USAble Life

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GROUP VOLUNTARY LONG TERM DISABILITY CERTIFICATE OF INSURANCE

PLEASE READ YOUR CERTIFICATE CAREFULLY.
This Certificate is renewable at the option of USAble Life.
Important Cancellation Information – Please read Section 4 – Termination Provisions.

Policyholder: TOWN OF TARBORO
Class: 003 - ALL OTHER FULL TIME ACTIVE EMPLOYEES
State of Residence: NORTH CAROLINA

This is to certify that USAble Life has issued and delivered The Group Long Term Disability Insurance Policy to the Policyholder.

The policy insures the employees 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.

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:

James L. Towse — Secretary

Jason Mann — President

This certificate is not a Medicare Supplement Certificate. If you are eligible for Medicare, review the "Guide to Health Insurance for People with Medicare," which is available from USAble Life.

Pre-existing Condition Exclusion: No benefits will be provided during the first 24 months after your effective date for loss caused by pre-existing conditions, except as noted in Section 8 – Limitations and Exclusions

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Schedule of Insurance

Policyholder: TOWN OF TARBORO

Group Policy Number: 50003285-LTD

Policy Effective Date: August 1, 2012*
*This certificate replaces any certificate issued before the date shown.

Contributions:
You do contribute toward the cost of the Plan.

Eligible Class: Class 003 - ALL OTHER FULL TIME ACTIVE EMPLOYEES

Renewal Date: August 1, 2014

Annual Enrollment Date: August 1 of each year

Waiting Period: You will be eligible for coverage on the 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 – 30 days
2. If you start working for the employer after the policy effective date – 30 days

Full-time Employment: 25 hours weekly

Elimination Period: 180 days

Monthly Benefit: Amount elected by you on your enrollment form. Elected in increments of $100 not to exceed 60% of your basic monthly earnings.

Maximum Monthly Benefit: $5,000

Guaranteed Issue Maximum Monthly Benefit: $3,000. Amounts over this will be subject to Evidence of Insurability.

Minimum Monthly Benefit: The lesser of: $50 or 10% of the benefit based on Pre-Disability Earnings.

Maximum Interruption During Elimination Period: 30 days
This Maximum applies to all returns to active work during any one elimination period.

Maximum Benefit Period
We will not pay benefits beyond the maximum benefit period stated below, based on the person's age on the day the period of disability started.

AGE	MAXIMUM BENEFIT PERIOD
Less Than 61	60 months
61	48 months
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 or over	12 months

Section 1 – Definitions

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

Accommodation Expense means the costs your employer incurs to accommodate your disability, as required by the Americans with Disabilities Act or similar legislation. It also means costs you incur for tools, equipment, furniture, computer software, or other items necessary for you to return to work. The amount of the accommodation expense will be limited to $3,000 for each period of disability.

Active Work or Actively at Work mean 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 workday 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.

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.

Basic Monthly Earnings means your regular monthly rate of pay from the employer just prior to the date you become disabled:

1. including contributions you make through a salary reduction agreement with the employer to:
   a. an Internal Revenue Code (IRC) Section 401(k), 403(b) or 457 deferred compensation arrangement;
   b. an executive non qualified deferred compensation arrangement;
   c. a salary reduction arrangement under an IRC Section 125 plan;
2. including commissions;
3. not including:
   a. expense reimbursements;
   b. overtime pay; or
   c. bonuses;

for the same period as above.

Commissions means the monthly average of commissions paid to you by the policyholder or associated company over the 1 calendar year(s) ending just prior to the date you become disabled, or over the number of calendar months of employment if less than this period.

Contributory means you pay part of the premium.

Covered Person means an eligible person who is also an eligible employee or member of the policyholder, or an associated company who has become insured for coverage. Covered persons do not include contract, temporary, seasonal, or part-time workers.

Date of Disability means the first day that you are under the regular care of a physician and meet the definition of disability as defined below.

Disability or Disabled means you satisfy either the Occupation Test or the Earnings Test as described below. You need only satisfy one Test to be considered disabled.

Occupation Test

1. During the elimination period and the first 24 months of a period of disability, an injury, sickness, or pregnancy requires that you be under the regular care of a physician, and prevents you from performing at least one of the material duties of your regular occupation with reasonable accommodations; and
2. After 24 months of disability payments, an injury, sickness, or pregnancy prevents you from performing at least one of the material duties of any gainful occupation with reasonable accommodations for which your education, training, and experience qualifies you.

