Group Accident Insurance
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Group Accident Certificate of Insurance

For Residents of All States Except CA, ID, IN, LA, MT, NH, VT, WA

For Residents of CA
For Residents of ID
For Residents of IN
For Residents of LA
For Residents of MT
For Residents of NH
For Residents of VT
For Residents of WA
Applies to all employees except those who reside in the following states: CA, ID, IN, LA, MT, NH, VT, WA

POLICYHOLDER: Concordia Plan Services

POLICY NUMBER: 76013

THIS CERTIFICATE IS NOT MAJOR MEDICAL INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL INSURANCE. IT DOES NOT QUALIFY AS MINIMUM ESSENTIAL HEALTH COVERAGE UNDER THE FEDERAL AFFORDABLE CARE ACT. THIS CERTIFICATE DOES NOT SATISFY THE FEDERAL REQUIREMENT THAT YOU HAVE HEALTH INSURANCE COVERAGE, WHICH BECAME EFFECTIVE JANUARY 1, 2014.

THIS IS A LIMITED BENEFIT CERTIFICATE: This certificate provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses. Read your certificate carefully.

THIS CERTIFICATE IS NOT A MEDICARE SUPPLEMENT CONTRACT. If you are eligible for Medicare, review the Guide to Health Insurance for people with Medicare available from us.

Read Your Certificate Carefully

If you meet the eligibility and enrollment requirements herein, you are insured under the group policy shown on the specifications page. This certificate summarizes the principal provisions of the group policy that affect you. The provisions summarized in this certificate are subject in every respect to the group policy. You may examine the group policy at the principal office of the policyholder during regular working hours.

Legal Actions

No legal action may be brought to recover on this certificate within the first sixty days after written proof of loss has been given as required by this certificate. No such action may be brought after three years from the time written proof of loss is required to be given.

Secretary

President

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GROUP ACCIDENT CERTIFICATE OF INSURANCE

15-32401
IMPORTANT NOTICE

To obtain information or make a complaint:

You may call Securian Life's toll-free telephone number for information or to make a complaint at:

1-855-651-3500

You may also write to Securian Life at:

Securian Life Insurance Company
400 Robert Street North
St. Paul, MN 55101-2098

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights, or complaints at:

1-800-252-3439

You may write the Texas Department of Insurance:

P.O. Box 149104
Austin, TX 78714-9104

Fax: (512) 490-1007
Web: www.tdi.texas.gov
E-mail: ConsumerProtection@tdi.texas.gov

PREMIUM OR CLAIM DISPUTES:

Should you have a dispute concerning your premium or about a claim, you should contact the company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY:

This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para obtener información o para presentar una queja:

Usted puede llamar al número de teléfono gratis de Securian Life's para obtener información o para presentar una queja al:

1-855-651-3500

Usted también puede escribir a Securian Life:

Securian Life Insurance Company
400 Robert Street North
St. Paul, MN 55101-2098

Usted puede comunicarse con el Departamento de Seguros de Texas para obtener información sobre compañías, coberturas, derechos, o quejas al:

1-800-252-3439

Usted puede escribir al Departamento de Seguros de Texas a:

P.O. Box 149104
Austin, TX 78714-9104

Fax: (512) 490-1007
Sitio web: www.tdi.texas.gov
E-mail: ConsumerProtection@tdi.texas.gov

DISPUTAS POR PRIMAS DE SEGUROS O RECLAMACIONES:

Si tiene una disputa relacionada con su prima de seguro o con una reclamación, usted debe comunicarse con la compañía primero. Si la disputa no es resuelta, usted puede comunicarse con el Departamento de Seguros de Texas.

ADJUNTE ESTE AVISO A SU PÓLIZA:

Este aviso es solamente para propósitos informativos y no se convierte en parte o en condición del documento adjunto.
GENERAL INFORMATION

POLICYHOLDER: Concordia Plan Services

POLICY NUMBER: 76013

ASSOCIATED COMPANIES: All subsidiaries and affiliates reported to Securian Life by the policyholder for inclusion in the policy.

POLICY SITUS: The policy was issued and delivered in Missouri.

POLICY EFFECTIVE DATE: January 1, 2019.

This certificate and/or certificate specifications page replaces any and all certificates and/or certificate specifications pages previously issued to you under the group policy. Please replace any certificate and/or certificate specifications page previously issued to you with this new certificate and/or specifications page.

GROUP: The group is composed of all active employees of the policyholder and its associated companies working in the United States in the following class:

Class 1: Active employees working at least 20 hours per week.

All new employees of the employer will be added to such group and classes for which they become eligible.

NO DOUBLE COVERAGE: A person cannot be covered under more than one class. A person cannot be covered as both an active employee and a retiree. Any person who is eligible as an employee or retiree under the policy, or insured under the portability provisions, is not eligible as a dependent. Only one person can insure an eligible dependent child.

ENROLLMENT PERIOD: 90 days from the first day of eligibility for contributory insurance.

WAITING PERIOD: None

MINIMUM HOURS PER WEEK REQUIREMENT: 20 hours per week

PLAN OF INSURANCE

EMPLOYEE BENEFIT SCHEDULE

EMPLOYEE GROUP ACCIDENT INSURANCE:

Supplemental Group Accident Insurance

<table>
<thead>
<tr>
<th>Eligible Class</th>
<th>Employee Supplemental Group Accident Insurance Benefit Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class 1</td>
<td>Low Plan or High Plan as elected by the employee.</td>
</tr>
</tbody>
</table>
GENERAL PROVISIONS FOR EMPLOYEE INSURANCE

RETIREMENT REDUCTIONS: All insurance terminates at retirement, except as otherwise provided for under any applicable certificate supplement.

CONTRIBUTORY/NONCONTRIBUTORY: Supplemental insurance is contributory insurance.

PORTABILITY BENEFIT (not available to residents of Colorado): Low Plan or High Plan as elected by the employee.

DEPENDENT BENEFIT SCHEDULE

An employee must be insured in order to elect dependent group accident insurance.

SPOUSE GROUP ACCIDENT INSURANCE

Supplemental Group Accident Insurance

<table>
<thead>
<tr>
<th>Eligible Class</th>
<th>Spouse Supplemental Group Accident Insurance Benefit Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class 1</td>
<td>Spouse benefit plan will match the employee’s Supplemental Group Accident Benefit Plan.</td>
</tr>
</tbody>
</table>

CHILD GROUP ACCIDENT INSURANCE

Supplemental Group Accident Insurance

<table>
<thead>
<tr>
<th>Eligible Class</th>
<th>Child Supplemental Group Accident Insurance Benefit Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class 1</td>
<td>Child benefit plan will match the employee’s supplemental Group Accident Benefit Plan.</td>
</tr>
</tbody>
</table>

GENERAL PROVISIONS FOR DEPENDENT INSURANCE

CONTRIBUTORY/NONCONTRIBUTORY: Supplemental insurance is contributory insurance.

SPOUSE AND CHILD PORTABILITY BENEFIT (not available to residents of Colorado):

Spouse benefit plan will match the employee’s Group Accident Benefit Plan. Child benefit plan will match the employee’s Group Accident Benefit Plan.

COVERED BENEFITS

The Schedule of Benefits applicable to an insured is based on the employee’s state of residence at the time coverage under this certificate became effective as follows:

Schedule A: All states except those noted below
Schedule B: Colorado
Schedule C: Minnesota and New Mexico
Schedule D: North Dakota
COVERED BENEFITS  Schedule A
Applies to all states except CO, MN, ND, NM,

Refer to the Injury Benefits, Emergency Care, Hospital Care, Surgery Benefits, Follow-up Care and Support Care sections of the Certificate for additional benefit details.

<table>
<thead>
<tr>
<th>INJURY BENEFITS</th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burn Benefit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2nd degree burns</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 10% of the body</td>
<td>$100</td>
<td>$300</td>
</tr>
<tr>
<td>Between 10% and 20% of the body</td>
<td>$250</td>
<td>$750</td>
</tr>
<tr>
<td>20% or more of the body</td>
<td>$500</td>
<td>$1,500</td>
</tr>
<tr>
<td>3rd degree burns</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 10% of the body</td>
<td>$1,000</td>
<td>$3,000</td>
</tr>
<tr>
<td>Between 10% and 20% of the body</td>
<td>$2,500</td>
<td>$7,500</td>
</tr>
<tr>
<td>20% or more of the body</td>
<td>$5,000</td>
<td>$15,000</td>
</tr>
<tr>
<td>Child Organized Sports Injury</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$50</td>
<td>$100</td>
</tr>
<tr>
<td>Concussion</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$100</td>
<td>$200</td>
</tr>
<tr>
<td>Dislocation</td>
<td>$2,000</td>
<td>$5,000</td>
</tr>
<tr>
<td>Principal Amount (Surgical)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hand or wrist (excluding fingers)</td>
<td>Hand: 20%</td>
<td>Hand: 20%</td>
</tr>
<tr>
<td>Wrist: 30%</td>
<td>Wrist: 30%</td>
<td></td>
</tr>
<tr>
<td>Hip/Thigh</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Foot</td>
<td>40%</td>
<td>40%</td>
</tr>
<tr>
<td>Ankle</td>
<td>40%</td>
<td>40%</td>
</tr>
<tr>
<td>Knee</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Lower jaw</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Shoulder</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Collarbone</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Ribs</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Finger</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Toe</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Elbow</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Non-surgical</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Partial dislocation</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Eye Injury - with Surgery</td>
<td>$120</td>
<td>$300</td>
</tr>
<tr>
<td>Eye Injury – Removal of Foreign Object without Surgery</td>
<td>$30</td>
<td>$75</td>
</tr>
<tr>
<td>Fracture</td>
<td>$2,000</td>
<td>$5,000</td>
</tr>
<tr>
<td>Principal Amount (Surgical)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hip/Thigh</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Vertebral body</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Vertebral processes</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Pelvis</td>
<td>75%</td>
<td>75%</td>
</tr>
<tr>
<td>Sternum</td>
<td>75%</td>
<td>75%</td>
</tr>
<tr>
<td>Coccyx</td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td>Skull – non depressed</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Skull – depressed</td>
<td>150%</td>
<td>150%</td>
</tr>
<tr>
<td>Lower leg</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Foot</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>INJURY BENEFITS</td>
<td>LOW PLAN</td>
<td>HIGH PLAN</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>----------</td>
<td>-----------</td>
</tr>
<tr>
<td>Ankle</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Kneecap</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Upper arm</td>
<td>35%</td>
<td>35%</td>
</tr>
<tr>
<td>Facial excluding lower jaw</td>
<td>35%</td>
<td>35%</td>
</tr>
<tr>
<td>Forearm</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Hand or wrist (except fingers)</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Lower jaw</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Shoulder blade</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Collarbone</td>
<td>15%</td>
<td>15%</td>
</tr>
<tr>
<td>Ribs</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Finger</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Toe</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Nose</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Non-surgical</td>
<td>50% of surgical benefit</td>
<td>50% of surgical benefit</td>
</tr>
<tr>
<td>Chip fracture</td>
<td>25% of non-surgical benefit</td>
<td>25% of non-surgical benefit</td>
</tr>
</tbody>
</table>

**Lacerations**

<table>
<thead>
<tr>
<th>Type</th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>With stitches or staples</td>
<td>$100</td>
<td>$500</td>
</tr>
<tr>
<td>Without stitches or staples</td>
<td>25% of benefit provided with stitches or staples</td>
<td>25% of benefit provided with stitches or staples</td>
</tr>
</tbody>
</table>

**Paralysis**

<table>
<thead>
<tr>
<th>Principal Amount</th>
<th>% of Principal Amount</th>
<th>% of Principal Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quadriplegia</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Paraplegia</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Hemiplegia</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Uniplegia</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Traumatic Brain Injury</td>
<td>$200</td>
<td>$400</td>
</tr>
</tbody>
</table>

**EMERGENCY CARE**

<table>
<thead>
<tr>
<th>Type</th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ground or water</td>
<td>$100</td>
<td>$200</td>
</tr>
<tr>
<td>Air</td>
<td>$500</td>
<td>$1,000</td>
</tr>
<tr>
<td>Blood, Plasma or Platelets Transfusion</td>
<td>$300</td>
<td>$600</td>
</tr>
<tr>
<td>Emergency Dental</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crown</td>
<td>$150</td>
<td>$300</td>
</tr>
<tr>
<td>Extraction</td>
<td>$50</td>
<td>$100</td>
</tr>
<tr>
<td>Emergency Room Treatment</td>
<td>$100</td>
<td>$300</td>
</tr>
<tr>
<td>Initial Physician’s Office Visit</td>
<td>$50</td>
<td>$100</td>
</tr>
<tr>
<td>Hospital Stay</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initial benefit, non-ICU</td>
<td>$400</td>
<td>$1,200</td>
</tr>
<tr>
<td>Initial benefit, ICU</td>
<td>$800</td>
<td>$2,400</td>
</tr>
<tr>
<td>Daily benefit, non-ICU</td>
<td>$100</td>
<td>$300</td>
</tr>
<tr>
<td>Daily benefit, ICU</td>
<td>$200</td>
<td>$600</td>
</tr>
</tbody>
</table>
### SURGERY

<table>
<thead>
<tr>
<th></th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal or Pelvic Surgery</td>
<td>$1,000</td>
<td>$2,000</td>
</tr>
<tr>
<td>Cranial Surgery</td>
<td>$1,000</td>
<td>$2,000</td>
</tr>
<tr>
<td>Knee Cartilage Surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Open</td>
<td>$500</td>
<td>$1,000</td>
</tr>
<tr>
<td>Arthroscopic</td>
<td>$250</td>
<td>$500</td>
</tr>
<tr>
<td>Ruptured Disc Surgery</td>
<td>$500</td>
<td>$1,000</td>
</tr>
<tr>
<td>Tendon, Ligament or Rotator Cuff Surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Open</td>
<td>$500</td>
<td>$1,000</td>
</tr>
<tr>
<td>Arthroscopic</td>
<td>$250</td>
<td>$500</td>
</tr>
<tr>
<td>Thoracic Surgery</td>
<td>$1,000</td>
<td>$2,000</td>
</tr>
</tbody>
</table>

### FOLLOW-UP CARE

<table>
<thead>
<tr>
<th></th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adaptive Home and Vehicle Benefit</td>
<td>$500</td>
<td>$1,000</td>
</tr>
<tr>
<td>Appliances</td>
<td>$50</td>
<td>$250</td>
</tr>
<tr>
<td>Follow-Up Physician’s Office Visit</td>
<td>$50</td>
<td>$100</td>
</tr>
<tr>
<td>Prosthetics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>One prosthesis</td>
<td>$500</td>
<td>$1,000</td>
</tr>
<tr>
<td>Two or more prosthetics</td>
<td>2x one prosthetic</td>
<td>2x one prosthetic</td>
</tr>
<tr>
<td>Transportation</td>
<td>$200 per visit</td>
<td>$500 per visit</td>
</tr>
</tbody>
</table>

### SUPPORT CARE

<table>
<thead>
<tr>
<th></th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Companion Lodging</td>
<td>$75 per day</td>
<td>$150 per day</td>
</tr>
</tbody>
</table>

### ADDITIONAL INFORMATION

**ANNUAL OPEN ENROLLMENTS:**

During the policyholder’s annual open enrollment an employee may elect or change employee and dependent accident insurance benefit plans.

Coverage will be effective on the January 1 following the annual enrollment, subject to the actively at work requirement for employee and the hospitalization/non-confinement provision for dependents (this does not apply to a newborn child).

