENERAL PROVISIONS

Certificate of Insurance Contents

Coverage for an Insured is provided under this Certificate of Insurance which is a part of the Policy issued to the Policyholder. The Policy consists of:

1. all Policy provisions, and any Riders, amendments and endorsements, and other attachments to the Policy;
2. the Certificate of Insurance, and any Riders, amendments and endorsements, and other attachments to the Certificate of Insurance;
3. the Policyholder's application for group insurance; and
4. Employee's enrollment forms, if applicable.

Statements

Any statements made by the Policyholder, Participating Employer or by You will be considered a representation and not a warranty. We will not use such statements to avoid insurance, reduce benefits, or deny a claim unless it is included in an application signed by You.

Contestability

We can take legal or other action using statements made in signed applications for coverage only when a Covered Loss occurs during the first two years after a Covered Person's Effective Date. However, in the event of Fraud, We can take Legal Action at any time as permitted by applicable law.

Misstatements

If You or Your Participating Employer provide Us information about a Covered Person that is incorrect, We will:

1. use the facts to decide whether the Covered Person has coverage under this Certificate and the Policy and in what amounts; and
2. if necessary, make the applicable premium adjustments.

Agency

For purposes of the Policy, Your Participating Employer acts on their own behalf or as Your agent. Under no circumstances will Your Participating Employer be deemed Our agent.

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. The assignment will take effect on the date the assignment is signed by You. The assignment will be subject to any action We may have taken prior to the receipt of the assignment. We are not liable 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.

Conformity with Laws

Any provision of the Policy that is contrary to the law of the jurisdiction in which it is delivered or with any other applicable law is amended to meet the minimum requirements of the law.

Workers' Compensation or State Disability Insurance

This Certificate does not replace or affect the requirements for coverage by any workers' compensation or state disability insurance.

Time Periods

For the purpose of all dates under this Certificate of Insurance, all days begin at 12:00 a.m. and end at 12:00 a.m.

Fraud

Insurance fraud occurs when any person and/or the Policyholder, and/or the Participating Employer provide Us with false information or file a claim for benefits that contains any false, incomplete or misleading information with the intent to injure, defraud or deceive Us. It may be a crime if a person and/or the Policyholder, and/or the Participating Employer commit insurance fraud. We will use all means available to Us to detect, investigate, deter and prosecute those who commit insurance fraud. We will pursue all available legal remedies if a person and/or the Policyholder, and/or the Participating Employer perpetrate insurance fraud.

Legal Action

You may not begin legal action:

1. until 60 days after Proof of Loss has been given;
2. more than 3 years after the time proof of loss is required to be given; unless otherwise required by law in Your or the claimant's jurisdiction of residence.

GLOSSARY

Accident means a sudden, unforeseen event that:

1. Is identifiable by date and time; and
2. Occurs without the Covered Person's intent; and
3. Occurs while this Certificate is in force; and
4. Results in an Injury to the Covered Person independent of disease, infirmity or any other cause; and
5. Is not subject to any exclusion in the Policy.

Actively at Work or Active Work means that You are:

1. Performing all the regular duties of Your job for the Participating Employer in the usual way for 10 or more hours each week; and
2. Receiving compensation from the Participating Employer for work performed.

This must be done at:

1. the Participating Employer place of business; or
2. an alternate place approved by the Policyholder; or
3. a place to which the Participating Employer business requires You to travel.

You will be deemed to be Actively at Work during weekends or Participating Employer approved vacations, holidays or temporary business closures if You were Actively at Work on the last scheduled work day preceding such time off.

Additional Enrollment Event means a period of time designated for enrollment under the Policy, other than an Annual Enrollment Period, as agreed to in writing by Our authorized representative in Our Home Office.

Ambulatory Surgical Center means a freestanding facility, other than a Physician's office, where surgical and diagnostic services are provided on an ambulatory basis.

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.

Brain Injury means a concussion, cerebral laceration, cerebral contusion, or intracranial hemorrhage that is diagnosed through imaging tests.

Burn is a type of Injury to skin caused by heat, cold, electricity, chemicals, friction, or radiation. Covered burns include Second Degree Burns and Third Degree Burns.

Second Degree Burn means a Burn in which damage penetrates into some of the underlying layers of skin.

Third Degree Burn means a Burn which extends to all layers of skin.

Certificate means this document prepared by Us which describes the Covered Person's benefits and rights under the Policy, and which includes any Riders, endorsements, amendments, applications, notices or other attachments to the Certificate.

Change in Family Status means one of the following events:

1. Birth, adoption, or addition of a Child;
2. A change in legal marital or domestic partnership status;
3. A change in employment status; or
4. Death of an insured.