If, during the elimination period and the first 24 months of a period of disability, you can perform the material duties of your regular occupation with reasonable accommodation(s), you will not be considered disabled. If, after 24 months of a period of disability, you can perform any gainful occupation for which your education, training, and experience qualifies you, with reasonable accommodation(s), you will not be considered disabled. The inability to perform a material duty because of the discontinuation of reasonable accommodation(s) on the part of the employer does not, in itself, constitute disability.

Earnings Test

1. During the elimination period and the first 24 months of a period of disability, you may be considered disabled in any month in which you are actually working, if an injury, sickness, or pregnancy prevents you from being capable of earning more than 80% of your indexed pre-disability earnings in that month. On each anniversary of the date your disability started, we will use your indexed pre-disability earnings to decide whether you are disabled under this test. Any month in which you are capable of earning more than 80% of your indexed pre-disability earnings, you will not be considered disabled under the Earnings Test even if your actual earnings in that month are less than 80% of your indexed pre-disability earnings.
2. After 24 months of disability payments, you may be considered disabled in any month in which you are actually working, if an injury, sickness, or pregnancy prevents you from being capable of earning more than 60% of your indexed pre-disability earnings in that month in any occupation for which your education, training or experience qualifies you. On each anniversary of the date your disability started, we will use your indexed pre-disability earnings to decide whether you are disabled under this test. Any month in which you are capable of earning more than 60% of your indexed pre-disability earnings, you will not be considered disabled under the Earnings Test even if your actual earnings in that month are less than 60% of your indexed pre-disability earnings.

If your actual earnings during any month are more than the percentage noted above, you will not be considered disabled under the Earnings Test during that month. In making this determination, salary, wages, partnership or proprietorship draw, commissions, bonuses, or similar pay, and any other income you receive or are entitled to receive will be included. Any lump sum payment will be pro-rated, based on the time over which it accrued or the period for which it was paid.

Education Expense means, in your rehabilitation plan, the costs you incur which are required for your education or training to return to work.

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.

Elimination Period means the number of days during a period of disability that must pass before benefits are payable. No benefits are payable for the Elimination Period. You cannot satisfy any part of the elimination period with any period of non-covered disability. The elimination period is shown on the Schedule of Insurance and begins on the first day of your disability.

If you return to active work during the elimination period for no more than the number of days in the Maximum Interruption During Elimination Period shown in the Schedule of Insurance, you will not have to satisfy that part of the elimination period already fulfilled if you:

1. remain insured under the policy; and
2. become disabled by the Occupation Test or the Earnings Test again for the same cause or one related to it.

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.

Family Member means a person who is a parent, spouse, child, sibling, domestic partner, 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.

Gainful Occupation means any employment that exists in the national economy that you may be expected to follow based on your education, training, experience, age, and physical and mental capacity.

Government Plan means the United States Social Security Act, the Railroad Retirement Act, the Canadian Pension Plan, similar plans provided under the laws of other nations, and any plan provided under the laws of a state, province, or other political subdivision. It also includes any public employee retirement plan or any teachers' employment retirement plan, or any plan provided as an alternative to any of the above acts or plans. It does not include any Workers' Compensation Act or similar law, or the Maritime Doctrine of Maintenance, Wages, or Cure.

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

Hospital means a facility supervised by one or more physicians which is licensed and operated under state and local laws. It must have 24-hour nursing service by registered graduate nurses. It may specialize in treating alcoholism, drug addiction, chemical dependency, or mental disease, but it cannot be a rest home, convalescent home, or a home for the aged.

Hospital Confined and Hospital Confinement means staying in a hospital as a registered inpatient for 24 hours a day.

Indexed Pre-disability Earnings means your pre-disability earnings increased by 4% on each anniversary of the date your disability started.

Injury means accidental bodily injury. It does not mean intentionally self-inflicted injury while sane or insane.

Intoxicated means that you were under the influence of alcohol as determined by the laws of the jurisdiction in which the accident occurred. Conviction is not necessary for a determination of being intoxicated.

Long Term Disability Insurance means the group long term disability insurance provided under the policy.

Material Duty or Material Duties mean the sets of tasks or skills required generally by employers from those engaged in an occupation. We will consider one material duty of your regular occupation to be the ability to work for an employer on a full-time basis as defined in the policy.

Mental Illness means a mental disorder as listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders, as published by the American Psychiatric Association. A mental illness, as so defined, may be related to or be caused by physical or biological factors, or result in physical symptoms or expressions. For the purposes of the policy, mental illness does not include any mental disorder listed within any of the following categories found in the Diagnostic and Statistical Manual of Mental Disorders, as published by the American Psychiatric Association:

1. mental retardation;
2. motor skills disorder;
3. pervasive developmental disorders;
4. delirium, dementia, and amnestic and other cognitive disorders;
5. schizophrenia; and
6. narcolepsy, obstructive sleep apnea, and sleep disorder due to a general medical condition.