**Special Enrollment Periods:** Upon mutual agreement between the Policyholder and Securian, one or more special enrollment periods may be offered to eligible employees. These special enrollment periods (if offered) will be in addition to the annual enrollment opportunities described above. In the event that a special enrollment period is offered, the details of the special enrollment, including enrollment dates, allowed changes, and evidence of insurability requirements, will be communicated to you in advance of the special enrollment period and documented in the group policy on file with the policyholder and Securian.
QUALIFIED STATUS CHANGES:

An employee who experiences a Qualified Status Changes as defined below may elect or change employee and dependent accident insurance benefit plans provided enrollment is made within 60 days of the status change.

- An active employee may elect accident insurance for the first time or increase coverage from the low plan to the high plan.
- An active employee may elect dependent coverage.

Coverage will be effective on the date of the election. All increases are subject to the actively at work requirement for employees and the hospitalization/non-confinement provision for dependents (this does not apply to a newborn child)

A qualified status change for the purpose of waiving the evidence of insurability requirement means marriage, birth or adoption.

SUPPLEMENTS TO THE CERTIFICATE

Portability
Refer to the **Injury Benefits, Emergency Care, Hospital Care, Surgery Benefits, Follow-up Care** and **Support Care** sections of the Certificate for additional benefit details.

### INJURY BENEFITS

<table>
<thead>
<tr>
<th></th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Burn Benefit</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2(^{nd}) degree burns</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 10% of the body</td>
<td>$105</td>
<td>$315</td>
</tr>
<tr>
<td>Between 10% and 20% of the body</td>
<td>$263</td>
<td>$788</td>
</tr>
<tr>
<td>20% or more of the body</td>
<td>$525</td>
<td>$1,575</td>
</tr>
<tr>
<td>3(^{rd}) degree burns</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 10% of the body</td>
<td>$1,050</td>
<td>$3,150</td>
</tr>
<tr>
<td>Between 10% and 20% of the body</td>
<td>$2,625</td>
<td>$7,875</td>
</tr>
<tr>
<td>20% or more of the body</td>
<td>$5,250</td>
<td>$15,750</td>
</tr>
<tr>
<td><strong>Child Organized Sports Injury</strong></td>
<td>$53</td>
<td>$105</td>
</tr>
<tr>
<td><strong>Concussion</strong></td>
<td>$105</td>
<td>$210</td>
</tr>
</tbody>
</table>

### Dislocation

<table>
<thead>
<tr>
<th>Principal Amount (Surgical)</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$2,100</td>
<td>$5,250</td>
</tr>
</tbody>
</table>

|                      | % of Principal Amount | % of Principal Amount |
|----------------------|                       |                       |
| Hip/Thigh            | 100%                  | 100%                  |
| Foot                 | 40%                   | 40%                   |
| Ankle                | 40%                   | 40%                   |
| Knee                 | 50%                   | 50%                   |
| Hand or wrist (excluding fingers) | Hand: 20%  | Hand: 20%           |
|                      | Wrist: 30%            | Wrist: 30%            |
| Lower jaw            | 20%                   | 20%                   |
| Shoulder             | 20%                   | 20%                   |
| Collarbone           | 20%                   | 20%                   |
| Ribs                 | 20%                   | 20%                   |
| Finger               | 5%                    | 5%                    |
| Toe                  | 5%                    | 5%                    |
| Elbow                | 20%                   | 20%                   |
| Non-surgical         | 50% of surgical benefit | 50% of surgical benefit |
| Partial dislocation  | 25% of non-surgical benefit | 25% of non-surgical benefit |
| Eye Injury - with Surgery | $126               | $315               |
| Eye Injury – Removal of Foreign Object without Surgery | $32       | $79               |

### Fracture

<table>
<thead>
<tr>
<th>Principal Amount (Surgical)</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>$2,100</td>
<td>$5,250</td>
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</tbody>
</table>

<p>|                      | % of Principal Amount | % of Principal Amount |
|----------------------|                       |                       |
| Hip/Thigh            | 100%                  | 100%                  |
| Vertebral body       | 50%                   | 50%                   |
| Vertebral processes  | 20%                   | 20%                   |
| Pelvis               | 75%                   | 75%                   |
| Sternum              | 75%                   | 75%                   |
| Coccyx               | 10%                   | 10%                   |
| Skull – non depressed | 100%                 | 100%                 |
| Skull – depressed    | 150%                  | 150%                 |
| Lower leg            | 50%                   | 50%                   |</p>
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<th>INJURY BENEFITS</th>
<th>LOW PLAN</th>
<th></th>
<th>HIGH PLAN</th>
<th></th>
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<tbody>
<tr>
<td>Foot</td>
<td>25%</td>
<td></td>
<td>25%</td>
<td></td>
</tr>
<tr>
<td>Ankle</td>
<td>25%</td>
<td></td>
<td>25%</td>
<td></td>
</tr>
<tr>
<td>Kneecap</td>
<td>25%</td>
<td></td>
<td>25%</td>
<td></td>
</tr>
<tr>
<td>Upper arm</td>
<td>35%</td>
<td></td>
<td>35%</td>
<td></td>
</tr>
<tr>
<td>Facial excluding lower jaw</td>
<td>35%</td>
<td></td>
<td>35%</td>
<td></td>
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<tr>
<td>Forearm</td>
<td>25%</td>
<td></td>
<td>25%</td>
<td></td>
</tr>
<tr>
<td>Hand or wrist (except fingers)</td>
<td>25%</td>
<td></td>
<td>25%</td>
<td></td>
</tr>
<tr>
<td>Lower jaw</td>
<td>25%</td>
<td></td>
<td>25%</td>
<td></td>
</tr>
<tr>
<td>Shoulder blade</td>
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<td>50%</td>
<td></td>
</tr>
<tr>
<td>Collarbone</td>
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<td>15%</td>
<td></td>
</tr>
<tr>
<td>Ribs</td>
<td>25%</td>
<td></td>
<td>25%</td>
<td></td>
</tr>
<tr>
<td>Finger</td>
<td>5%</td>
<td></td>
<td>5%</td>
<td></td>
</tr>
<tr>
<td>Toe</td>
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<tr>
<td>Nose</td>
<td>5%</td>
<td></td>
<td>5%</td>
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<tr>
<td>Non-surgical</td>
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<tr>
<td>Chip fracture</td>
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<td>Lacerations</td>
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<tr>
<td>With stitches or staples</td>
<td>$105</td>
<td>$525</td>
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<tr>
<td>Without stitches or staples</td>
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<td>Paralysis</td>
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<tr>
<td>Quadriplegia</td>
<td>50%</td>
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<tr>
<td>Paraplegia</td>
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<td>50%</td>
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<tr>
<td>Hemiplegia</td>
<td>25%</td>
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<tr>
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<tr>
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<td>$420</td>
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<tr>
<td>EMERGENCY CARE</td>
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<tr>
<td>Ambulance</td>
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<tr>
<td>Crown</td>
<td>$158</td>
<td>$315</td>
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<tr>
<td>Extraction</td>
<td>$53</td>
<td>$105</td>
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<tr>
<td>Emergency Room Treatment</td>
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<td>Initial Physician's Office Visit</td>
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<td>$105</td>
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<tr>
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<td>Daily benefit, non-ICU</td>
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<td>$315</td>
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### INJURY BENEFITS

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<td>$630</td>
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### SURGERY

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<td>Cranial Surgery</td>
<td>$1,050</td>
<td>$2,100</td>
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#### Knee Cartilage Surgery

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<td>$525</td>
<td>$1,050</td>
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<tr>
<td>Arthroscopic</td>
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<tr>
<td>Ruptured Disc Surgery</td>
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<td>$1,050</td>
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#### Tendon, Ligament or Rotator Cuff Surgery

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<td>$1,050</td>
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<tr>
<td>Arthroscopic</td>
<td>$263</td>
<td>$525</td>
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<tr>
<td>Thoracic Surgery</td>
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### FOLLOW-UP CARE

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<td>Appliances</td>
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<td>$105</td>
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#### Prosthetics

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<tr>
<td>One prosthetic</td>
<td>$525</td>
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<tr>
<td>Two or more prosthetics</td>
<td>2x one prosthetic</td>
<td>2x one prosthetic</td>
</tr>
<tr>
<td>Transportation</td>
<td>$210 per visit</td>
<td>$525 per visit</td>
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### ADDITIONAL INFORMATION

#### ANNUAL OPEN ENROLLMENTS:

During the policyholder’s annual open enrollment an employee may elect or change employee and dependent accident insurance benefit plans.

Coverage will be effective on the January 1 following the annual enrollment, subject to the actively at work requirement for employees and the hospitalization/non-confinement provision for dependents (this does not apply to a newborn child).

**Special Enrollment Periods:** Upon mutual agreement between the Policyholder and Securian, one or more special enrollment periods may be offered to eligible employees. These special enrollment periods (if offered) will be in addition to the annual enrollment opportunities described above. In the event that a special enrollment period is offered, the details of the special enrollment, including enrollment dates, allowed changes, and evidence of insurability requirements,
QUALIFIED STATUS CHANGES:

An employee who experiences a Qualified Status Changes as defined below may elect or change employee and dependent accident insurance benefit plans provided enrollment is made within 60 days of the status change.

- An active employee may elect accident insurance for the first time or increase coverage from the low plan to the high plan.
- An active employee may elect dependent coverage.

Coverage will be effective on the date of the election. All increases are subject to the actively at work requirement for employees and the hospitalization/non-confinement provision for dependents (this does not apply to a newborn child).

A qualified status change for the purpose of waiving the evidence of insurability requirement means marriage, birth or adoption.


COVERED BENEFITS  Schedule C  
Applies Residents of Minnesota and New Mexico

Refer to the **Injury Benefits**, **Emergency Care**, **Hospital Care**, **Surgery Benefits**, **Follow-up Care**, and **Support Care** sections of the Certificate for additional benefit details.

<table>
<thead>
<tr>
<th>INJURY BENEFITS</th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
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</thead>
<tbody>
<tr>
<td><strong>Burn Benefit</strong></td>
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<tr>
<td>2nd degree burns</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 10% of the body</td>
<td>$107</td>
<td>$321</td>
</tr>
<tr>
<td>Between 10% and 20% of the body</td>
<td>$268</td>
<td>$803</td>
</tr>
<tr>
<td>20% or more of the body</td>
<td>$535</td>
<td>$1,605</td>
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<tr>
<td>3rd degree burns</td>
<td></td>
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<tr>
<td>Less than 10% of the body</td>
<td>$1,070</td>
<td>$3,210</td>
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<tr>
<td>Between 10% and 20% of the body</td>
<td>$2,675</td>
<td>$8,025</td>
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<tr>
<td>20% or more of the body</td>
<td>$5,350</td>
<td>$16,050</td>
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<table>
<thead>
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<th></th>
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<tbody>
<tr>
<td><strong>Child Organized Sports Injury</strong></td>
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<tr>
<td><strong>Concussion</strong></td>
<td>$107</td>
<td>$214</td>
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<table>
<thead>
<tr>
<th>Dislocation</th>
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<td>$5,350</td>
</tr>
<tr>
<td>% of Principal Amount</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hip/Thigh</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Foot</td>
<td>40%</td>
<td>40%</td>
</tr>
<tr>
<td>Ankle</td>
<td>40%</td>
<td>40%</td>
</tr>
<tr>
<td>Knee</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Hand or wrist (excluding fingers)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hand: 20%</td>
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<td></td>
</tr>
<tr>
<td>Wrist: 30%</td>
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</tr>
<tr>
<td>Lower jaw</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Shoulder</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Collarbone</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Ribs</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Finger</td>
<td>5%</td>
<td>5%</td>
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<tr>
<td>Toe</td>
<td>5%</td>
<td>5%</td>
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<tr>
<td>Elbow</td>
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<tr>
<td>Non-surgical</td>
<td>50%</td>
<td>50%</td>
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<tr>
<td>Partial dislocation</td>
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<tr>
<td>Eye Injury - with Surgery</td>
<td>$128</td>
<td>$321</td>
</tr>
<tr>
<td>Eye Injury – Removal of Foreign Object without Surgery</td>
<td>$32</td>
<td>$80</td>
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<table>
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<tr>
<th>Fracture</th>
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<td>$5,350</td>
</tr>
<tr>
<td>% of Principal Amount</td>
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<td></td>
</tr>
<tr>
<td>Hip/Thigh</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Vertebral body</td>
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<td>50%</td>
</tr>
<tr>
<td>Vertebral processes</td>
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<tr>
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<tr>
<td>Coccyyx</td>
<td>10%</td>
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</tr>
<tr>
<td>Skull – non depressed</td>
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<td>100%</td>
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<tr>
<td>Skull – depressed</td>
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<td>Lower leg</td>
<td>50%</td>
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<tr>
<td>INJURY BENEFITS</td>
<td>LOW PLAN</td>
<td>HIGH PLAN</td>
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<tr>
<td>----------------------------</td>
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<td>-----------</td>
</tr>
<tr>
<td>Foot</td>
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<td>25%</td>
</tr>
<tr>
<td>Ankle</td>
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<td>25%</td>
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<tr>
<td>Kneecap</td>
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<td>25%</td>
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<tr>
<td>Upper arm</td>
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<tr>
<td>Facial excluding lower jaw</td>
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<td>35%</td>
</tr>
<tr>
<td>Forearm</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Hand or wrist (except fingers)</td>
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<td>25%</td>
</tr>
<tr>
<td>Lower jaw</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Shoulder blade</td>
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<tr>
<td>Collarbone</td>
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<td>15%</td>
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<td>Ribs</td>
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<td>5%</td>
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<td>Toe</td>
<td>5%</td>
<td>5%</td>
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<tr>
<td>Nose</td>
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<tr>
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<td>25% of non-surgical benefit</td>
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<tr>
<td>Lacerations</td>
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<tr>
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<td>$107</td>
<td>$535</td>
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<td>Paralysis</td>
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<td>Paraplegia</td>
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<td>50%</td>
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<tr>
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<tr>
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<td></td>
</tr>
<tr>
<td>Initial benefit, non-ICU</td>
<td>$428</td>
<td>$1,284</td>
</tr>
<tr>
<td>Initial benefit, ICU</td>
<td>$856</td>
<td>$2,568</td>
</tr>
<tr>
<td>Daily benefit, non-ICU</td>
<td>$107</td>
<td>$321</td>
</tr>
<tr>
<td>INJURY BENEFITS</td>
<td>LOW PLAN</td>
<td>HIGH PLAN</td>
</tr>
<tr>
<td>----------------</td>
<td>----------</td>
<td>-----------</td>
</tr>
<tr>
<td>Daily benefit, ICU</td>
<td>$214</td>
<td>$642</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SURGERY</th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal or Pelvic Surgery</td>
<td>$1,070</td>
<td>$2,140</td>
</tr>
<tr>
<td>Cranial Surgery</td>
<td>$1,070</td>
<td>$2,140</td>
</tr>
<tr>
<td>Knee Cartilage Surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Open</td>
<td>$535</td>
<td>$1,070</td>
</tr>
<tr>
<td>Arthroscopic</td>
<td>$268</td>
<td>$535</td>
</tr>
<tr>
<td>Ruptured Disc Surgery</td>
<td>$535</td>
<td>$1,070</td>
</tr>
<tr>
<td>Tendon, Ligament or Rotator Cuff Surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Open</td>
<td>$535</td>
<td>$1,070</td>
</tr>
<tr>
<td>Arthroscopic</td>
<td>$268</td>
<td>$535</td>
</tr>
<tr>
<td>Thoracic Surgery</td>
<td>$1,070</td>
<td>$2,140</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FOLLOW-UP CARE</th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adaptive Home and Vehicle Benefit</td>
<td>$535</td>
<td>$1,070</td>
</tr>
<tr>
<td>Appliances</td>
<td>$54</td>
<td>$268</td>
</tr>
<tr>
<td>Follow-Up Physician’s Office Visit</td>
<td>$54</td>
<td>$107</td>
</tr>
<tr>
<td>Prosthetics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>One prosthetic</td>
<td>$535</td>
<td>$1,070</td>
</tr>
<tr>
<td>Two or more prosthetics</td>
<td>2x one prosthetic</td>
<td>2x one prosthetic</td>
</tr>
<tr>
<td>Transportation</td>
<td>$214 per visit</td>
<td>$535 per visit</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SUPPORT CARE</th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Companion Lodging</td>
<td>$80 per day</td>
<td>$161 per day</td>
</tr>
</tbody>
</table>

**ADDITIONAL INFORMATION**

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A qualified status change for the purpose of waiving the evidence of insurability requirement means marriage, birth or adoption.