Coma means a continuous state of profound unconsciousness which lasts 7 or more consecutive days as a result of an Accident. A coma is characterized by an absence of spontaneous eye movements, response to painful stimuli and vocalization. The condition must require intubation for respiratory assistance. It does not include medically induced comas.

Common Carrier means commercial airlines; passenger trains; inter-city bus lines; trolleys; or boats. It does not include intra-city bus lines, taxis, limousines or privately chartered vehicles.

Confined or Confinement means medically necessary care as a resident bed patient in a Hospital. A Physician must recommend and supervise the Confinement.

Contributory means You pay part or all of the cost for Your and Your Dependent's coverage.

Covered Loss means an accidental death, dismemberment, loss or other Injury for which benefits are payable under this Certificate.

Covered Person means any person who meets the definition of Employee or Dependent and has coverage under this Certificate.

Dependent means Your Spouse and/or Dependent Children.

Dependent Children means:

1. an Employee's or Spouse's natural child, legally adopted child or stepchild;
2. a child placed into the Employee's or Spouse's custody for adoption (regardless of whether the adoption has become final);
3. a child for whom the Employee or Spouse is ordered by a court or administrative order to provide coverage regardless of whether he/she is the custodial or non-custodial parent; or
4. an Employee's or Spouse's foster child or any other child for whom the Employee or Spouse has been appointed legal guardian; or
5. any other child who lives with the Employee in a regular parent/child relationship and is dependent on the Employee for support and maintenance;

who is/are:

1. unmarried; and
2. under 26 years of age.

If an unmarried child is age 26 or older and is:

- a. incapable of self-sustaining employment because of a mental or physical disability;
- b. chiefly dependent on the Employee or Spouse for financial support and maintenance; and

proof has been provided of his/her disability upon Our request, that child will continue to be a Dependent child until these conditions cease to exist.

The term Dependent Children does not mean an unborn or stillborn child.

Diagnostic Examination means a medical test given in response to symptoms to detect, diagnose, or monitor an Injury, susceptibility, or to determine a course of treatment. Diagnostic Examination does not include x-rays or laboratory studies.

Durable Medical Equipment means items which are:

1. Ordered or prescribed by a Physician; and
2. Designed for repeated use by more than one person; and
3. Primarily used to serve a medical purpose; and
4. Not useful in the absence of Injury; and
5. Appropriate for use in the home; and
6. Not disposable.

Eligibility Waiting Period means the period of time an Employee must be a member in an Eligible Class before coverage is effective, as shown in the Schedule of Benefits.

Emergency Room means a portion of a Hospital where emergency diagnosis and treatment of Illness or Injury is provided.

Employee means an Employee of the union who was covered by a Collective Bargaining Agreement or like agreements for which contributions were been made by a Participating Employer to the SEIU Local 503, Oregon Public Employees Union.

Directors, officers, consultants, elected officials, appointed officials, proprietors, owners, partners, commissioners or other persons not Actively at Work on behalf of the Participating Employer will not be considered an Employee.

Family or Family Member means a Covered Person's Spouse (current and former); domestic partner (or equivalent); child; sibling; or parent.

Functional Loss means an Injury that, directly and independently of all other causes, results in the complete severance of a body extremity or the complete loss of sight, speech, or hearing. Loss of a hand means the entire loss of at least four fingers. Loss of a finger or toe means complete severance at the joint of the hand or foot. Loss of a foot means complete severance at or above the ankle joint. Loss of an arm means complete severance above the elbow. Loss of a leg means complete severance above the knee. Loss of sight, speech, or hearing means total and permanent loss of sight, speech, or hearing.

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

Hospital means a facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of Physicians to patients admitted for a variety of medical conditions.

Hospital Confinement means staying in a Hospital as a registered Inpatient.

Illness means a physical or mental condition, disease, disorder, sickness, or infection that is not caused solely by nor is the result of an Accident. Illness includes organ donation and quarantine in a Hospital due to an identifiable exposure to a life-threatening contagious and/or infectious disease.

Initial Enrollment Period means one of the following periods during which You may first apply, in writing, for coverage under the Policy:

1. a period before the Policy effective date as set by Us and the Policyholder if You are eligible for coverage on the Policy Effective Date; or
2. the period ending 31 days after the date You are first eligible to apply for coverage if You become eligible for coverage after the Policy Effective Date.

Injury or Injuries means bodily harm or pain that is the direct result of an Accident and is independent of disease or bodily infirmity or any other cause.

Inpatient means a day on which a Covered Person is Confined and charged room and board by a medical facility. The requirement that a Covered Person be charged by the medical facility does not apply to Confinement in a charity hospital or Veteran's Administration Hospital or other federal government Hospital.