Moving Expense means the costs you incur to move more than 100 miles so that you can attend school or accept gainful work.

Noncontributory means the policyholder pays the premium.

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.

Other Disability Plan means any group disability plan sponsored by your employer, the policyholder, or an associated company, except the one provided under the policy.

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.

Period of Disability means the time that begins on the day you become disabled and ends on the day before you return to active work. If you satisfy the elimination period and then return to active work, become disabled again, and remain insured under the policy; the same period of disability may continue. Your return to active work must be for less than:

1. 6 months, if the later disability results from the same cause, or a related one; or

2. 1 day, if the later disability results from a different cause.

If your return to active work meets either of the above conditions, you do not have to satisfy the elimination period again. The Maximum Benefit Period will continue on the day you become disabled again.

If you return to active work for more than the time shown above, and then become disabled again, you will start a new period of disability. You must satisfy the elimination period again and the Maximum Benefit Period will start over.

Physician means a person acting within the scope of his or her license to practice medicine, prescribe drugs or perform surgery. Also, a person whom we are required to recognize as a physician by the laws or regulations of the governing jurisdiction. However, neither you nor a family member will be considered a physician.

Plan means the policy and certificates of insurance provided for covered persons.

Plan Administrator means the employer that sponsors the plan for the benefit of its employees and eligible dependents.

Policy means the 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.

Pre-disability Earnings means your Basic Monthly Earnings in effect on the day before you became disabled.

Reasonable Accommodation(s) means any modification(s) to the worksite, the job or employment practices, which would allow you to perform the material duties of the occupation and which would not create an undue hardship for the employer.

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

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

Rehabilitation Plan means a written statement, developed by us, which describes:

1. the vocational rehabilitation goals for you;
2. our responsibilities, your responsibilities, and the responsibilities of any other parties to the plan;
3. the timing of the implementation and expected completion of the plan, to the extent that it can be established, assuming your full cooperation; and
4. the costs of the rehabilitation services.

The rehabilitation plan will be designed to enable you to return to work in a gainful occupation.

Retirement Plan means a formal or informal retirement plan, whether or not under an insurance or annuity contract. It also means any public employee retirement plan, or teachers' employment retirement plan provided as an alternative to rather than a supplement for such plans.

It does not include:

1. a plan you pay for entirely;
2. a qualified profit-sharing plan;

3. a thrift plan;
4. an individual retirement account (IRA);
5. a tax sheltered annuity (TSA);
6. a stock ownership plan;
7. a government plan; or
8. a plan that qualifies under Internal Revenue Service Code 401(k).

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.

Sickness means a disease or illness, including pregnancy.

Social Security plan means:
1. the United States Social Security Act;
2. the Railroad Retirement Act;
3. the Canadian Pension Plan; or
4. any similar plan provided under the laws of any other nation.

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

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

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

We, Us, and Our mean USAble Life.

You and Your mean an employee or member of the policyholder or an associated company who has met all the eligibility requirements for coverage.

Section 2 – Eligibility and Effective Date Provisions

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.

Eligibility Date

If you are working for your employer, 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 employer, 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 Insurance

You must use forms provided 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 (non-contributory), you will be covered 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 (contributory), you will be covered 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 in the Schedule of Insurance if you enroll during the annual enrollment period. If you do not apply for voluntary 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.

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.

Section 3 – Changes In Coverage Provisions

When Coverage Amounts Change (Redetermination Date)

The policy redetermines your Basic Monthly Earnings on the first day of the policy month after a change occurs. The policyholder must report updates to all covered person's earnings as they occur. Changes to a covered person's earnings are subject to any proof of insurability requirements of the policy. As of the policy's redetermination date, we use a covered person's Basic Monthly Earnings on record with us to: (a) set rates; (b) set benefit amounts and limits; and (c) calculate premium payable under the policy.

Delayed Effective Date of Change

You must be actively at work on a full-time basis on the redetermination date. If you are not, your coverage amount will not change until the date you return to active work on a full-time basis. Changes in earnings will not apply to a recurring disability.

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 following limitations will apply to an increase:

1. the Delayed Effective Date provision; and
2. the Pre-existing Condition Exclusion.

Section 4 – Termination Provisions

When a Person's Insurance Ends

A covered person's insurance will end on the date:

1. the policy ends;
2. the policy is changed to end the insurance for a person's eligible class;
3. a person is no longer in an eligible class;
4. a person stops active work; or
5. a required contribution was not paid.