**SUPPLEMENTS TO THE CERTIFICATE**

Portability
Covered Benefits Schedule D
Applies Residents of North Dakota

Refer to the Injury Benefits, Emergency Care, Hospital Care, Surgery Benefits, Follow-up Care and Support Care sections of the Certificate for additional benefit details.

<table>
<thead>
<tr>
<th>INJURY BENEFITS</th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Burn Benefit</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2nd degree burns</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 10% of the body</td>
<td>$119</td>
<td>$357</td>
</tr>
<tr>
<td>Between 10% and 20% of the body</td>
<td>$298</td>
<td>$893</td>
</tr>
<tr>
<td>20% or more of the body</td>
<td>$595</td>
<td>$1,785</td>
</tr>
<tr>
<td>3rd degree burns</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 10% of the body</td>
<td>$1,190</td>
<td>$3,570</td>
</tr>
<tr>
<td>Between 10% and 20% of the body</td>
<td>$2,975</td>
<td>$8,925</td>
</tr>
<tr>
<td>20% or more of the body</td>
<td>$5,950</td>
<td>$17,850</td>
</tr>
<tr>
<td><strong>Child Organized Sports Injury</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$60</td>
<td>$119</td>
</tr>
<tr>
<td><strong>Concussion</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$119</td>
<td>$238</td>
</tr>
<tr>
<td><strong>Dislocation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Principal Amount (Surgical)</td>
<td>$2,380</td>
<td>$5,950</td>
</tr>
<tr>
<td></td>
<td>% of Principal Amount</td>
<td>% of Principal Amount</td>
</tr>
<tr>
<td>Hip/Thigh</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Foot</td>
<td>40%</td>
<td>40%</td>
</tr>
<tr>
<td>Ankle</td>
<td>40%</td>
<td>40%</td>
</tr>
<tr>
<td>Knee</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Hand or wrist (excluding fingers)</td>
<td>Hand: 20%</td>
<td>Hand: 20%</td>
</tr>
<tr>
<td></td>
<td>Wrist: 30%</td>
<td>Wrist: 30%</td>
</tr>
<tr>
<td>Lower jaw</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Shoulder</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Collarbone</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Ribs</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Finger</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Toe</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Elbow</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Non-surgical</td>
<td>50% of surgical benefit</td>
<td>50% of surgical benefit</td>
</tr>
<tr>
<td>Partial dislocation</td>
<td>25% of non-surgical benefit</td>
<td>25% of non-surgical benefit</td>
</tr>
<tr>
<td><strong>Eye Injury - with Surgery</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$143</td>
<td>$357</td>
</tr>
<tr>
<td><strong>Eye Injury – Removal of Foreign Object without Surgery</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$36</td>
<td>$89</td>
</tr>
<tr>
<td><strong>Fracture</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Principal Amount (Surgical)</td>
<td>$2,380</td>
<td>$5,950</td>
</tr>
<tr>
<td></td>
<td>% of Principal Amount</td>
<td>% of Principal Amount</td>
</tr>
<tr>
<td>Hip/Thigh</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Vertebral body</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Vertebral processes</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Pelvis</td>
<td>75%</td>
<td>75%</td>
</tr>
<tr>
<td>Sternum</td>
<td>75%</td>
<td>75%</td>
</tr>
<tr>
<td>Coccyx</td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td>Skull – non depressed</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Skull – depressed</td>
<td>150%</td>
<td>150%</td>
</tr>
<tr>
<td>Lower leg</td>
<td>50%</td>
<td>50%</td>
</tr>
</tbody>
</table>
### INJURY BENEFITS

<table>
<thead>
<tr>
<th>Body Part</th>
<th>LOW PLAN (%)</th>
<th>HIGH PLAN (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foot</td>
<td>25</td>
<td>25</td>
</tr>
<tr>
<td>Ankle</td>
<td>25</td>
<td>25</td>
</tr>
<tr>
<td>Kneecap</td>
<td>25</td>
<td>25</td>
</tr>
<tr>
<td>Upper arm</td>
<td>35</td>
<td>35</td>
</tr>
<tr>
<td>Facial excluding lower jaw</td>
<td>35</td>
<td>35</td>
</tr>
<tr>
<td>Forearm</td>
<td>25</td>
<td>25</td>
</tr>
<tr>
<td>Hand or wrist (except fingers)</td>
<td>25</td>
<td>25</td>
</tr>
<tr>
<td>Lower jaw</td>
<td>25</td>
<td>25</td>
</tr>
<tr>
<td>Shoulder blade</td>
<td>50</td>
<td>50</td>
</tr>
<tr>
<td>Collarbone</td>
<td>15</td>
<td>15</td>
</tr>
<tr>
<td>Ribs</td>
<td>25</td>
<td>25</td>
</tr>
<tr>
<td>Finger</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Toe</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Nose</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Non-surgical</td>
<td>50% of surgical benefit</td>
<td>50% of surgical benefit</td>
</tr>
<tr>
<td>Chip fracture</td>
<td>25% of non-surgical benefit</td>
<td>25% of non-surgical benefit</td>
</tr>
</tbody>
</table>

#### Lacerations

<table>
<thead>
<tr>
<th>Type</th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>With stitches or staples</td>
<td>$119</td>
<td>$595</td>
</tr>
<tr>
<td>Without stitches or staples</td>
<td>25% of benefit provided with stitches or staples</td>
<td>25% of benefit provided with stitches or staples</td>
</tr>
</tbody>
</table>

#### Paralysis

<table>
<thead>
<tr>
<th>Type</th>
<th>LOW PLAN Principal Amount</th>
<th>HIGH PLAN Principal Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>$23,800</td>
<td>$71,400</td>
<td></td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Type</th>
<th>LOW PLAN % of Principal Amount</th>
<th>HIGH PLAN % of Principal Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quadriplegia</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Paraplegia</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Hemiplegia</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Uniplegia</td>
<td>25%</td>
<td>25%</td>
</tr>
</tbody>
</table>

#### Traumatic Brain Injury

<table>
<thead>
<tr>
<th>Type</th>
<th>LOW PLAN Principal Amount</th>
<th>HIGH PLAN Principal Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>$238</td>
<td>$476</td>
<td></td>
</tr>
</tbody>
</table>

### EMERGENCY CARE

<table>
<thead>
<tr>
<th>Type</th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ground or water</td>
<td>$119</td>
<td>$238</td>
</tr>
<tr>
<td>Air</td>
<td>$595</td>
<td>$1,090</td>
</tr>
<tr>
<td>Blood, Plasma or Platelets Transfusion</td>
<td>$357</td>
<td>$714</td>
</tr>
<tr>
<td>Emergency Dental</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crown</td>
<td>$179</td>
<td>$357</td>
</tr>
<tr>
<td>Extraction</td>
<td>$60</td>
<td>$119</td>
</tr>
<tr>
<td>Emergency Room Treatment</td>
<td>$119</td>
<td>$357</td>
</tr>
<tr>
<td>Initial Physician’s Office Visit</td>
<td>$60</td>
<td>$119</td>
</tr>
<tr>
<td>Hospital Stay</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initial benefit, non-ICU</td>
<td>$476</td>
<td>$1,428</td>
</tr>
<tr>
<td>Initial benefit, ICU</td>
<td>$952</td>
<td>$2,856</td>
</tr>
<tr>
<td>Daily benefit, non-ICU</td>
<td>$119</td>
<td>$357</td>
</tr>
<tr>
<td>INJURY BENEFITS</td>
<td>LOW PLAN</td>
<td>HIGH PLAN</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>----------</td>
<td>-----------</td>
</tr>
<tr>
<td>Daily benefit, ICU</td>
<td>$238</td>
<td>$714</td>
</tr>
<tr>
<td>SURGERY</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abdominal or Pelvic Surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cranial Surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knee Cartilage Surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Open</td>
<td>$595</td>
<td>$1,190</td>
</tr>
<tr>
<td>Arthroscopic</td>
<td>$298</td>
<td>$595</td>
</tr>
<tr>
<td>Ruptured Disc Surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tendon, Ligament or Rotator Cuff Surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Open</td>
<td>$595</td>
<td>$1,190</td>
</tr>
<tr>
<td>Arthroscopic</td>
<td>$298</td>
<td>$595</td>
</tr>
<tr>
<td>Thoracic Surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FOLLOW-UP CARE</td>
<td>LOW PLAN</td>
<td>HIGH PLAN</td>
</tr>
<tr>
<td>Adaptive Home and Vehicle Benefit</td>
<td>$595</td>
<td>$1,190</td>
</tr>
<tr>
<td>Appliances</td>
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<td>$298</td>
</tr>
<tr>
<td>Follow-Up Physician’s Office Visit</td>
<td>$60</td>
<td>$119</td>
</tr>
<tr>
<td>Prosthetics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>One prosthetic</td>
<td>$595</td>
<td>$1,190</td>
</tr>
<tr>
<td>Two or more prosthetics</td>
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<td>2x one prosthetic</td>
</tr>
<tr>
<td>Transportation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$238 per visit</td>
<td>$595 per visit</td>
<td></td>
</tr>
<tr>
<td>SUPPORT CARE</td>
<td>LOW PLAN</td>
<td>HIGH PLAN</td>
</tr>
<tr>
<td>Adult Companion Lodging</td>
<td>$89 per day</td>
<td>$179 per day</td>
</tr>
</tbody>
</table>

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**SUPPLEMENTS TO THE CERTIFICATE**

Portability
Definitions

Any use in this certificate of a term defined in this section is to be given the meaning defined in this section unless otherwise defined in another provision of this certificate.

accident

An act or event which is:

1. unintended, unexpected and unforeseen; and
2. directly results in bodily injury to the insured.

application

Your application or enrollment for insurance under the group policy.

associated company

Any company which is a subsidiary or affiliate of the policyholder which is designated by the policyholder and agreed to by us to participate under the group policy.

child or children

Your or your spouse’s natural, adopted, stepchild or foster child who is less than 26 years old. An adopted child includes a child legally placed for adoption with you. Eligibility begins at live birth (stillborn or unborn children are not eligible). Children age 26 or older are also eligible so long as they are physically or mentally incapable of self-support, were incapable of self-support prior to age 26 and remain financially dependent on you for more than one-half of their support and maintenance.

covered accident

An accident which:

1. is not excluded under the Exclusions and Limitations section or any other terms of this certificate; and
2. occurs while the insured’s coverage is in force; and
3. occurs in the United States or a United States territory.

dependent

Your children or spouse.

If both parents of a child qualify as eligible employees under the group policy, the child shall be considered a dependent of only one parent for purposes of this certificate. If any child qualifies as an eligible employee under the group policy, he or she is not eligible to be insured as a dependent child.

emergency room

A department of a hospital or a satellite emergency center that is designated for persons requiring immediate medical care. This area must be staffed and equipped to handle trauma, be supervised and provide treatment by physicians, and provide care seven days per week, 24 hours per day.

A satellite emergency center is a licensed facility providing outpatient care under the direction of a licensed physician on a 24-hour basis. Available services must include:

1. diagnostic care, including laboratory services and diagnostic x-rays; and
2. treatment or medical care, including availability of the means for stabilization of emergency medical conditions.

A satellite emergency center does not include a hospital or an office maintained by a licensed physician for the practice of medicine or dentistry.

employee

An individual who is employed by the policyholder or by an associated company. A sole proprietor will be considered the employee of the proprietorship. A partner in a partnership will be considered an employee so long as the partner’s principal work is the conduct of the partnership’s business. The term employee does not include temporary employees nor corporate directors who are not otherwise employees.

employer

The policyholder or any designated associated companies.

family member

A parent, spouse, child, sibling, grandparent, aunt, uncle, first cousin, niece or nephew. This includes adopted, in-law and step relatives.

hospital

A short-term, acute care general facility that:

1. is legally licensed and operated as a hospital;
2. provides overnight care of injured and sick people;
3. requires that every patient be supervised by a physician;
4. provides 24 hour nursing service by or under the supervision of a registered nurse;
5. has on-site or pre-arranged use of x-ray equipment, laboratory, and surgical facilities; and
6. maintains permanent medical history records.

A hospital is not a rehabilitation center, nursing home, rest home, extended-care facility, convalescent home, a place for alcoholics or drug addicts or a mental institution, even if such facilities are affiliated with or adjoined to a hospital.
injury or injuries
A bodily injury which is sustained as a direct result of a covered accident.

insured
An employee, spouse or child covered for insurance under this certificate.

noncontributory insurance
Insurance for which you are not required to make premium contributions.

non-work day
A day on which you are not regularly scheduled to work, including scheduled time off for vacations, personal holidays, weekends and holidays, and approved leaves of absence for non-medical reasons.

Non-work day does not include time off for medical leave of absence, temporary layoff, employer suspension of operations in total or in part, strike, and any time off due to sickness or injury including sick days, short-term disability, or long term disability.

physician
A medical doctor or other person recognized by law or regulation in the United States or United States territory where services are rendered as a physician. The person must be licensed as required by the United States jurisdiction where care is given and must be operating in the scope of his or her license.

A physician cannot be a person who:

(1) ordinarily resides in your household; or
(2) is a family member.

policyholder
The owner of the group policy as shown on the specifications page.

specifications page
The summary of the plan specifics available under the group policy.

spouse
Your legally married spouse as recognized under the laws of the jurisdiction of celebration.

Spouse does not include any person who is eligible as an employee.

surgery
Medical treatment in which a physician cuts into someone’s body in order to repair or remove damaged parts as a result of a covered accident. The surgery must be performed solely because of injuries sustained in a covered accident.

urgent care center
A health care facility that is separate from a hospital or a separate unit within a hospital and whose primary purpose is the offering and provision of immediate, short term medical care, without appointment, for urgent care.

we, our, us
Securian Life Insurance Company.

you, your, certificate holder
An insured employee.

General Information
What is your agreement with us?
If you meet the eligibility and enrollment requirements, you are insured under the group policy shown on the specifications page. Your application is deemed a part of this certificate. This certificate summarizes the principal provisions of the group policy that affect your insurance coverage. The provisions summarized in this certificate are subject in every respect to the group policy.

Any statements made in your application will, in the absence of fraud, be considered representations and not warranties. Also, any statement made will not be used to void your insurance nor defend against a claim unless the statement is contained in the application.