Intensive Care Unit (ICU), Cardiac Care Unit (CCU), or Burn Unit means a specifically designated area of the Hospital that provides the highest level of medical care; is restricted to patients who are critically ill or injured and who require comprehensive observation and care; and is permanently equipped with special lifesaving equipment.

Laceration means an open wound or cut on the outside of the body.

Non-contributory means Your Participating Employer pays all of the cost for Your and Your Dependent's coverage.

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;
2. is staffed by nurses assigned specifically to that unit; and
3. provides care seven days per week, 24 hours per day.

On-the-Job Coverage means coverage provided under the Policy for Injuries resulting from an Accident that occurs while the Covered Person is working for pay or profit.

Paralysis means loss of use, without severance, of a limb. The loss must be determined by a Physician to be complete and not reversible.

The following types of Paralysis meet the definition of Paralysis:

- **Hemiplegia** means the complete and irreversible Paralysis of one arm and one leg on the same side.
- **Paraplegia** means the complete and irreversible Paralysis of both legs.
- **Quadriplegia** means the complete and irreversible Paralysis of both arms and both legs.

Participating Employer means any contributing Employer or Employee who meets the requirements to participate in the SEIU Local 503, Oregon Public Employees Union.

The Policyholder will maintain a list of Employees and the effective dates of coverage for each. The Policyholder may, by written request, add to or delete from the list of Employees at any time.

Physician means a person who is:

1. a doctor of medicine, osteopathy, psychology or where required by state law, any other legally qualified practitioner of healing art;
2. licensed to practice in the jurisdiction where care is being given;
3. operating within the scope of his or her license; and
4. not the Covered Person or a Family Member.

Plan means the insurance provided for Covered Persons as outlined in the Policy and Certificates of Insurance.

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

Plan Year means January 1, 2026 to December 31, 2026 and each following January 1st to December 31st.

Policy means the instrument by which the benefits under the Plan are approved and issued to the Policyholder, including any Riders, endorsements or amendments, notices or other attachments to the Policy.

Policyholder means SEIU Local 503, Oregon Public Employees Union.

Preventative Examination means a physical examination that includes screenings or assessments to detect health concerns prior to developing noticeable symptoms.

Qualified Health Care Professional means a person who is:

1. a Physician, Physician assistant, nurse practitioner, or a registered nurse;
2. licensed to practice in the jurisdiction where care is being given;
3. operating within the scope of his or her license; and
4. not the Covered Person or a Family Member.

Rehabilitation Treatment means multidisciplinary and coordinated care provided on an Inpatient basis for purposes of providing physical restorative services to inpatients under the direction of a Physician who is knowledgeable and experienced in rehabilitative medicine. Beds must be set up and staffed in a unit or facility specifically designated for this service.

Spouse means a Person to whom You are married as legally recognized in a jurisdiction within the United States of America. Spouse also includes Your domestic partner or civil union partner.

Surgery means an invasive or open medical procedure requiring an incision and manipulation (typically with instruments) performed on a person's body to repair damage or arrest disease. Any procedure that is covered as a Preventative Examination or Diagnostic Examination is not considered Surgery.

United States of America means the fifty (50) states of the United States and the District of Columbia.

Urgent Care Facility means a location, distinct from a Hospital Emergency Room, an office, or a clinic, whose purpose is to diagnose and treat Illness or Injury for unscheduled, ambulatory patients seeking immediate medical attention.

We, Us, and Our mean USAble Life.

You and Your means an Employee who is insured under the Group Policy for the insurance described in this Certificate.



17500 Chenal Pkwy | Little Rock, AR 72223
 P.O. Box 1650 Little Rock, AR 72203
 (501) 375-7200 | (800) 370-5856 | www.usablelife.com

ACCIDENT CARE RIDER

Benefits are subject to all of the terms, conditions, and provisions of the Certificate and any attached riders. All terms defined and used in the Certificate apply to this rider unless otherwise provided in this rider.

This Rider takes effect on January 1, 2026 and expires at the same time as the Policy or Certificate.

Benefit Information

We pay a benefit when a Covered Person is diagnosed by a Physician with a Covered Loss covered under this rider if:

1. the Injury is after the effective date of this rider; and
2. the Injury is while this rider is in force; and
3. the Covered Loss is not excluded by name or specific description in the Certificate or any attached rider.

Schedule of Benefits

The benefit amount for each Covered Loss covered under this rider is shown below.