Continuation of Insurance

If a person is unable to perform active work for a reason shown below, the policyholder may continue the person's insurance on a premium-paying basis provided the person remains in other respects a member of an eligible class. The continuation cannot be more than the maximum continuation shown below. The employer must act so as not to discriminate unfairly among employees in similar situations.

The maximum continuation for long term disability insurance is the longest applicable period described below:

1. the end of the calendar month following the month active work stopped, due to temporary lay-off or approved leave of absence; or
2. the end of the period the policyholder is required to allow after the last day of active work due to family or medical leave of absence under:
   a. the federal Family and Medical Leave Act; or
   b. any similar state law.

Any leave of absence, including a family or medical leave of absence described above, must be approved in advance in writing by the policyholder if the person's insurance is to be continued.

Section 5 – Claim Provisions

Payment of Benefits

We will pay benefits at the end of each month (or shorter period) for which we are liable, after we receive the required proof. If any amount is unpaid when disability ends, we will pay it when we receive the required proof.

To Whom Payable

We will pay all benefits to you. However, if we receive proof that a legal guardian or conservator has been appointed, we will pay benefits to such guardian or conservator. If any amount remains unpaid when you die, we will pay at our discretion, 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.

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: (a) if a covered person is eligible for this insurance; (b) if a covered person meets the requirements for benefits to be paid; and (c) 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.

Filing a Claim

1. You must send us notice of the claim. We must have written notice of any insured loss within 30 days after it occurs, or as soon as reasonably possible. You can send the notice to our Home Office or to any of our authorized agents. We need enough information to identify you as a covered person.
2. Within 15 days after the date of your notice, we will send you certain 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.
3. For loss for which this policy provides any periodic payment, the time limit for filing a claim, by submission of a completed claim form, is 180 days after the end of the first month (or shorter period) for which we are liable, and in the case of a claim for any other loss within 180 days after the date of such loss.
4. To decide our liability, we may require:
   a. proof of benefits from other sources, and
   b. proof that you have applied for all benefits from other sources, and that you have furnished any proof required to get them.

Proof of Loss

Within 30 days of the start of your disability, you should give us proof that you are currently disabled and have been continuously disabled since your last day of active work. Proof must be given within 180 days after the end of the first of the month for which we are liable. 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.

Continuing proof of disability must be given as often as we may reasonably require. Continuing proof must be given within 60 days of our request.

You must provide us with all of the information we specify as necessary to determine proof of loss and decide our liability. This may include but is not limited to: medical records; hospital records; pharmacy records; test results; therapy and office notes; mental health progress notes; medical exams and consultations; tax returns; business records; Workers' Compensation records; payroll and attendance records; job descriptions; Social Security award and denial notices; and Social Security earnings records.

You must provide us with a written authorization allowing the sources of medical, vocational, occupational, financial, and governmental information to release documents to us which enables us to decide our liability. If you do not provide us with continuing proof of disability and the items and authorization necessary to allow us to determine our liability, we will not pay benefits.

Right to Examine or Interview

We may ask you to be examined as often as we require at any time we choose. We may require you to be interviewed by our authorized representative. We will pay third party charges for any independent medical exam or interview which we require. If you fail to attend or fully participate, we will not pay your benefits.

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 expiration of three (3) years from the date written proof of loss is required to be furnished.

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.

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, P.O. 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.

Binding Arbitration

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.

You may request that the dispute be submitted for resolution by binding 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.

You should be aware and understand that you may be giving up certain rights to have your dispute settled in and by a court of law, unless the law in your state provides for judicial review of arbitration proceedings.

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. 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 can not 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: (a) shall consider the dispute individually and shall not certify or consider multiple disputes as part of a class action; (b) shall be required to issue a reasoned written decision explaining the basis of his or her decision and the manner of calculating any award; (c) may not vary or disregard the terms of the policy; and (d) 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. The arbitrators' award, order or judgment shall be final and binding upon the parties. That decision may be entered and enforced in any state or federal court of competent jurisdiction. That arbitration award may only be modified, corrected, or vacated for the reasons set forth in the United States Arbitration Act (9 USC § 1).

Contact Information

General Counsel
USAble Life
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Email: AppealCoordinator@usablelife.com

Office of the Dispute Resolution Coordinator
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Section 6 – 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 application, and any attached papers; and 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 you.

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 you 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.

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 24 months.

No claim for loss starting 24 months after the covered person's effective date may be reduced or denied because a disease or physical condition existed 12 months 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 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; and (e) birth dates. Give us updates of such records as needed.
3. In order to start case management, give us prompt notice of a covered person'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 covered person has not been able to perform active work for 30 days.
4. In order to support case management, give us occupational data for all disabled covered persons. This includes, but is not limited to: (a) job descriptions and analyses; and (b) environmental factors.