Can this certificate be amended?
Yes. We retain the right to amend this certificate at any time without your consent. Any amendment will be without prejudice to any claim incurred for benefits prior to the date of the amendment.

Who is eligible for insurance?
You are eligible for group accident insurance if you:

(1) are a member of the eligible group and of an eligible class as defined on the specifications page; and
(2) work for the employer for at least the number of hours per week shown as the minimum hours per week requirement on the specifications page; and
(3) have satisfied the waiting period as shown on the specifications page; and
(4) meet the actively at work requirement described in the “What is the actively at work requirement?” provision of this section.
Are your dependents eligible for insurance?

Yes. If you are insured for group accident coverage, your dependents are eligible for insurance.

Are employees of associated companies eligible for insurance under the group policy?

Yes. Employees of associated companies may be eligible for insurance under the group policy. The policyholder represents any associated company in all transactions pertaining to the group policy. The policyholder's acts or omissions and every notice given by us to the policyholder shall be binding on every associated company. When an associated company ceases its participation under the policy, the policy shall be considered to be terminated for all employees of the associated company. All provisions related to policy termination will apply to such employees.

What is the actively at work requirement?

To be eligible to become insured or to receive an increase in the benefit amount, you must be actively at work, fully performing your customary duties for your regularly scheduled number of hours at the employer's normal place of business, or at other places the employer's business requires you to travel.

If you are not working due to illness or injury, you do not meet the actively at work requirement. If you are receiving sick pay, short-term disability benefits or long-term disability benefits, you do not meet the actively at work requirement.

If you are not actively at work on the date coverage would otherwise begin, or on the date an increase in your benefit amount would otherwise be effective, you will not be eligible for the coverage or increase until you return to active work. However, if the absence is on a non-work day, coverage will not be delayed provided you were actively at work on the work day immediately preceding the non-work day.

Except as otherwise provided for in this certificate, you are eligible to continue to be insured only while you remain actively at work.

Any insurance or increase in insurance which is elected or put in force while you are not actively at work will not be eligible for claim payment. You or your beneficiary will receive a refund of premium for any contributory insurance for which you were not eligible.

What is the dependent non-confinement requirement?

If a dependent is hospitalized or confined because of illness or disease on the date his or her insurance would otherwise become effective, his or her effective date shall be delayed until he or she is released from such hospitalization or confinement. This does not apply to a newborn child.

In no event will insurance on a dependent be effective before your insurance is effective.

Can your coverage be continued during sickness, injury, leave of absence or temporary layoff?

Yes. Insurance may be continued on an insured employee who is not actively at work due to sickness, injury, leave of absence or temporary layoff, subject to the employer's practices and procedures, including the employer's limits on the length of continuation allowed for the type of absence. Continuation is contingent upon continued premium payment.

Coverage during a leave of absence and upon return from a leave of absence shall meet all state and federal requirements.

Enrollment

When can you elect or make changes to your insurance?

You must enroll in order to be insured for contributory coverage under the group policy. You can enroll for coverage within 90 days of when you first become eligible. After that period, you can only enroll for coverage or make changes during your annual open enrollment or within 60 days of a qualified status change event, as defined by the state and federal rules and regulations.

When does your insurance become effective?

Your insurance becomes effective on the date all of the following conditions have been met:

1. you meet all eligibility requirements, including the actively at work requirement; and
2. for contributory coverage, application is made in accordance with the application methods agreed upon by the policyholder and us

When does insurance for a dependent become effective?

Insurance on a dependent becomes effective on the date when all of the following conditions have been met:

1. your insurance becomes effective;
2. the dependent meets all eligibility requirements; and
3. for contributory insurance, you apply for dependent coverage on forms which are approved by us.

When will changes in your coverage amount be effective?

Requested changes in the amount of your contributory insurance are effective on the first day of the month following receipt of your request for a change.
However, elections made during an enrollment period will not become effective prior to the effective date for that enrollment.

**Premiums**

**When and how often are your premium contributions due?**

Unless the policyholder and we have agreed to some other premium payment procedure, any premium contributions you are required to make for contributory insurance are to be paid by you to the policyholder on a periodic basis. Premium rates are subject to change in accordance with the group policy.

**How is the premium determined?**

The premium will be the applicable premium rate in force on the date premiums are due. The premium may also be computed by any other method on which the policyholder and we agree.

Premium rates are subject to change according to the provisions of the group policy.

**Can a premium be paid after the date it is due?**

Yes. The group policy has a 31-day grace period. If a premium is not paid on or before the date it is due, that premium may be paid during the 31-day period following the due date. The insurance under the group policy will remain in effect during the 31-day grace period.

**Injury Benefits**

**Burn Benefit**

If an insured sustains a second or third degree burn in a covered accident, we will pay the appropriate amount shown on the specifications page based on the type of burn and the percentage of the body surface burned.

The burn must be treated by a physician within 72 hours after the covered accident. If the burn meets more than one of the burn classifications shown on the specifications page, the amount we pay will be based on the burn classification that pays the highest benefit.

We will pay the burn benefit no more than one time per insured per covered accident. No benefits are payable for sunburns or first degree burns.

**Child Organized Sports Injury**

The child organized sports injury benefit is subject to the following conditions.

(1) the insured dependent child suffers an injury in a covered accident while participating in an organized sport; and

(2) a benefit is payable for the insured dependent child under another provision of the group policy for the same covered accident; and

(3) the insured dependent child has not attained 19 years of age and is insured on the date the covered accident occurs;

A child organized sport refers to a sport activity that is governed by an organization and requires formal registration to participate. Adult supervision of practice and competition is required. Proof of registration must be submitted with claims.

The child organized sports injury benefit amount is shown on the specifications page.

This benefit is limited to one payment per insured dependent child per calendar year.

**Concussion**

If an insured is injured in a covered accident and the injury causes a concussion, we will pay the amount shown on the specifications page. The insured must be treated by a physician within 72 hours of a covered accident and the concussion must be diagnosed by a physician within 15 days of the covered accident.

Concussion refers to a disruption of brain function resulting from a traumatic blow to the head.

This benefit is limited to one payment per insured per covered accident per calendar year.

The concussion benefit is not payable if a traumatic brain injury benefit is payable under this certificate for the same accident.

**Dislocation**

If a joint is dislocated in a covered accident, and it is diagnosed and treated by a physician within 90 days after the covered accident, we will pay the amount shown on the specifications page. The amount varies based on the joint that is dislocated, whether the dislocation is a full or a partial dislocation, and whether surgery is required to treat the dislocation.

A full dislocation refers to a completely separated joint due to a covered accident. A partial dislocation means the joint is misaligned but not completely dislocated, as diagnosed by a physician.

If more than one dislocation benefit is payable resulting from the same covered accident, we will pay the lesser of:

(1) the total of the benefit amounts shown for each applicable dislocation on the specifications page; or

(2) 2 times the highest dislocation benefit that would otherwise be payable for any one of the dislocations involved.
Eye Injury – with Surgery

If an insured is injured in a covered accident and the injury results in an eye injury that requires surgery, we will pay the amount shown on the specifications page. The insured must be seen by a physician within 60 days of the covered accident and surgery must be performed within 180 days of the covered accident. This benefit is limited to one payment per eye per insured per covered accident.

Eye Injury – Removal of Foreign Object without Surgery

If an insured is injured in a covered accident and the injury results in an eye injury that requires removal of a foreign object, but does not require surgery, we will pay the amount shown on the specifications page. The insured must be seen by a physician within 60 days of the covered accident and removal of the foreign object must be performed within 180 days of the covered accident. This benefit is limited to one payment per eye per insured per covered accident.

Fracture

If a bone is fractured in a covered accident, and it is diagnosed and treated by a physician within 90 days after the covered accident, we will pay the amount shown on the specifications page. The amount varies based on the bone that is fractured, whether or not the fracture is a chip fracture, and whether surgery is required to treat the fracture.

Fracture refers to a break in a bone that can be seen by x-ray. A chip fracture is a fracture in which a small fragment of the bone is broken off.

If more than one fracture benefit is payable resulting from the same covered accident, we will pay the lesser of:

1. the total of the benefit amounts shown for each applicable fracture on the specifications page; or
2. 3 times the highest fracture benefit that would otherwise be payable for any one of the bones involved.

We will pay no more than one fracture benefit per bone, per covered accident per insured. In no event will multiple fracture benefits be paid for the same fracture shown on the specifications page unless it is a bi-lateral fracture. Bi-lateral fracture means the fracture of the same bone on both the left and right sides of the body.

Lacerations

If an insured is injured in a covered accident and the injury results in a laceration, we will pay the appropriate amount shown on the specifications page based on the type of treatment provided.

The laceration must be treated by a physician within 72 hours after the covered accident. This benefit is limited to one payment per insured per covered accident. In no event will we pay more than one laceration benefit per calendar year.

Paralysis

If an insured is injured in a covered accident and the injury causes paralysis which lasts more than 180 days we will pay the appropriate amount shown on the specifications page. Paralysis refers to the total, permanent, and irrevocable loss of movement. The paralysis must be diagnosed by a physician within 180 days after the accident.

The amount payable will be based on the type of paralysis, as follows:

Quadriplegia refers to paralysis of both upper limbs (from the shoulder down including total paralysis of both hands) and both lower limbs (from the waist down including total paralysis of both feet).

Paraplegia refers to paralysis of both lower limbs (from the waist down including total paralysis of both feet).

Hemiplegia refers to paralysis of both the upper limb (from the shoulder down including total paralysis of the hand) and lower limb (from the waist down including total paralysis of the foot) on one side of the body.

Uniplegia refers to paralysis of one limb (from the shoulder down including total paralysis of the hand if claiming an upper limb and from the waist down including total paralysis of the foot if claiming a lower limb).

We will pay no more than one paralysis benefit per covered accident per insured. In the event that an insured qualifies under multiple types of paralysis, the highest benefit amount will be paid.

Traumatic Brain Injury

If an insured is injured in a covered accident and the injury results in a traumatic brain injury, we will pay the amount shown on the specifications page.

Traumatic brain injury means only the following: intracranial hemorrhage, cerebral contusion or cerebral laceration.

The insured must be treated by a physician within 72 hours after the covered accident. The traumatic brain injury must be diagnosed within 30 days after the accident by computer tomography (CT) scan or magnetic resonance imaging (MRI). This benefit is payable only once per insured per covered accident. Scalp hematomas and scalp lacerations are not covered under this benefit.

Emergency Care

Ambulance

If an insured is injured in a covered accident and requires transportation to a hospital (or between hospitals) we will pay the appropriate ambulance benefit shown on the
specifications page. Ground or water transportation must be provided by a licensed professional ambulance service within 90 days of the covered accident. Air transportation must be provided by a licensed professional ambulance service within 72 hours. This benefit is limited to one payment per insured per covered accident.

If an insured requires more than one ambulance transport, the highest benefit amount will be paid.

Ambulance means any publicly or privately owned surface, water or air vehicle, including a helicopter that is specifically designed and constructed or modified and equipped to be used, maintained or operated primarily for the transportation of individuals who are sick, injured or wounded.

Ambulance does not include a surface, water or air vehicle that is owned and operated to accommodate an incapacitated or disabled person who does not require medical monitoring, care or treatment during transport.

Blood, Plasma or Platelets Transfusion

If an insured is injured in a covered accident and requires a blood, plasma or platelets transfusion, we will pay the blood/plasma/platelets transfusion benefit shown on the specifications page. The transfusion must occur within 90 days of the covered accident. This benefit is limited to one payment per insured per covered accident.

Emergency Dental (not available to residents of South Dakota)

If an insured has an injury to sound natural teeth as a result of a covered accident, we will pay the appropriate emergency dental benefit shown on the specifications page. A benefit is payable for a broken tooth repaired with crown(s) or a broken tooth requiring extraction. Treatment must occur within 60 days of the covered accident. The maximum number of crown benefits payable per insured per covered accident is two. The maximum number of extraction benefits payable per insured per covered accident is two.

Proof of the soundness of the injured tooth must be submitted with claims. Injuries resulting from biting or chewing are not covered under this benefit.

Sound natural teeth are defined as teeth that are free of active or chronic clinical decay, have at least 50% bone support and are functional in the arch.

Emergency Room Treatment

If an insured is injured in a covered accident and requires treatment in an emergency room, we will pay the emergency room treatment benefit shown on the specifications page. Treatment must occur within 72 hours of the covered accident.

This benefit is limited to one payment per insured per covered accident.

Initial Physician’s Office Visit

If an insured is injured in a covered accident, we will pay the initial physician’s office visit benefit shown on the specifications page. Benefits are payable for the initial treatment received in a physician’s office or an urgent care center for injuries resulting from a covered accident. Treatment must occur within 72 hours of the covered accident. The maximum number of benefits per insured per calendar year is two. The benefit is not payable if the insured receives care in an emergency room within the same 72 hour period. Only one benefit is payable per covered accident.

Hospital Care

Hospital Stay

If an insured is injured in a covered accident and requires treatment in a hospital for the injury within 180 days of a covered accident, we will pay the hospital stay benefit shown on the specifications page subject to the following.

Initial Benefit

We will pay the initial benefit shown on the specifications page for the first day of a hospital stay provided the insured is receiving treatment for a covered accident in the hospital for a minimum of 18 continuous hours.

The benefit payment will be based on the type of room and level of care the insured receives. The Intensive Care Unit (ICU) benefit is payable if the insured is receiving treatment in an ICU room of a hospital. The non-ICU benefit is payable if the insured is receiving treatment in a non-ICU room.

This benefit is limited to one payment per insured per covered accident. In the event the insured receives treatment in both a non-ICU and an ICU room, the higher benefit will be payable as an initial benefit.

Daily Benefit

If an initial benefit is payable, the insured will also receive a daily benefit for each day he or she is treated in the hospital, including the first day. The amount payable for the daily benefit is shown on the specifications page.

The daily benefit payment will be based on the type of room and level of care the insured receives. The ICU benefit is payable if the insured is receiving treatment in an ICU room of a hospital. The non-ICU benefit is payable if the insured is receiving treatment in a non-ICU room.
The ICU daily benefit will be limited to a maximum of 15 days per insured per covered accident. The combination of the both ICU and non-ICU benefits will be limited to a cumulative maximum of 120 days per insured per covered accident.

If an insured is released from the hospital and subsequently requires treatment in a hospital for injuries sustained in the same covered accident, the subsequent treatment will be considered a continuation of the same hospital stay for purposes of determining the cumulative maximum daily benefit so long as the treatment occurs within two years of the date of the covered accident.

Intensive Care Unit (ICU) refers to a specifically designated part of a hospital that provides the highest level of medical care and is restricted to patients who are critically ill or injured and who require intensive comprehensive observation and care. Hospital Intensive Care Units must be:

1. separate and apart from the surgical recovery room; and
2. separate and apart from rooms, beds, and wards customarily used for patient confinement; and
3. permanently equipped with special life-saving equipment to care for the critically ill or injured; and
4. under constant and continuous observation by nursing staffs assigned to the Intensive Care Unit.

### Surgery Benefits

#### Abdominal or Pelvic Surgery

If an insured is injured in a covered accident and requires abdominal or pelvic surgery to treat the injuries, we will pay the abdominal or pelvic surgery benefit shown on the specifications page. The surgery must be performed within 72 hours of the covered accident. This benefit is limited to one payment per insured per covered accident. Surgery required to treat a fracture or dislocation is payable under the fracture or dislocation benefit and is not covered under the abdominal or pelvic surgery benefit.