Benefit	Benefit Amount Plan 1
Confinement Benefits	
Hospital Admission	\$800
Hospital Confinement	\$100 per day
Intensive Care Unit Confinement	\$200 per day
Rehabilitation	\$100 per day
Treatment and Services Benefits	
Surgery	<ul style="list-style-type: none"> • Inpatient: \$1,000 per day • Outpatient: \$500 per day

BENEFITS

If, while this Certificate is in force, a Covered Person incurs an Injury resulting in the losses described in the Benefits provision, and diagnosis is made by or treatment is prescribed by a Physician, We will pay the following benefits for such loss. The Injury must be initially diagnosed within 30 days of the Accident, unless otherwise stated. Benefits will not be paid for losses or medical expenses for an Injury incurred prior to the Effective Date of Coverage.

Confinement Benefits

Hospital Admission: We will pay the Benefit Amount shown in the Schedule of Benefits on the first day of Confinement if a Covered Person, as a result of an Accident, is Confined to a Hospital as a resident bed patient, including in an Observation Unit.

Benefit Conditions:

1. Confinement must start within 90 days of the Accident.
2. If there are more than 90 days between Confinements for the same or related condition, they are considered separate Confinements. If there are less than 90 days between Confinements for the same or related condition, they are considered as the same Confinement.

Benefit Limitations:

1. We will pay this benefit a maximum of 1 time per Covered Person per Accident.
2. We will not pay the Hospital Admission and Intensive Care Unit Admission benefits concurrently.

Hospital Confinement: We will pay the Benefit Amount shown in the Schedule of Benefits if a Covered Person, as a result of an Accident, is Confined to a Hospital as a resident bed patient.

Benefit Conditions:

1. Confinement must start within 90 days of the Accident.
2. If there are more than 90 days between Confinements for the same or related condition, they are considered separate Confinements. If there are less than 90 days between Confinements for the same or related condition, they are considered as the same Confinement.

Benefit Limitations:

1. We will pay this benefit a maximum of 30 days per Covered Person per Accident, not to exceed 365 days per calendar year.
2. We will not pay this benefit for a stay in an Observation Unit.
3. We will not pay the Hospital Confinement, Intensive Care Confinement, or Rehabilitation benefits concurrently.

Intensive Care Unit Confinement: We will pay the Benefit Amount shown in the Schedule of Benefits if a Covered Person, as a result of an Accident, is Confined to an Intensive Care Unit as a resident bed patient.

Benefit Conditions:

1. Confinement must start within 90 days of the Accident.
2. If there are more than 90 days between Confinements for the same or related condition, they are considered separate Confinements. If there are less than 90 days between Confinements for the same or related condition, they are considered as the same Confinement.

Benefit Limitations:

1. We will pay this benefit a maximum of 15 days per Covered Person per Accident, not to exceed 60 days per calendar year.
2. We will not pay the Hospital Confinement and Intensive Care Unit Confinement benefits concurrently.

Rehabilitation: We will pay the Benefit Amount shown in the Schedule of Benefits if a Covered Person, as a result of an Accident, receives Rehabilitation Treatment.

Benefit Conditions:

1. Treatment must start within 7 days following a related Hospital Confinement of 3 consecutive days or more for which benefits were paid.

Benefit Limitations:

1. We will pay this benefit a maximum of 30 days per Covered Person per Accident.
2. We will not pay the Hospital Confinement and Rehabilitation benefits concurrently.

Treatment and Services Benefits

Surgery: We will pay the Benefit Amount shown in the Schedule of Benefits if a Covered Person, as a result of an Accident, requires and receives surgery.

Benefit Conditions:

1. The Surgery must be performed by a Physician in a Hospital or Ambulatory Surgical Center within 180 days of the Accident.
2. If abdominal or thoracic Surgery is performed, We will pay 200% of the Surgery benefit.

Benefit Limitations:

1. We will pay this benefit a maximum of 2 times per Covered Person per Accident.
2. If exploratory Surgery is performed with no repair to the Injury, We will pay 50% of the Surgery benefit.
3. If hernia Surgery is performed, We will pay 50% of the Surgery benefit.
4. If We pay this benefit, We will not pay for any other Surgery benefit for the same day.
5. If a Covered Person receives a subsequent Surgery for the same Injury, We will pay an additional benefit only if the subsequent procedure was performed more than 30 days after the last covered procedure was performed.

Definitions

Rider date means the effective date of coverage under this rider. The rider date is the Certificate date, unless this rider is applied for at a later date. If this rider is applied for at a later date, the rider date is the effective date assigned by Our Home Office.

Limitations and Exclusions

All Limitations and Exclusions of the Certificate apply to this Rider.

Termination

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

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

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

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

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


Secretary


President



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

Health Insurance Portability and Accountability Act (HIPAA) Privacy Notice

By law, 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:

- 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.
- If you are covered by one or more of our Duo Accident, Duo Critical Illness, or Duo Hospital Indemnity policies, we share information with your health insurer for purposes of paying claims under those policies.

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.



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

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.