Duties of Covered Persons: Your primary duties under the policy are listed below.

1. Give notice of claim as soon as possible after the date of your injury or the start of your sickness. Prompt notice will permit us to start case management.
2. Give a complete account of the details of your sickness or injury. This will include: (a) the cause of your disability, if known; (b) a description of your sickness or the accident that caused your injury; and (c) a list of all physicians, hospitals, or other facilities where you have been treated for the cause of your disability.
3. Allow release of medical and/or income data needed to assess your claim.
4. Give periodic medical updates as required by the policy.
5. Take part in any medical, financial or vocational assessment as required by the policy.
6. Apply for other income benefits to which you may be entitled.
7. Promptly report to us the receipt or denial of such other income benefits. And, appeal any denials to the extent possible.
8. Promptly report to us changes in your personal status. This includes: (a) change of address or phone number; (b) changes in how your disability affects your daily living; and (c) changes in your level of social, volunteer or business activities.
9. If we overpay benefits, promptly report and repay any amount overpaid.
10. If you are working while disabled, promptly report to us the amount of your income for such work.

11. Give us proof of your earnings for the period prior to your disability and while you are disabled.

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.

Section 7 – Long Term Disability Benefits

Insurance Provided

If you become disabled while insured under the policy, we will pay long term disability insurance benefits after you satisfy the elimination period. We will continue to pay benefits during your disability but not beyond the Maximum Benefit Period. Any benefits are subject to the provisions of the policy.

Monthly Benefit Calculation

Your monthly benefit is the amount you selected as shown on your enrollment form, subject to the Maximum Monthly Benefit, minus the Eligible Offsets.

However, if you are disabled and working and your disability earnings are at least 20% but less than 80% of your indexed pre-disability earnings, the following calculation will be used to determine if your benefits will be further reduced:

During the first 12 months benefits are paid while you are working, your monthly benefit payment will not be reduced as long as your disability earnings, including all Eligible Offsets, plus your monthly benefit do not exceed 100% of your indexed pre-disability earnings.

1. Add your monthly disability earnings and the amount of all Eligible Offsets to your monthly benefit.
2. Compare the answer in item 1 to your indexed pre-disability earnings.

   If the answer from item 1 is less than or equal to 100% of your indexed pre-disability earnings, we will not further reduce your monthly benefit.

   If the answer from item 1 is more than 100% of your indexed pre-disability earnings, we will subtract the amount over 100% from your monthly benefit.

After 12 months of benefit payments while you are working, you will receive payments based on the percentage of income you are losing due to disability as follows:

1. Subtract your disability earnings from your indexed pre-disability earnings.
2. Divide the answer from item 1 by your indexed pre-disability earnings. This is your percentage of lost earnings.
3. Multiply your monthly benefit by the answer in item 2.

This is the amount we will pay you each month.

If you are disabled and working, and your disability earnings are more than 80% of your monthly earnings prior to disability, no benefit will be payable.

If Your Disability Earnings Fluctuate

If your disability earnings fluctuate from month to month, we may average your disability earnings over the most recent three months to determine if your claim should continue.

If we average your disability earnings, we will not terminate your claim unless the average of your disability earnings from the last three months exceeds 80% of your pre-disability earnings.

Minimum Monthly Benefit: If you are eligible for a benefit under the policy, we will never pay less than the Minimum Benefit shown on the Schedule of Insurance.

Eligible Offsets

If you or your family are eligible for any of the following benefits for loss of income as a result of the period of disability for which you are claiming benefits under this plan, the total of all monthly benefits and other amounts will be subtracted from your monthly benefit. This includes any

such benefits for which you or your family are eligible or that are paid to you, to your family, or to a third party on your behalf, pursuant to any of the following:

1. temporary disability benefits under a Workers' Compensation Law, the Jones Act, occupational disease law, similar law, or substitutes or exchanges for such benefits;
2. governmental law or program that provides disability or unemployment benefits as a result of your job with the employer;
3. a plan or arrangement of coverage, whether insured or not, as a result of employment by or association with the employer or as a result of membership in or association with any group, association, union or other organization, including benefits required by state law, under an employer sponsored short term disability program or under a sick leave or salary continuation program;
4. an individual insurance policy where the premium is wholly or partially paid by the employer;
5. disability benefits under:
   a. the United States Social Security Act, or alternative plan offered by a state or municipal government;
   b. the Railroad Retirement Act;
   c. the Canada Pension Plan, the Canada Old Age Security Act, the Quebec Pension Plan, or any provincial pension or disability plan; or
   d. similar plan or act

   that you, your spouse and children, are eligible to receive because of your disability; or
6. disability benefit from the Department of Veterans Affairs, or any other foreign or domestic governmental agency:
   a. that begins after you become disabled; or
   b. if you were receiving the benefit before becoming disabled, the amount of any increase in the benefit that is attributed to your disability.