#### Cranial Surgery

If an insured is injured in a covered accident and requires cranial surgery to treat the injuries, we will pay the cranial surgery benefit shown on the specifications page. The surgery must be performed within 72 hours of the covered accident. This benefit is limited to one payment per insured per covered accident.

Surgery required to treat a skull fracture is payable under the fracture benefit and is not covered under the cranial surgery benefit.

### Knee Cartilage Surgery

If an insured is injured in a covered accident and requires knee cartilage surgery to treat the injury, we will pay the knee cartilage surgery benefit shown on the specifications page. The insured must be treated by a physician within 60 days of the covered accident and surgery must be performed within 180 days of the covered accident. This benefit is limited to one payment per insured per covered accident.

If both open and arthroscopic surgeries are required for the same injury, only the open benefit will be paid.

### Ruptured Disc Surgery

If an insured is injured in a covered accident and requires surgery for one or more ruptured discs to treat the injury, we will pay the ruptured disc surgery benefit shown on the specifications page. The insured must be treated by a physician within 60 days of the covered accident and surgery must be performed within 180 days of the covered accident. This benefit is limited to one payment per insured per covered accident.

### Tendon, Ligament or Rotator Cuff Surgery

If an insured is injured in a covered accident and requires tendon, ligament or rotator cuff surgery to treat the injuries, we will pay the tendon, ligament or rotator cuff surgery benefit shown on the specifications page. The insured must be treated by a physician within 60 days of the covered accident and surgery must be performed within 180 days of the covered accident. This benefit is limited to one payment per insured per covered accident.

If both open and arthroscopic surgeries are required, only the open benefit will be paid.

### Thoracic Surgery

If an insured is injured in a covered accident and requires thoracic surgery to treat the injuries, we will pay the thoracic surgery benefit shown on the specifications page. The surgery must be performed within 72 hours of the covered accident. This benefit is limited to one payment per insured per covered accident.

Surgery required to treat a fracture or dislocation is payable under the fracture or dislocation benefit and is not covered under the thoracic surgery benefit.

### Follow-Up Care

#### Adaptive Home and Vehicle Benefit

If an insured is injured in a covered accident and requires adaptive modifications to his or her primary residence or private vehicle to be made drivable or rideable,
we will pay the adaptive home and vehicle benefit shown on the specifications page subject to the following conditions:

1. a benefit is payable under the paralysis benefit of the Injury Benefits section of this certificate; and
2. the modification must take place within two years of the covered accident; and
3. such home alterations are made by a person or persons with experience in such alterations and recommended by a recognized organization associated with the injury; and
4. such vehicle modifications are carried out by a person or persons with experience in such matters and approved by the Motor Vehicle Department.

This benefit is limited to one payment per insured per covered accident.

Appliances

If an insured is injured in a covered accident and a medical appliance is prescribed by a physician for mobility, we will pay the appliance benefit shown on the specifications page. The order for the appliance must be placed within 180 days of the covered accident. This benefit is limited to payment for two covered appliances per insured per covered accident.

Covered appliances means only the following: crutches, canes, wheelchairs/scooters, leg braces and back braces. This benefit does not cover replacement appliances.

Follow-Up Physician’s Office Visit

If an insured is injured in a covered accident and follow-up care for the injury is ordered by the treating physician, we will pay the follow-up physician’s office visit benefit shown on the specifications page. The follow-up visit(s) must occur within 180 days of the covered accident. This benefit is limited to three payments per insured per covered accident. Follow-up at an urgent care center is not covered under this benefit.

Prosthetics

If an insured is injured in a covered accident and sustains the loss of a limb, hand, foot or sight in an eye, we will pay the prosthetic benefit shown on the specifications page, subject to the following:

1. this benefit is limited to payment for two prosthetic devices per insured per covered accident; and
2. the prosthetic device(s) must be prescribed by a physician and ordered within 180 days after the covered accident.

Prosthetic device refers to an artificial device that replaces a missing limb, hand, foot or an eye.

For purposes of this benefit, the term prosthetic device does not include corrective lenses or other cosmetic prostheses.

In addition, this benefit does not provide coverage for damaged prosthetics; more than one prosthetic device for the same limb, hand, foot or eye; the replacement of a prosthetic device; or a joint replacement.

Transportation

If an insured receives follow-up treatment ordered by a physician for an injury sustained in a covered accident and is required to travel more than 100 miles (one way) from the insured’s primary residence to a hospital or other treatment facility, we will pay the transportation benefit shown on the specifications page subject to the following:

1. a benefit is payable under this certificate for the same injury; and
2. the follow-up treatment is ordered by a physician and is not available within 100 miles (one way) of the insured’s primary residence; and
3. the Ambulance benefit is not payable for the same trip.

Mileage is measured from the insured’s primary residence to the hospital or treatment facility where the follow-up treatment is provided.

This benefit is limited to two payments per insured per covered accident.

Support Care

Adult Companion Lodging (not available to residents of Colorado)

If an insured is injured in a covered accident, we will pay the adult companion lodging benefit shown on the specifications page for each day the insured is receiving treatment in a hospital or rehabilitative facility for the injury, and for the 24 hours following the last day the insured is receiving treatment in a hospital or rehabilitative facility for the injury subject to the following conditions:

1. a companion who accompanies the insured stays in lodging for which a charge is made; and
2. either the hospital stay benefit or rehabilitative therapy (inpatient) benefit is payable for the same day the adult companion lodging benefit is payable; and
3. the companion is 18 or older.

Lodging refers to an establishment licensed under the laws applicable to where it is located, such as a motel, hotel, or other facility that provides sleeping accommodations to the general public in exchange for a
fee and is located at least 100 miles from the insured’s primary residence.

This benefit is limited to 30 days per covered accident. Proof must be provided that the companion incurred an expense for staying at a lodging.

Exclusions and Limitations

Are there any other exclusions that apply?

Yes. In no event will we pay benefits where the insured’s accident, injury or loss is caused directly or indirectly by, results in whole or in part from or during, or there is contribution from, any of the following:

1. intentionally self-inflicted injury while sane; or
2. suicide or attempted suicide, while sane; or
3. your participation in, or your attempt to commit, a crime, assault, felony, or any illegal activity, regardless of any legal proceedings thereto; or
4. the use of alcohol; or
5. the use of prescription drugs (unless taken upon the advice of a licensed physician in the verifiable prescribed manner and dosage), non-prescription drugs, illegal drugs, medications, poisons, gases, fumes or other substances taken, absorbed, inhaled, ingested or injected; or
6. motor vehicle collision or accident where you are the operator of the motor vehicle and your blood alcohol level meets or exceeds the level at which intoxication is defined in the state where the collision or accident occurred, regardless of any legal proceedings thereto; or
7. war or any act of war, whether declared or undeclared; or
8. bodily or mental infirmity, illness or disease; or
9. infection, other than pyogenic infection occurring simultaneously with, and as a direct and independent result of, the injury, and other than bacterial infection due to accidental ingestion of a contaminated substance; or
10. repetitive stress syndromes including but not limited to rotator cuff syndrome, bursitis, tendonitis, carpal tunnel syndrome, ulnar nerve syndrome, stress fractures, neuropathy, epicondylitis or neuritis; or
11. medical or surgical treatment or diagnostic procedures including any resulting complications, or when the outcome is not as planned or expected, including claims of medical malpractice; or
12. travel in or descent from any aircraft, except as a fare-paying passenger on a regularly scheduled commercial flight on a licensed passenger aircraft carrier; or
13. participation in the following activities: scuba diving, bungee jumping, base jumping, hang gliding, sail gliding, parasailing, parakiting, or mountain climbing; or
14. riding or driving in any motor-driven vehicle in a race, stunt show or speed test; or
15. practicing for or participating in any semi-professional or professional competitive athletics.

Are there any additional limitations that apply?

Yes. Benefits are not payable for any care, treatment or diagnostic measures which were received outside of the United States or United States territory.

Claims

What notice of claim must be provided?

Written notice of claim must be given to us within 20 days of the date of a loss resulting from a covered accident, or as soon thereafter as reasonably possible. Notice given by or on the insured’s behalf to us at our home office or to any authorized agent of ours, with information to identify the insured, shall be deemed notice to us.

Will claim forms be provided?

Upon receipt of notice of claim, we will provide a claim form. If the claim form is not provided within 15 days after the insured has given notice of claim, we will deem the insured to have complied with the requirements for filing proof of a loss resulting from a covered accident if the insured submits, within the time period for filing proof of the loss, written proof of the occurrence, character and extent of the loss for which claim is made which is satisfactory to us.

When is proof of a loss resulting from a covered accident required?

Written proof of a loss resulting from a covered accident satisfactory to us must be provided to us within 90 days of the date of the loss. Failure to provide proof of the loss within this time will not invalidate or reduce a claim if it was not reasonably possible to provide proof within this 90 day period. However, proof must be provided within 1 year of the date of the loss, except in the absence of legal capacity.

When will the benefit be paid?

We will pay a benefit for a loss resulting from a covered accident after receipt at our home office of written proof of the loss which meets all policy requirements and is satisfactory to us. You are responsible for all costs associated with claim form(s) completion, records, and the submission of your claim.

To whom will benefits be paid?

All benefits including dependent’s benefits will be paid to you, if you are living. If you die before the claim is paid, benefits will be paid to your estate.
What are our physical examination rights?

After an insured has filed a claim and provided at his or her expense all requested claim forms and records, we have the right to have the insured examined by a physician of our choice and at our expense. This right may be exercised as often as reasonably necessary while an insured has a claim pending with us.

Termination

When does your coverage terminate?

Coverage ends on the earliest of the following:

1. the date you no longer meet the eligibility requirements; or
2. 31 days (the grace period) after the due date of any premium which is not paid; or
3. the last day for which premium contributions have been paid following your request to cancel your coverage; or
4. the date the group policy ends.

When does an insured dependent’s coverage terminate?

An insured dependent’s coverage ends on the earliest of the following:

1. the date the dependent no longer meets the eligibility requirements; or
2. 31 days (the grace period) after the due date of any premium contribution which is not paid; or
3. the last day for which premium contributions have been paid following your written request that insurance on your eligible dependents be terminated; or
4. the date you are no longer covered under the group policy.

You must notify us or your employer when you no longer have dependents eligible for coverage under this certificate so that premiums may be discontinued. All premiums paid for dependents who are no longer eligible for coverage under this certificate will be refunded without any payment of claim.

Additional Information

Can your insurance coverage be contested?

Yes. If an insured experiences a loss resulting from a covered accident within two years of the original effective date of coverage or increase in coverage, we will verify the accuracy of the information provided during the application process. If we discover a material misrepresentation, the affected coverage will be rescinded and an otherwise valid claim will be denied. This two year period will be extended by fraud or as otherwise allowed by applicable laws.

Is the policyholder required to maintain records?

Yes. The policyholder is required to maintain adequate records of any information necessary for us to administer the policy, and shall provide access to such records when required for us to administer the policy. If a clerical error is made in keeping records on the insurance under the group policy, it will not affect otherwise valid insurance.

A clerical error does not continue insurance which is otherwise stopped, make insurance effective when it should not have been or change the benefit amount provided by the provisions of the policy and no claim shall be paid on amounts affected by a clerical error. If an error causes a change in premium payment, a fair adjustment will be made.

Will the provisions of this certificate conform with applicable state law?

Yes. If any provision in this certificate, or in the provisions of the group policy, is in conflict with the applicable laws of the state governing the certificates or the group policy, the provision will be deemed to be amended to conform to such laws.

What if an insured’s age has been misstated?

If an insured’s age has been misstated, all amounts payable will be adjusted to that amount which the premium would have purchased at the correct age. This will be determined by applying the ratio of the paid premium over the required premium to the initial benefit amount.

Can this insurance be assigned?

No. Insurance coverage under the group policy cannot be assigned.

What is the policy interpretation right and authority?

The following applies only when the administration of the policy is governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. 1001 et seq.:

Securian Life has the exclusive right and authority, in its sole discretion, to interpret the group policy and decide all matters arising thereunder. Securian Life’s exercise of that authority shall be conclusive and binding on all persons unless it can be shown that the determination was arbitrary and capricious.
General Information

This certificate supplement is subject to every term, condition, exclusion, limitation and provision of the certificate unless otherwise expressly provided for herein.

What does this supplement provide?

This supplement provides for continuation of insurance if an insured no longer meets the eligibility requirements of the certificate, except as provided for herein.

To continue insurance the insured must make a written request and make the first premium payment within 31 days after insurance provided by the group policy would otherwise terminate. Coverage provided by this supplement will then be deemed effective retroactive to the beginning of the 31-day period. This date is considered to be the insured's portability date and the insured is then considered to have portability status.

Who is eligible to continue insurance under this supplement?

An insured employee is eligible to continue group accident insurance under the terms of this supplement if he or she no longer meets the eligibility requirements of the certificate due to any of the following:

1. the employee terminates employment, including retirement; or
2. the employee is no longer in a class eligible for insurance or is on a leave or layoff; or
3. a class or group of employees insured under the policy are no longer considered eligible and there is no successor plan for that class or group. Successor plan means an insurance policy or policies provided by us or another insurer that replaces insurance provided under this policy.

Regardless of whether an insured is otherwise eligible under this supplement to continue, an insured will not be eligible to request coverage under this supplement if he or she:

1. has attained the age of 70; or
2. is an employee and was not actively at work due to sickness or injury on the date immediately preceding his or her portability date; or
3. loses eligibility due to a class or group of employees no longer being eligible under the policy and there is a successor plan for that class or group of employees; or
4. loses eligibility due to termination of the group policy.

What insurance can be continued under this supplement?

Group accident insurance may be continued under this supplement. If an employee elects to continue his or her own coverage according to the provisions of this supplement, he or she may also elect to continue insurance for any other individual insured under his or her certificate.

What benefit amounts can be continued under this supplement?

The benefit amounts that can be continued under this supplement shall be the amounts shown on the specifications page applicable to the insured based on the benefit plan selected by the insured employee.

Can an insured request a change in the benefit plan continued under this supplement?

Yes. The insured employee may change the benefit plan to one that provides lower benefit amounts, but may not change the benefit plan to one that provides higher benefit amounts.

How will premiums be paid?

Premiums will be paid directly to us on a monthly, quarterly, semi-annual, or annual basis and will be subject to an administrative charge per billing period.

Can the premium rate change?

Yes. The premium rates for ported coverage may be different than the premium rates for active employees, and are not subject to the premium rate provision of the policy.

What happens if an insured again becomes eligible under the certificate?

If an insured is continuing coverage under the terms of this supplement, and again meets the eligibility requirements of the certificate the insured shall no longer be considered to have portability status. Insurance may be continued only under the terms of the certificate, not including this supplement, unless and until the insured no longer meets the eligibility requirements of the certificate and again returns to portability status as provided for herein.

What happens to insurance provided under this supplement when the group policy terminates?

Any insurance continued under the terms of this supplement will remain in force until terminated by the provisions of the section entitled "When will insurance continued under this supplement terminate?"
No individual may elect coverage under this supplement on or after the date of termination of the group policy.

**When will insurance continued under this supplement terminate?**

An insured’s insurance being continued under this supplement will terminate on the earliest of the following:

1. the insured’s 70th birthday;
2. the date the insured again meets the eligibility requirements of the certificate, not including the terms of this supplement;
3. in the case of a dependent child or a spouse, the date your coverage is no longer being continued under this supplement or the date the spouse or child ceases to be eligible as defined under the terms of your certificate; or
4. the date the group policy is terminated; or
5. 31 days after the due date of any premium contribution which is not made.

Secretary  
President
This Certificate Endorsement is a part of the certificate of insurance describing the benefits available to you under Group Policy No. 76013, issued by Securian Life Insurance Company to Concordia Plan Services. This endorsement is subject to every term, condition, exclusion and provision of the certificate unless otherwise expressly provided for herein.

The following applies to you if you were a resident of the state of MO, AL, AZ, DE, DC, FL, GA, HI, IL, IA, KY, ME, MD, MA, MI, NV, NJ, NY, OH, PA, RI, TN, VA, WY at the time your coverage under this certificate became effective:

1. The following notice is provided to comply with Missouri Insurance Code 375.924:

   **MISSOURI NOTICE**

   In the event you need to contact someone regarding this certificate, you may contact the insurance company issuing this certificate at the following address and telephone number:

   Securian Life Insurance Company
   400 Robert Street North
   St. Paul, MN  55101-2098
   Telephone:  855-750-2019

2. The provision entitled What is your agreement with us? in the General Information section of the certificate is amended in its entirety and replaced with the following:

   **What is your agreement with us?**

   If you meet the eligibility and enrollment requirements, you are insured under the group policy shown on the specifications page. Your application is deemed a part of this certificate. This certificate summarizes the principal provisions of the group policy that affect your insurance coverage. The provisions summarized in this certificate are subject in every respect to the group policy.

   Any statements made in your application will be considered representations and not warranties. No written statement made by any insured shall be used in any contest unless a copy of the statement has been furnished to the insured, and in the event of the insured’s death or incapacity, to his or her beneficiary or personal representative.

3. The provision entitled Are there any other exclusions that apply? in the Exclusions and Limitations section of the certificate is amended in its entirety and replaced with the following:

   **Are there any other exclusions that apply?**

   Yes. In no event will we pay benefits where the insured’s accident, injury or loss is caused directly or indirectly by, results in whole or in part from or during, or there is contribution from, any of the following:

   (1) intentionally self-inflicted injury while sane; or
   (2) suicide or attempted suicide, while sane; or
   (3) your participation in, or your attempt to commit, a crime, assault, felony, or any illegal activity, regardless of any legal proceedings thereto; or
   (4) the use of alcohol; or
   (5) the use of prescription drugs (unless taken upon the advice of a licensed physician in the verifiable prescribed manner and dosage), non-prescription drugs, illegal drugs, medications, poisons, gases, fumes or other substances taken, absorbed, inhaled, ingested or injected; or
   (6) motor vehicle collision or accident where you are the operator of the motor vehicle and your blood alcohol level meets or exceeds the level at which intoxication is defined in the state where the collision or accident occurred, regardless of any legal proceedings thereto; or
   (7) war or any act of war, whether declared or undeclared; or
   (8) bodily or mental infirmity, illness or disease; or
(9) infection, other than pyogenic infection occurring simultaneously with, and as a direct and independent result of, the injury, and other than bacterial infection due to accidental ingestion of a contaminated substance; or
(10) repetitive stress syndromes including but not limited to rotator cuff syndrome, bursitis, tendonitis, carpal tunnel syndrome, ulnar nerve syndrome, stress fractures, neuropathy, epicondylitis or neuritis; or
(11) medical or surgical treatment or diagnostic procedures including any resulting complications, or when the outcome is not as planned or expected, including claims of medical malpractice; or
(12) travel in or descent from any aircraft, except as a fare-paying passenger on a regularly scheduled commercial flight on a licensed passenger aircraft carrier; or
(13) participation in the following activities: scuba diving, bungee jumping, base jumping, hang gliding, sail gliding, parasailing, parakiting, or mountain climbing; or
(14) riding or driving in any motor-driven vehicle in a race, stunt show or speed test; or
(15) practicing for or participating in any semi-professional or professional competitive athletics.

4. The provision entitled **When is proof of a loss resulting from a covered accident required?** in the **Claims** section of the certificate is amended in its entirety and replaced with the following:

**When is proof of a loss resulting from a covered accident required?**

Written proof of a loss resulting from a covered accident satisfactory to us must be provided to us within 90 days of the date of the loss. Failure to provide proof of the loss within this time will not invalidate or reduce a claim if it was not reasonably possible to provide proof within this 90 day period. However, proof must be provided within 1 year of the date it is otherwise required, except in the absence of legal capacity.

5. The provision entitled **When will the benefit be paid?** in the **Claims** section of the certificate is amended in its entirety and replaced with the following:

**When will the benefit be paid?**

We will pay a benefit for a loss resulting from a covered accident within 30 days after receipt at our home office of written proof of the loss which meets all policy requirements and is satisfactory to us. You are responsible for all costs associated with claim form(s) completion, records, and the submission of your claim.

6. The provision entitled **Can your insurance coverage be contested?** in the **Additional Information** section of the certificate is amended in its entirety and replaced with the following:

**Can your insurance coverage be contested?**

Yes. If an insured experiences a loss resulting from a covered accident within two years of the original effective date of coverage or increase in coverage, we will verify the accuracy of the information provided during the application process. If we discover a material misrepresentation, the affected coverage will be rescinded and an otherwise valid claim will be denied.

Any statements made in your application will be considered representations and not warranties. Also, any statement an insured makes will not be used to void his or her insurance, or defend against a claim, unless the statement is contained in the application, and a copy of the instrument containing the statement is or has been furnished to the insured, or in the event of the insured’s death or incapacity, to the insured’s beneficiary or personal representative. This provision shall not preclude the assertion at any time of defenses based upon provisions in the policy that relate to eligibility for coverage.

Secretary

President
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The following applies to you if you were a resident of the state of Alaska at the time your coverage under this certificate became effective:

1. The provision entitled **What is your agreement with us?** under the **General Information** section of the certificate is amended in its entirety and replaced with the following:

   **What is your agreement with us?**

   If you meet the eligibility and enrollment requirements, you are insured under the group policy shown on the specifications page. Your application is deemed a part of this certificate. This certificate summarizes the principal provisions of the group policy that affect your insurance coverage. The provisions summarized in this certificate are subject in every respect to the group policy.

   Any statements made in your application will, in the absence of fraud, be considered representations and not warranties. Also, any statement made by you will not be used to void your insurance nor defend against a claim unless the statement is contained in the application, a copy of which has been furnished to you or your beneficiary.

2. The provision entitled **Are there any other exclusions that apply?** under the **Exclusions and Limitations** section of the certificate is amended in its entirety and replaced with the following:

   **Are there any other exclusions that apply?**

   Yes. In no event will we pay benefits where the insured’s accident, injury or loss is caused directly or indirectly by, results in whole or in part from or during, or there is contribution from, any of the following:

   1. Intentionally self-inflicted injury while sane; or
   2. suicide or attempted suicide, while sane; or
   3. your participation in, or your attempt to commit, a crime, assault, felony, or any illegal activity, regardless of any legal proceedings thereto; or
   4. your being legally intoxicated; or
   5. the use of prescription drugs, non-prescription drugs, illegal drugs, medications, unless taken as prescribed by a physician; or
   6. poisons, gases, fumes or other substances taken, absorbed, inhaled, ingested or injected; or
   7. motor vehicle collision or accident where you are the operator of the motor vehicle and your blood alcohol level meets or exceeds the level at which intoxication is defined in the state where the collision or accident occurred, regardless of any legal proceedings thereto; or
   8. war or any act of war, whether declared or undeclared; or
   9. bodily or mental infirmity, illness or disease; or
   10. infection, other than infection occurring simultaneously with, and as a direct and independent result of, the injury; or
   11. repetitive stress syndromes including but not limited to rotator cuff syndrome, bursitis, tendonitis, carpal tunnel syndrome, ulnar nerve syndrome, stress fractures, neuropathy, epicondylitis or neuritis; or
   12. medical or surgical treatment or diagnostic procedures including any resulting complications, or when the outcome is not as planned or expected, including claims of medical malpractice; or
   13. travel in or descent from any aircraft, except as a fare-paying passenger on a regularly scheduled commercial flight on a licensed passenger aircraft carrier; or
   14. participation in the following activities: scuba diving, bungee jumping, base jumping, hang gliding, sail gliding, parasailing, parakiting, or mountain climbing; or
   15. riding or driving in any motor-driven vehicle in a race, stunt show or speed test; or
   16. practicing for or participating in any semi-professional or professional competitive athletics.
3. The provision entitled **Will claim forms be provided?** under the **Claims** section of the certificate is amended in its entirety and replaced with the following:

**Will claim forms be provided?**

Upon receipt of notice of claim, we will provide a claim form. If the claim form is not provided within 10 days after the insured has given notice of claim, we will deem the insured to have complied with the requirements for filing proof of a loss resulting from a covered accident if the insured submits, within the time period for filing proof of the loss, written proof of the occurrence, character and extent of the loss for which claim is made which is satisfactory to us.

4. The provision entitled **When will the benefit be paid?** under the **Claims** section of the certificate is amended in its entirety and replaced with the following:

**When will the benefit be paid?**

We will pay a benefit for a loss resulting from a covered accident within 30 calendar days after receipt of a clean claim submitted to our home office of written proof of the loss which meets all policy requirements and is satisfactory to us. You are responsible for all costs associated with claim form(s) completion, records, and the submission of your claim. Claims other than clean claims will be paid within 15 days of receipt of needed information.

5. The provision entitled **What is the policy interpretation right and authority?** under the **Additional Information** section of the certificate is deleted in its entirety.

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Secretary

President
This Certificate Endorsement is a part of the certificate of insurance describing the benefits available to you under Group Policy No. 76013, issued by Securian Life Insurance Company to Concordia Plan Services. This endorsement is subject to every term, condition, exclusion and provision of the certificate unless otherwise expressly provided for herein.

The following applies to you if you were a resident of the state of Arkansas at the time your coverage under this certificate became effective:

1. The definition of child or children in the Definitions section of the certificate is amended in its entirety and replaced with the following:

   **child or children**

   Your or your spouse’s natural, adopted, stepchild or foster child who is less than 26 years old. Eligibility begins at live birth (stillborn or unborn children are not eligible).

   An adopted child includes a child legally placed for adoption with you or a child that you have filed a petition to adopt. Coverage shall begin on the date of the filing of a petition for adoption if any required enrollment is made within 60 days after the filing of the petition for adoption. A newly born adopted child will be covered from the moment of birth if a petition for adoption and any required enrollment is filed within 60 days of the birth of the child.

   After age 26, coverage for an unmarried child who is incapable of sustaining employment by reason of mental retardation or physical disability, who became so incapacitated prior the attainment of 19 years of age and who is chiefly dependent upon the employee for support and maintenance, shall not terminate but coverage shall continue so long as the coverage of the employee remains in force and so long as the dependent remains in such condition.

2. The provision entitled When will the benefit be paid? in the Claims section of the certificate is amended in its entirety and replaced with the following:

   **When will the benefit be paid?**

   We will pay a benefit for a loss resulting from a covered accident immediately after receipt at our home office of written proof of the loss which meets all policy requirements and is satisfactory to us. You are responsible for all costs associated with claim form(s) completion, records, and the submission of your claim.

Secretary

President
This Certificate Endorsement is a part of the certificate of insurance describing the benefits available to you under Group Policy No. 76013, issued by Securian Life Insurance Company to Concordia Plan Services. This endorsement is subject to every term, condition, exclusion and provision of the certificate unless otherwise expressly provided for herein.

The following applies to you if you were a resident of the state of Colorado at the time your coverage under this certificate became effective:

1. The disclosures on the cover page of the certificate are amended in their entirety and replaced with the following:

   THIS CERTIFICATE INCLUDES THE FOLLOWING COVERAGE: ACCIDENT-ONLY WITH INJURY BENEFITS; ACCIDENT-ONLY WITH EMERGENCY CARE BENEFITS; ACCIDENT-ONLY WITH HOSPITAL CARE BENEFITS; ACCIDENT-ONLY WITH SURGERY BENEFITS; ACCIDENT-ONLY WITH FOLLOW-UP CARE BENEFITS.

   THIS IS A SUPPLEMENTAL POLICY THAT IS NOT INTENDED TO PROVIDE THE MINIMUM ESSENTIAL COVERAGE REQUIRED BY THE AFFORDABLE CARE ACT (ACA). UNLESS YOU HAVE ANOTHER PLAN (SUCH AS MAJOR MEDICAL COVERAGE) THAT PROVIDES MINIMUM ESSENTIAL COVERAGE IN ACCORDANCE WITH THE ACA, YOU MAY BE SUBJECT TO A FEDERAL TAX PENALTY. ALSO, THE BENEFITS PROVIDED BY THIS POLICY CANNOT BE COORDINATED WITH THE BENEFITS PROVIDED BY OTHER COVERAGE. PLEASE REVIEW THE BENEFITS PROVIDED BY THIS POLICY CAREFULLY TO AVOID A DUPLICATION OF COVERAGE.

2. The provision entitled “What is your agreement with us?” under the General Information section of the certificate is amended in its entirety and replaced with the following:

   What is your agreement with us?

   If you meet the eligibility and enrollment requirements, you are insured under the group policy shown on the specifications page. Your application is deemed a part of this certificate. This certificate summarizes the principal provisions of the group policy that affect your insurance coverage. The provisions summarized in this certificate are subject in every respect to the group policy.

   Any statements made in your application will, in the absence of fraud, be considered representations and not warranties. Also, any statement made will not be used to void your insurance nor defend against a claim unless the statement is contained in a written instrument signed by you and a copy of that instrument is or has been furnished to you or your beneficiary.

3. The provision entitled “Can this certificate be amended?” under the General Information section of the certificate is amended in its entirety and replaced with the following:

   Can this certificate be amended?

   Yes. We retain the right to amend this certificate at any time without your consent. Any amendment will be without prejudice to any claim incurred for benefits prior to the date of the amendment. Any amendment will not be valid unless approved by an officer of the company.

4. The provision entitled “Adult Companion Lodging” under the Support Care section of the certificate is removed in its entirety.
5. The provision entitled “Can your insurance coverage be contested?” under the Additional Information section of the certificate is amended in its entirety and replaced with the following:

**Can your insurance coverage be contested?**

Yes. If an insured experiences a loss resulting from a covered accident within two years of the original effective date of coverage or increase in coverage, we will verify the accuracy of the information provided during the application process. If we discover a material misrepresentation, the affected coverage will be rescinded and an otherwise valid claim will be denied.

/Signature/ Secretary

/Signature/ President
This Certificate Endorsement is a part of the certificate of insurance describing the benefits available to you under Group Policy No. 76013, issued by Securian Life Insurance Company to Concordia Plan Services. This endorsement is subject to every term, condition, exclusion and provision of the certificate unless otherwise expressly provided for herein.

The following applies to you if you were a resident of the state of Connecticut at the time your coverage under this certificate became effective:

1. The following Notice is added to page one of the certificate:

   **This is an accident only certificate and it does not pay benefits for loss from sickness.**

2. The provision entitled **What is your agreement with us?** under the **General Information** section of the certificate is amended in its entirety and replaced with the following:

   **What is your agreement with us?**

   If you meet the eligibility and enrollment requirements, you are insured under the group policy shown on the specifications page. Your application is deemed a part of this certificate. This certificate summarizes the principal provisions of the group policy that affect your insurance coverage. The provisions summarized in this certificate are subject in every respect to the group policy.

   Any statements made in your application will be considered representations and not warranties. Also, any statement made will not be used to void your insurance nor defend against a claim unless the statement is contained in the application.