Eligible Offsets also include any payments that are made to you, your family, or to a third party on your behalf, pursuant to any of the following:

1. disability benefit under the Employer's Retirement Plan;
2. permanent disability or impairment benefits under a Workers' Compensation Law, the Jones Act, occupational disease law, similar law, or substitutes or exchanges for such benefits;
3. retirement benefit from a Retirement Plan that is wholly or partially funded by employer contributions, unless:
   a. you were receiving it prior to becoming disabled; or
   b. you immediately transfer the payment to another plan qualified by the United States Internal Revenue Service for the funding of a future retirement.

   Eligible Offsets will not include the portion, if any, of such retirement benefit that was funded by your after-tax contributions; or
4. retirement benefits under:
   a. the United States Social Security Act, or alternative plan offered by a state or municipal government;
   b. the Railroad Retirement Act;
   c. the Canada Pension Plan, the Canada Old Age Security Act, the Quebec Pension Plan, or any provincial pension or disability plan; or
   d. similar plan or act

   that you, your spouse and children, receive because of your retirement, unless you were receiving them prior to becoming Disabled.

If you are paid benefits under any of the Eligible Offsets in a lump sum or settlement, you must provide proof satisfactory to us of:

1. the amount attributed to loss of income; and
2. the period of time covered by the lump sum or settlement. We will pro-rate the lump sum or settlement over this period of time. If you cannot or do not provide this information, we will assume the entire sum to be for loss of income, and the time period to be 24 months. We may make a retroactive allocation of any retroactive Eligible Offset. A retroactive allocation may result in an overpayment of your claim.

The amount of any increase in any of the Eligible Offsets will not be included as an Eligible Offset if such increase:

1. takes effect after the date benefits become payable under this/your employer sponsored plan; and
2. is a general increase which applies to all persons who are entitled to such benefits.

Estimate of Benefits or Other Amounts

If you:

1. are eligible for benefits or other amounts from any of the above sources; or
2. it is reasonable to believe that you would be paid such benefits or other amounts if you had applied for them or had applied for them on time;

we will figure your monthly benefit as though you are receiving these other benefits, even if you are not.

For the purposes of this provision, we will estimate an amount equal to the amount you and your dependents would receive under the United States Social Security Act. This amount will reduce your monthly benefit beginning after five full months of disability. This reduction will continue unless you submit proof to us that you have applied for benefits under such Act, but you are not eligible to receive such benefits after completing the application and appeals processes, at least through the Administrative Law Judge hearing level, with the Social Security Administration. Any lump sum payment received by you shall be deducted immediately from your monthly disability benefits.

Social Security Assistance

Your claim for Social Security disability benefits may be denied. If it is, we may provide you with assistance for your appeal.

Adjustment of Benefits

If we find that the amount of benefit which we should have paid is different from the amount we actually paid you, we will adjust your benefit.

If we paid you less than we should have, we will pay you the difference.

If we paid you more than we should have, you or your estate must reimburse us within 60 days. Any future benefits we determine to be due, including the Minimum Benefit, will be applied to the overpayment until we are reimbursed in full.

Lump Sum Benefit

If you receive benefits from any source in a lump sum, we will pro-rate it over the time in which it accrued, based on information from the source of the payment. If we do not receive all the information we need, we will pro-rate the payment according to its nature and purpose.

Benefit Freeze

We will not reduce your monthly benefit further if the amount of benefits from any source, other than the policy, changes because of a cost of living increase that occurs automatically or by law after you satisfy the elimination period.

Waiver of Premium Benefit

While you are receiving benefits, your premiums do not have to be paid. However for coverage to be continued if you return to active work with the employer, premium payments must resume once you are no longer receiving benefits under the policy.

Managed Rehabilitation

You may be eligible to receive vocational rehabilitation services. In order to be eligible for such services you must have the functional capability to successfully complete a rehabilitation plan.

Vocational rehabilitation services will include the preparation of a rehabilitation plan for you, with input from you and your physician. We, you, your physician, or your employer can begin the process of developing a rehabilitation plan. Vocational rehabilitation services may include, but are not limited to, payment of your education expense, moving expense, or accommodation expense. We have the right to determine which services are appropriate.