3. The provision entitled **Ambulance** under the **Emergency Care** section of the certificate is amended in its entirety and replaced with the following:

   **Ambulance**

   If an insured is injured in a covered accident and requires transportation to a hospital (or between hospitals) we will pay the appropriate ambulance benefit shown on the specifications page. Ground or water transportation must be provided by a licensed ambulance service within 90 days of the covered accident. Air transportation must be provided by a licensed ambulance service within 72 hours. This benefit is limited to one payment per insured per covered accident. If an insured requires more than one ambulance transport, the highest benefit amount will be paid.

   We will pay the benefit directly to the provider rendering such service when such provider has not previously received payment for such transportation from any other source. We shall not be required to provide benefits in excess of the maximum allowable rate(s) published by the Connecticut Department of Public Health in accordance with Section 19A-177 for such transportation.

   **Ambulance** means any publicly or privately owned surface, water or air vehicle, including a helicopter that is specifically designed and constructed or modified and equipped to be used, maintained or operated primarily for the transportation of individuals who are sick, injured or wounded.

   **Ambulance** does not include a surface, water or air vehicle that is owned and operated to accommodate an incapacitated or disabled person who does not require medical monitoring, care or treatment during transport.
4. The following language is added to the provision entitled Hospital Stay under the Hospital Care section of the certificate:

If an insured requires emergency medical care arising from accidental ingestion of controlled drug during such hospital stay, the period of hospitalization for which benefits shall be payable shall be at least 30 days in any calendar year.

If an insured requires emergency medical care arising from accidental ingestion of controlled drugs while other than during such hospital stay, benefits shall be available for such expenses during any calendar year up to a maximum of $500.

6. The numbered exclusions under the provision entitled “Are there any other exclusions that apply?” under the Exclusions and Limitations section of the certificate are amended in their entirety and replaced with the following:

1. Intentionally self-inflicted injury while sane; or
2. suicide or attempted suicide, while sane; or
3. your commission of, or your attempt to commit, a felony or insurrection; or
4. the use of alcohol; or
5. the voluntary use of any controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as now or hereafter amended, unless as prescribed by your physician; or
6. motor vehicle collision or accident where you are the operator of the motor vehicle and your blood alcohol level meets or exceeds the level at which intoxication is defined in the state where the collision or accident occurred, regardless of any legal proceedings thereto; or
7. war or any act of war, whether declared or undeclared; or
8. bodily or mental infirmity, illness or disease; or
9. infection, other than infection occurring simultaneously with, and as a direct and independent result of, the injury; or
10. repetitive stress syndromes including but not limited to rotator cuff syndrome, bursitis, tendonitis, carpal tunnel syndrome, ulnar nerve syndrome, stress fractures, neuropathy, epicondylitis or neuritis; or
11. medical or surgical treatment or diagnostic procedures including any resulting complications, or when the outcome is not as planned or expected, including claims of medical malpractice; or
12. travel in or descent from any aircraft, except as a fare-paying passenger on a regularly scheduled commercial flight on a licensed passenger aircraft carrier; or
13. participation in the following activities: scuba diving, bungee jumping, base jumping, hang gliding, sail gliding, parasailing, parakiting, or mountain climbing; or
14. riding or driving in any motor-driven vehicle in a race, stunt show or speed test; or
15. practicing for or participating in any semi-professional or professional competitive athletics.

7. The provision entitled Can your insurance coverage be contested? under the Additional Information section of the certificate is amended in its entirety and replaced with the following:

Can your insurance coverage be contested?

Yes. If an insured experiences a loss resulting from a covered accident within two years of the original effective date of coverage or increase in coverage, we will verify the accuracy of the information provided during the application process. If we discover a material misrepresentation, the affected coverage will be rescinded and an otherwise valid claim will be denied.

Secretary  President

15-32413
Securian Life 2
EdF91292  03-2018
This Certificate Endorsement is a part of the certificate of insurance describing the benefits available to you under Group Policy No. 76013, issued by Securian Life Insurance Company to Concordia Plan Services. This endorsement is subject to every term, condition, exclusion and provision of the certificate unless otherwise expressly provided for herein.

The following applies to you if you were a resident of the state of Kansas at the time your coverage under this certificate became effective:

1. The provision entitled Legal Actions on the cover page of the certificate is amended in its entirety and replaced with the following:

   **Legal Actions**

   No legal action may be brought to recover on this certificate within the first sixty days after written proof of loss has been given as required by this certificate. No such action may be brought after five years from the time written proof of loss is required to be given.

2. The provision entitled What is your agreement with us? in the General Information section of the certificate is amended in its entirety and replaced with the following:

   **What is your agreement with us?**

   If you meet the eligibility and enrollment requirements, you are insured under the group policy shown on the specifications page. Your application is deemed a part of this certificate. This certificate summarizes the principal provisions of the group policy that affect your insurance coverage. The provisions summarized in this certificate are subject in every respect to the group policy.

   Any statements made in your application will be considered representations and not warranties. Also, any statement made will not be used to void your insurance nor defend against a claim unless the statement is contained in the application, and a copy is provided to you or your beneficiary.

3. The provision entitled When is proof of a loss resulting from a covered accident required? in the Claims section of the certificate is amended in its entirety and replaced with the following:

   **When is proof of a loss resulting from a covered accident required?**

   Written proof of a loss resulting from a covered accident satisfactory to us must be provided to us within 90 days of the date of the loss. Failure to provide proof of the loss within this time will not invalidate or reduce a claim if it was not reasonably possible to provide proof within this 90 day period. However, proof must be provided within 1 year of the date it is otherwise required, except in the absence of legal capacity.

4. The provision entitled When will the benefit be paid? in the Claims section of the certificate is amended in its entirety and replaced with the following:

   **When will the benefit be paid?**

   We will pay a benefit for a loss resulting from a covered accident immediately after receipt at our home office of written proof of the loss which meets all policy requirements and is satisfactory to us. You are responsible for all costs associated with claim form(s) completion, records, and the submission of your claim.
5. The provision entitled **Can your insurance coverage be contested?** in the **Additional Information** section of the certificate is amended in its entirety and replaced with the following:

**Can your insurance coverage be contested?**

Yes. If an insured experiences a loss resulting from a covered accident within two years of the original effective date of coverage or increase in coverage, we will verify the accuracy of the information provided during the application process. If we discover a material misrepresentation, the affected coverage will be rescinded and an otherwise valid claim will be denied.

Any statements made in your application will be considered representations and not warranties. Also, any statement made will not be used to void your insurance nor defend against a claim unless the statement is contained in the application, and a copy is provided to you or your beneficiary.

Secretary

President
This Certificate Endorsement is a part of the certificate of insurance describing the benefits available to you under Group Policy No. 76013, issued by Securian Life Insurance Company to Concordia Plan Services. This endorsement is subject to every term, condition, exclusion and provision of the certificate unless otherwise expressly provided for herein.

The following applies to you if you were a resident of the state of Minnesota at the time your coverage under this certificate became effective:

1. The definition of child or children in the Definitions section of certificate, 15-32401, is amended in its entirety and replaced with the following:

   **child or children**

   Your or your spouse’s natural, adopted, grandchild, a child whom you are legal guardian for, stepchild or foster child, who is less than 26 years old. An adopted child includes a child legally placed for adoption with you. A grandchild includes a grandchild who is financially dependent on you and who resides with you from the moment of birth.

   Eligibility begins at live birth (stillborn or unborn children are not eligible). Coverage for a child that reaches the limiting age does not terminate while the child continues to be both (1) incapable of self-sustaining employment by reason of developmental disability, mental illness or disorder, or a physical disability; and (2) chiefly dependent on you for support and maintenance.

2. A provision entitled Can new employees hired after the issue date of the group policy enroll for coverage? is added to the General Information section of certificate, 15-32401, as follows:

   **Can new employees hired after the issue date of the group policy enroll for coverage?**

   Yes. Any person who becomes eligible for coverage after the issue date of the group policy can enroll in accordance with the same requirements as any other member of the group or class.

3. The provision entitled Are there any other exclusions that apply? in the Exclusions and Limitations section of certificate, 15-32401, is amended in its entirety and replaced with the following:

   **Are there any other exclusions that apply?**

   Yes. In no event will we pay benefits where the insured’s accident, injury or loss is caused directly or indirectly by, results in whole or in part from or during, or there is contribution from, any of the following:

   (1) self-inflicted injury, self-destruction, or autoeroticism, whether sane or insane; or
   (2) your commission of, or your attempt to commit, a felony or your being engaged in an illegal occupation; or
   (3) the use of drugs or medications unless administered by a licensed physician in the verifiably prescribed manner and dosage; or
   (4) poisons, gases, fumes or other substances voluntarily taken, absorbed, inhaled, ingested or injected; or
   (5) motor vehicle collision or accident where you are the operator of the motor vehicle and your blood alcohol level meets or exceeds the legal limit of intoxication as defined by state law; or
   (6) war or any act of war, whether declared or undeclared; or
   (7) bodily or mental infirmity, illness or disease; or
   (8) infection, other than infection occurring simultaneously with, and as a direct and independent result of, the injury; or
   (9) repetitive stress syndromes including but not limited to rotator cuff syndrome, bursitis, tendonitis, carpal tunnel syndrome, ulnar nerve syndrome, stress fractures, neuropathy, epicondylitis or neuritis; or
   (10) medical or surgical treatment or diagnostic procedures including any resulting complications, or when the outcome is not as planned or expected, including claims of medical malpractice; or
   (11) travel in or descent from any aircraft, except as a fare-paying passenger on a regularly scheduled commercial flight on a licensed passenger aircraft carrier; or
participation in the following activities: scuba diving, bungee jumping, base jumping, hang gliding, sail gliding, parasailing, parakiting, or mountain climbing; or

riding or driving in any motor-driven vehicle in an organized race, stunt show or speed test; or

practicing for or participating in any semi-professional or professional competitive athletics.

4. The provision entitled **When will the benefit be paid?** under the Claims section of certificate, 15-32401, is amended in its entirety and replaced with the following:

**When will the benefit be paid?**

We will pay a benefit for a loss resulting from a covered accident immediately upon receipt at our home office of written proof of the loss which meets all policy requirements and is satisfactory to us. You are responsible for all costs associated with claim form(s) completion, records, and the submission of your claim.

5. The provision entitled **To whom will benefits be paid?** in the Claims section of certificate, 15-32401, is amended in its entirety and replaced with the following:

**To whom will benefits be paid?**

All benefits including dependent’s benefits will be paid to you, if you are living. If you die before the claim is paid, indemnity for loss of your life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment.

If there is no eligible beneficiary, or if you do not name one, we will pay the benefit amount to your estate. Any other accrued indemnities unpaid at your death may, at our option, be paid either to the named beneficiary or to your estate.

6. The provision entitled **What are our physical examination rights?** under the Claims section of certificate, 15-32401, is amended in its entirety and replaced with the following:

**Physical Examination and Autopsy**

After an insured has filed a claim and provided at his or her expense all requested claim forms and records, we have the right to have the insured examined by a physician of our choice and at our expense, and to make an autopsy in case of death where it is not forbidden by law. This right may be exercised as often as reasonably necessary while an insured has a claim pending with us.

7. A provision entitled **Reinstatement** is added to the Termination section of certificate, 15-32401, as follows:

**Reinstatement**

If any renewal premium be not paid within the time granted you for payment, a subsequent acceptance of premium by us or by any agent duly authorized by us to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the certificate. The reinstated certificate shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement. In all other respects, you and we shall have the same rights thereunder as existed under the certificate immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement.

8. The provision entitled **When does your coverage terminate?** under the Termination section of certificate, 15-32401, is amended in its entirety and replaced with the following:

**When does your coverage terminate?**

Coverage ends on the earliest of the following:

(1) the date you no longer meet the eligibility requirements; or
(2) 31 days (the grace period) after the due date of any premium which is not paid; or
(3) the last day for which premium contributions have been paid following your request to cancel your coverage; or
(4) 31 days after we provide notice of our intent to terminate the group policy.
Unless the Securian Life group policy is being replaced by a substantially similar accident insurance policy, we will notify you 31 days in advance of any termination of the group policy by Securian Life. In no event shall the terms of this section extend coverage under the group policy more than 120 days beyond the date coverage would otherwise terminate under the terms of the group policy.

9. The provision entitled **Can your insurance coverage be contested?** under the **Additional Information** section of certificate, 15-32401, is amended in its entirety and replaced with the following:

**Can your insurance coverage be contested?**

Yes. If an insured experiences a loss resulting from a covered accident within two years of the original effective date of coverage or increase in coverage, we will verify the accuracy of the information provided during the application process. If we discover a material misrepresentation, the affected coverage will be rescinded and an otherwise valid claim will be denied.

After two years from the effective date of this certificate, no misstatements, except fraudulent misstatements, made by you in your application for such certificate shall be used to void your insurance or to deny a claim for loss incurred commencing after the expiration of such two year period.

10. The third paragraph of the provision entitled **Who is eligible to continue insurance under this supplement?** under the **General Information** section of Group Accident Insurance Portability Certificate Supplement, 15-32405, is amended in its entirety and replaced with the following:

An insured child is eligible to continue insurance under this supplement if he or she no longer meets the eligibility requirements of the certificate due to attaining an age limit or otherwise ceases to be an eligible dependent.

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Secretary

President
This Certificate Endorsement is a part of the certificate of insurance describing the benefits available to you under Group Policy No. 76013, issued by Securian Life Insurance Company to Concordia Plan Services. This endorsement is subject to every term, condition, exclusion and provision of the certificate unless otherwise expressly provided for herein.

The following applies to you if you were a resident of the state of Mississippi at the time your coverage under this certificate became effective:

1. **Are there any other exclusions that apply?**

    
    Yes. In no event will we pay benefits where the insured’s accident, injury or loss is caused directly or indirectly by, results in whole or in part from or during, or there is contribution from, any of the following:

    - Intentionally self-inflicted injury while sane; or
    - Suicide or attempted suicide, while sane; or
    - Your participation in, or your attempt to commit, a crime, assault, felony, or any illegal activity, regardless of any legal proceedings thereto; or
    - Your being intoxicated; or
    - The use of prescription drugs, non-prescription drugs, illegal drugs or medications, unless administered on the advice of a physician; or
    - Poisons, gases, fumes or other substances taken, absorbed, inhaled, ingested or injected; or
    - Motor vehicle collision or accident where you are the operator of the motor vehicle and your blood alcohol level meets or exceeds the level at which intoxication is defined in the state where the collision or accident occurred, regardless of any legal proceedings thereto; or
    - War or any act of war, whether declared or undeclared; or
    - Bodily or mental infirmity, illness or disease; or
    - Infection, other than infection occurring simultaneously with, and as a direct and independent result of, the injury; or
    - Repetitive stress syndromes including but not limited to rotator cuff syndrome, bursitis, tendonitis, carpal tunnel syndrome, ulnar nerve syndrome, stress fractures, neuropathy, epicondylitis or neuritis; or
    - Medical or surgical treatment or diagnostic procedures including any resulting complications, or when the outcome is not as planned or expected, including claims of medical malpractice; or
    - Travel in or descent from any aircraft, except as a fare-paying passenger on a regularly scheduled commercial flight on a licensed passenger aircraft carrier; or
    - Participation in the following activities: scuba diving, bungee jumping, base jumping, hang gliding, sail gliding, parasailing, parakiting, or mountain climbing; or
    - Riding or driving in any motor-driven vehicle in a race, stunt show or speed test; or
    - Practicing for or participating in any semi-professional or professional competitive athletics.