If you return to work as part of a rehabilitation plan while you are disabled, we will pay your employer:

1. 100% of your salary, wages, partnership or proprietorship draw, commissions, or similar pay; or
2. the Schedule Amount, if less;

for the first month after you return to work, or your remaining period of disability, if less.

If your disability ends while you are participating, with your full cooperation, in your rehabilitation plan, and you are not able to find gainful work, we will:

1. pay you the amount of benefit, other than rehabilitation benefits, that would have been payable to you if you had remained disabled until:
   a. 3 months after your disability ends; or
   b. the date you are able to find gainful work, if earlier; and
2. provide or pay for reasonable job placement services for a period of up to 3 months after your disability ends.

Failure to participate with your full cooperation in the rehabilitation plan, without good cause, will result in the reduction or the termination of your long term disability insurance benefits. If benefits terminate, your long term disability insurance coverage under the policy will terminate. Reduction of benefits will be based on your projected income if you had met the goals of the rehabilitation plan. Benefits will be figured as though you were:

1. actually working in the occupation contemplated in the rehabilitation plan; and
2. earning the projected income amount.

If such work at the projected income amount would have resulted in the termination of your long term disability insurance benefits, your benefits will terminate as of the expected completion of the rehabilitation plan. “Good cause” means a medical reason preventing implementation of the rehabilitation plan.

We will make the final determination of any vocational rehabilitation services provided, of your eligibility for participation, and of any continued benefit payments.

Survivor Benefit

If you die while entitled to benefits under the policy, we will pay a survivor benefit. We must receive proof of your death and proof that the person claiming the benefit is entitled to it. We will pay the survivor benefit only to your lawful spouse, if living, otherwise, to your children. Children must be under age 25. “Children” include step-children or foster children that depended on you for support and maintenance. Adopted children and children placed for adoption are also included. If there are no survivors living at your death, we will pay your estate.

The survivor benefit is one lump-sum payment equal to 3 times your monthly benefit amount without reduction for Eligible Offsets.

Payment of the survivor benefit is subject to the other provisions of the policy.

Termination of Benefit Payments

We will terminate benefit payments on the earliest of the following dates:

1. the date you are no longer disabled as defined; or
2. the date you fail to furnish Proof of Loss, when requested by us; or
3. the date you are no longer under the regular care of a physician, or refuse our request that you submit to an examination by a physician, unless qualified medical professionals have determined that further medical care and treatment would be of no benefit to you; or
4. the date you die; or
5. the date your current monthly earnings exceed:
   a. 80% of your indexed pre-disability earnings if you are receiving benefits for being disabled from your regular occupation; or
   b. an amount that is equal to the product of your indexed pre-disability earnings and the benefit percentage not to exceed 60%, if you are receiving benefits for being disabled from any gainful occupation; or
6. the date you refuse to receive recommended treatment that is generally acknowledged by physicians to cure, correct or limit the disabling condition; or
7. the date you refuse to participate in your rehabilitation plan, or refuse to cooperate with or try:
   a. modifications made to the work site or job process to accommodate your identified medical limitations to enable you to perform the material duties of your regular occupation;
   b. adaptive equipment or devices designed to accommodate your identified medical limitations to enable you to perform the material duties of your regular occupation;
   c. modifications made to the work site or job process to accommodate your identified medical limitations to enable you to perform the material duties of any gainful occupation, if you were receiving benefits for being disabled from any gainful occupation; or
   d. adaptive equipment or devices designed to accommodate your identified medical limitations to enable you to perform the material duties of any gainful occupation, if you were receiving benefits for being disabled from any gainful occupation;

   provided, a qualified physician agrees that such modifications, adaptive equipment, or rehabilitation plan, accommodate your medical limitations; or
8. the date you receive retirement benefits from any employer's Retirement Plan, unless:
   a. you were receiving them prior to becoming disabled; or
   b. you immediately transfer the payment to another plan qualified by the United States Internal Revenue Service for the funding of a future retirement; or
9. the date determined by the Maximum Benefit Period table shown in the Schedule of Insurance; or
10. the date no further benefits are payable under any provision in the policy that limits benefit duration; or
11. after 12 months of payments if you are considered to reside outside the U.S. or Canada. You will be considered to reside outside these countries when you have been outside the U.S. or Canada for a total period of 6 months or more during any 12 consecutive months of benefits.

We will not pay benefits if:

1. your employer, the policyholder, or an associated company has offered you the opportunity to return to limited work while you are disabled;
2. you are functionally capable of performing the limited work which is offered; and you do not return to work when scheduled.

Benefits will end as of the date you were first scheduled to return to work.

Extension of Benefit Payments

If you are entitled to benefits while disabled and the policy terminates, benefits:

1. will continue as long as you remain disabled by the same disability, but
2. will not be provided beyond the date we would have ceased to pay benefits had the insurance remained in force.

Termination of the policy for any reason will have no effect on our liability under this provision.

Section 8 – Limitations and Exclusions

Alcoholism, Drug Addiction, Chemical Dependency, and Mental Illness Limitation

We pay only a limited benefit for a period of disability due to alcoholism, drug addiction, chemical dependency and mental illness. The Maximum Benefit Period for all such periods of disability is a total of 24 months. This is not a separate maximum for each such condition, or for each period of disability, but a combined maximum for all periods of disability and for all of these conditions.

Your period of disability will be considered due to alcoholism, drug addiction, chemical dependency or mental illness if:

1. you are limited by one or more of the stated conditions; and
2. you do not have other conditions which, in the absence of the stated conditions, would continue to exist, limit your activities, and lead us to conclude that you were disabled.

Benefits may be payable for more than 24 months, but not beyond the Maximum Benefit Period in the Schedule of Insurance, if you

1. are hospital confined at the end of the 24-month period above, and
2. remain disabled.

Benefits will be payable for the length of your confinement and for up to 60 days following the end of your confinement but not beyond the Maximum Benefit Period in the Schedule of Insurance.

If you are hospital confined again during the 60-day period for at least 14 consecutive days, benefits will be payable for the length of the second confinement and for up to 60 days following the end of the second confinement.

Pre-Existing Condition Exclusion

Benefits will not be paid if your disability begins in the first 24 months following the effective date of your coverage and your disability is caused by, contributed to by, or the result of a pre-existing condition, unless you had no treatment of the pre-existing condition for 6 consecutive months after your effective date of coverage.

Pre-Existing Condition means 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.

Exclusions

We will not pay benefits for any time you are confined to any facility because you were convicted of a crime or public offense.

We will not pay benefits for any disability caused by:

1. war or any act of war, or while serving in the armed forces of any country or international authority;
2. attempted suicide or intentional self-inflicted injury, while sane or insane; or
3. your active participation in a riot or insurrection; or
4. your voluntary commission of, or attempting to commit, an assault or a felony; or participating in an illegal occupation; or

5. injury occurring while intoxicated or under the influence of any narcotic unless administered on the advice of a physician; or
6. elective or cosmetic surgery, except for surgery to repair damage to the natural body caused by an injury or treatment of a sickness; or
7. your acting as an organ donor.

No benefits are payable for any period of disability during which you are incarcerated in a penal or correctional facility for a period of 30 or more consecutive days.

NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS UNDER THE NORTH CAROLINA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

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

DISCLAIMER

The North Carolina Life and Health Insurance Guaranty Association may or may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in North Carolina. You should not rely on coverage by the North Carolina Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.

The North Carolina Life and Health Insurance Guaranty Association
Post Office Box 10218
Raleigh, North Carolina 27605

North Carolina Department of Insurance
Consumer Services Division
1201 Mail Service Center
Raleigh, North Carolina 27699-1201

The state law that provides for this safety-net coverage is called the North Carolina Life and Health Insurance Guaranty Association Act. On the back of this page is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the guaranty association.

COVERAGE

Generally, individuals will be protected by the life and health insurance guaranty association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;
- their policy was issued by a non-profit hospital or medical services organization (such as Blue Cross), an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy-holder is subject to future assessments, or by an insurance exchange.

The association also does not provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed the average rate specified in the law;
- dividends;
- experience or other credits given in connection with the administration of a policy for a group contractholder;
- employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- unallocated annuity contracts (which give rights to group contractholders, not individuals), unless they fund a government lottery or a benefit plan of an employer, association or union, except that unallocated annuities issued to employee benefit plans protected by the Federal Pension Benefit Guaranty Corporation are not covered.

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the association is obligated to pay out as follows:

(1) The association cannot pay more than what the insurance company would owe under a policy or contract.
(2) Except as provided in (4) and (5) below, the guaranty association will pay a maximum of $300,000 per individual, per insolvency, no matter the number of policies or types of policies issued by the insolvent company.
(3) Except as provided in (4) and (5) below, the guaranty association will pay an aggregate maximum of $500,000 with respect to any one individual affected by multiple insolvencies.
(4) The guaranty association will pay a maximum of $1,000,000 with respect to any one structured settlement annuity contract holder.
(5) The guaranty association will pay a maximum of $5,000,000 to any one unallocated annuity contract holder.