2. **What notice of claim must be provided?**

    Written notice of claim must be given to us within 30 days of the date of a loss resulting from a covered accident, or as soon thereafter as reasonably possible. Notice given by or on the insured’s behalf to us at our home office or to any authorized agent of ours, with information to identify the insured, shall be deemed notice to us.
3. The provision entitled **When is proof of a loss resulting from a covered accident required?** under the **Claims** section of the certificate is amended in its entirety and replaced with the following:

**When is proof of a loss resulting from a covered accident required?**

Written proof of a loss resulting from a covered accident satisfactory to us must be provided to us within 90 days of the date of the loss. Failure to provide proof of the loss within this time will not invalidate or reduce a claim if it was not reasonably possible to provide proof within this 90 day period. However, proof must be provided within 1 year of the date it is otherwise required, except in the absence of legal capacity.

4. The provision entitled **When will the benefit be paid?** under the **Claims** section of the certificate is amended in its entirety and replaced with the following:

**When will the benefit be paid?**

We will pay a benefit for a loss resulting from a covered accident after receipt at our home office of written proof of the loss which meets all policy requirements and is satisfactory to us. You are responsible for all costs associated with claim form(s) completion, records, and the submission of your claim.

Claims must be paid within 25 days after receipt of written proof of loss in the form of a clean claim submitted electronically, and within 35 days after receipt of written proof of loss in the form of a clean claim submitted in paper format. Benefits due under this certificate are overdue if not paid within 25 days or 35 days, whichever is applicable, after we receive a clean claim.

A “clean claim” means a claim received by us for adjudication and which requires no further information, adjustment or alteration in order to be processed and paid by us. A claim is clean if it has no defect or propriety, including any lack of substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this provision. A clean claim includes resubmitted claims with previously identified deficiencies corrected.

We will pay interest at the rate of 1.5% per month on any overdue benefit for the period when such benefit is overdue until such benefit is finally paid. If we fail to pay such benefits when due, you have the right to bring action to recover such benefits, any interest which may accrue, and any other damages as may be allowable by law.

5. The provision entitled **Will the provisions of this certificate conform with applicable state law?** under the **Additional Information** section of the certificate is amended in its entirety and replaced with the following:

**Conformity with State Statutes**

Any provision in this certificate, or in the provisions of the group policy, which, on its effective date, is in conflict with the applicable laws of the state in which the insured resides on such date is hereby amended to conform to the minimum requirements of such statutes.

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Secretary

President
This Certificate Endorsement is a part of the certificate of insurance describing the benefits available to you under Group Policy No. 76013, issued by Securian Life Insurance Company to Concordia Plan Services. This endorsement is subject to every term, condition, exclusion and provision of the certificate unless otherwise expressly provided for herein.

The following applies to you if you were a resident of the state of Nebraska at the time your coverage under this certificate became effective:

1. The definition of child or children under the Definitions section of the certificate is amended in its entirety and replaced with the following:

   child or children

   Your or your spouse's natural, adopted, stepchild or foster child who is less than 26 years old. An adopted child includes a child legally placed for adoption with you. Eligibility begins at live birth (stillborn or unborn children are not eligible). Coverage for a child that reaches the limiting age does not terminate while the child continues to be both: (1) incapable of self-sustaining employment by reason of mental or physical handicap; and (2) chiefly dependent on you for support and maintenance.

2. The numbered exclusions in the provision entitled Are there any other exclusions that apply? under the Exclusions and Limitations section of the certificate are amended in entirety and replaced with the following:

   (1) Intentionally self-inflicted injury while sane; or
   (2) suicide or attempted suicide while sane; or
   (3) your commission of, or your attempt to commit, a felony or to which a contributing cause was your being engaged in an illegal occupation; or
   (4) the use of alcohol; or
   (5) the use of prescription drugs, non-prescription drugs, illegal drugs, or medications unless administered on the advice of a physician; or
   (6) poisons, gases, fumes or other substances taken, absorbed, inhaled, ingested or injected; or
   (7) motor vehicle collision or accident where you are the operator of the motor vehicle and your blood alcohol level meets or exceeds the level at which intoxication is defined in the state where the collision or accident occurred, regardless of any legal proceedings thereto; or
   (8) war or any act of war, whether declared or undeclared; or
   (9) bodily or mental infirmity, illness or disease; or
   (10) infection, other than infection occurring simultaneously with, and as a direct and independent result of, the injury; or
   (11) repetitive stress syndromes including but not limited to rotator cuff syndrome, bursitis, tendonitis, carpal tunnel syndrome, ulnar nerve syndrome, stress fractures, neuropathy, epicondylitis or neuritis; or
   (12) medical or surgical treatment or diagnostic procedures including any resulting complications, or when the outcome is not as planned or expected, including claims of medical malpractice; or
   (13) travel in or descent from any aircraft, except as a fare-paying passenger on a regularly scheduled commercial flight on a licensed passenger aircraft carrier; or
   (14) participation in the following activities: scuba diving, bungee jumping, base jumping, hang gliding, sail gliding, parasailing, parakiting, or mountain climbing; or
   (15) riding or driving in any motor-driven vehicle in an organized race, stunt show or speed test; or
   (16) practicing for or participating in any semi-professional or professional competitive athletics.
3. The provision entitled **When will the benefit be paid?** under the **Claims** section of the certificate is amended in its entirety and replaced with the following:

   **When will the benefit be paid?**

   We will pay a benefit for a loss resulting from a covered accident immediately upon receipt at our home office of written proof of the loss which meets all policy requirements and is satisfactory to us. You are responsible for all costs associated with claim form(s) completion, records, and the submission of your claim.

4. The provision entitled **Can your insurance coverage be contested?** under the **Additional Information** section of the certificate is amended in its entirety and replaced with the following:

   **Can your insurance coverage be contested?**

   Yes. If an insured experiences a loss resulting from a covered accident within two years of the original effective date of coverage or increase in coverage, we will verify the accuracy of the information provided during the application process. If we discover a material misrepresentation, the affected coverage will be rescinded and an otherwise valid claim will be denied. This two year period will be extended for fraudulent misstatements or as otherwise allowed by applicable laws.

5. The provision entitled **Will the provisions of this certificate conform with applicable state law?** under the **Additional Information** section of the certificate is amended in its entirety and replaced with the following:

   **Will the provisions of this certificate conform with applicable state and federal law?**

   Yes. Any provision in this certificate or in the provisions of the group policy which, on its effective date, is in conflict with the law of the federal government or the state in which the insured resides is hereby amended to conform to the minimum requirements of such law.

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**Secretary**

**President**
This Certificate Endorsement is a part of the certificate of insurance describing the benefits available to you under Group Policy No. 76013, issued by Securian Life Insurance Company to Concordia Plan Services. This endorsement is subject to every term, condition, exclusion and provision of the certificate unless otherwise expressly provided for herein.

The following applies to New Mexico residents:

1. The first paragraph on the face page of the certificate is amended in its entirety and replaced with the following:

   This type of plan is NOT considered "minimum essential coverage" under the Affordable Care Act and therefore does NOT satisfy the individual mandate that you have health insurance coverage. If you do not have other health insurance coverage, you may be subject to a federal tax penalty.

2. The definition of "physician" in the Definitions section of the certificate is amended in its entirety and replaced with the following:

   physician

   A medical doctor or other person recognized by law or regulation in the United States or United States territory, including a practitioner of the healing arts, where services are rendered as a physician. The person must be licensed as required by the United States jurisdiction where care is given and must be operating in the scope of his or her license.

   A physician cannot be a person who:

   (1) ordinarily resides in your household; or
   (2) is a family member.

3. The provision entitled "When will the benefit be paid?" under the Claims section of the certificate is amended in its entirety and replaced with the following:

   When will the benefit be paid?

   We will pay a benefit for a loss resulting from a covered accident immediately upon receipt at our home office of written proof of the loss which meets all policy requirements and is satisfactory to us. You are responsible for all costs associated with claim form(s) completion, records, and the submission of your claim.

4. A provision entitled "Reinstatement" is added to the Termination section of the certificate as follows:

   Reinstatement

   If any renewal premium be not paid within the time granted you for payment, a subsequent acceptance of premium by us or by any agent duly authorized by us to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the certificate. The reinstated certificate shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement. In all other respects, you and we shall have the same rights thereunder as existed under the certificate immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement.
5. The provision entitled “When does your coverage terminate?” under the Termination section of the certificate is amended in its entirety and replaced with the following:

**When does your coverage terminate?**

Coverage ends on the earliest of the following:

1. the date you no longer meet the eligibility requirements; or
2. 31 days (the grace period) after the due date of any premium which is not paid; or
3. the last day for which premium contributions have been paid following your request to cancel your coverage; or
4. the date the group policy ends.

If you are disabled or hospitalized on the date the group policy terminates, termination of the group policy during a disability or hospitalization shall have no effect on benefits payable for that disability or hospitalization.

6. The paragraph under the General Information section of the Certificate Specifications Page is amended in its entirety and replaced with the following:

This certificate specifications page replaces any and all certificate specifications pages previously issued to you under the group policy. Please replace any certificate specifications page previously issued to you with this new specifications page.

7. The provision entitled “What is the policy interpretation right and authority?” under the Additional Information section of the certificate is deleted in its entirety.

**Signature**

Secretary

President
This Certificate Endorsement is a part of the certificate of insurance describing the benefits available to you under Group Policy No. 76013, issued by Securian Life Insurance Company to Concordia Plan Services. This endorsement is subject to every term, condition, exclusion and provision of the certificate unless otherwise expressly provided for herein.

The following applies to you if you were a resident of the state of North Carolina at the time your coverage under this certificate became effective:

1. The cover page of the certificate is amended to include the following:

   **Important Cancellation Information – Please Read the Section Entitled, “Termination” Found on Page 13**

2. The definition of child or children in the Definitions section of the certificate is amended in its entirety and replaced with the following:

   **child or children**

   Your or your spouse's natural, adopted, foster, stepchild or child for whom an administrative order or court-appointed guardianship is granted, beginning on the date of the appointment, who is less than 26 years old. An adopted child includes a child from the moment of placement in the adoptive home regardless of whether or not the adoption has become final. A foster child includes a child from the moment of placement in the foster home. Eligibility begins at live birth (stillborn or unborn children are not eligible).

   After age 26, coverage for an unmarried child who is incapable of sustaining employment by reason of mental retardation or physical disability, who become so incapacitated prior to the attainment of 26 years of age and who is chiefly dependent upon you for support and maintenance, shall not terminate but coverage shall continue so long as your coverage remains in force and so long as the child remains in such condition. Proof of such dependency may be required with 31 days of the child reaching 26 years of age, but not more frequently than annually.

3. The definition of dependent in the Definitions section of the certificate is amended in its entirety and replaced with the following:

   **dependent**

   Your children or spouse.

   If both parents of a child qualify as eligible employees under the group policy, the child shall be considered a dependent of only one parent for purposes of this certificate. If any child qualifies as an eligible employee under the group policy, he or she is not eligible to be insured as a dependent child.

   If a child is born to you and you have not elected dependent coverage, such child shall be insured from the moment of live birth. The newborn child shall be insured for 31 days. The newborn child shall then cease to be insured unless you apply for dependent coverage within 31 days of the birth and pay the additional premium for coverage.

   The above 31 day coverage period will also apply to newly adopted, foster or step children, as of the date they become financially dependent on you for support, provided they are an eligible dependent child. The child shall then cease to be insured unless you apply for dependent coverage within 31 days of the date the child becomes financially dependent on you for support and pay the additional premium for coverage.

4. The definition of hospital in the Definitions section of the certificate is amended in its entirety and replaced with the following:

   **hospital**

   A short-term, acute care general facility that:
(1) is legally licensed and operated as a hospital;
(2) provides overnight care of injured and sick people;
(3) requires that every patient be supervised by a physician;
(4) provides 24 hour nursing service by or under the supervision of a registered nurse;
(5) has on-site or pre-arranged use of x-ray equipment, laboratory, and surgical facilities; and
(6) maintains permanent medical history records.

A hospital is not a rehabilitation center, nursing home, rest home, extended-care facility, convalescent home, a place for alcoholics or drug addicts or a mental institution, even if such facilities are affiliated with or adjoined to a hospital.

A State tax-supported institution is not excluded from the definition of a hospital, even though it may not have an operating room and related equipment for the performance of surgery.

5. The provision entitled What is your agreement with us? in the General Information section of the certificate is amended in its entirety and replaced with the following:

What is your agreement with us?

If you meet the eligibility and enrollment requirements, you are insured under the group policy shown on the specifications page. Your application is deemed a part of this certificate. This certificate summarizes the principal provisions of the group policy that affect your insurance coverage. The provisions summarized in this certificate are subject in every respect to the group policy.

Any statements made in your application will be considered representations and not warranties. Also, any statement made will not be used to void your insurance nor defend against a claim unless the statement is contained in the application.

6. The provision entitled What is the actively at work requirement? in the General Information section of the certificate is amended in its entirety and replaced with the following:

What is the actively at work requirement?

To be eligible to become insured or to receive an increase in the benefit amount, you must be actively at work, fully performing your customary duties for your regularly scheduled number of hours at the employer’s normal place of business, or at other places the employer’s business requires you to travel.

If you are not actively at work on the date coverage would otherwise begin, or on the date an increase in your benefit amount would otherwise be effective, you will not be eligible for the coverage or increase until you return to active work. However, if the absence is on a non-work day, coverage will not be delayed provided you were actively at work on the work day immediately preceding the non-work day.

Except as otherwise provided for in this certificate, you are eligible to continue to be insured only while you remain actively at work.

Any insurance or increase in insurance which is elected or put in force while you are not actively at work will not be eligible for claim payment. You or your beneficiary will receive a refund of premium for any contributory insurance for which you were not eligible.

7. The provision entitled Are there any other exclusions that apply? in the Exclusions and Limitations section of the certificate is amended in its entirety and replaced with the following:

Are there any other exclusions that apply?

Yes. In no event will we pay benefits where the insured’s accident, injury or loss is caused directly or indirectly by, results in whole or in part from or during, or there is contribution from, any of the following:

(1) intentionally self-inflicted injury while sane; or
(2) suicide or attempted suicide, while sane; or
(3) your participation in, or your attempt to commit a felony, or your being engaged in an illegal occupation, regardless of any legal proceedings thereto; or
(4) the use of alcohol; or
(5) the use of prescription drugs, non-prescription drugs, illegal drugs, medications, poisons, gases, fumes or other substances taken, absorbed, inhaled, ingested or injected. This does not include involuntary inhalation of gases and fumes, or the involuntary taking of poison; or

(6) motor vehicle collision or accident where you are the operator of the motor vehicle and your blood alcohol level meets or exceeds the level at which intoxication is defined in the state where the collision or accident occurred, regardless of any legal proceedings thereto; or

(7) war or any act of war (not including acts of terrorism), whether declared or undeclared. This exclusion does not apply when you are a known service member at the time of sale; or

(8) exposure to nuclear explosion, nuclear energy or nuclear elements, hazardous waste and other toxins, except as the result of involuntary exposure to such; or

(9) bodily or mental infirmity, illness or disease, except for accidental ptomaine poisoning; or

(10) infection, other than bacterial infection occurring simultaneously with, and as a direct and independent result of, the injury; or

(11) repetitive stress syndromes including but not limited to rotator cuff syndrome, bursitis, tendonitis, carpal tunnel syndrome, ulnar nerve syndrome, stress fractures, neuropathy, epicondylitis or neuritis; or

(12) medical or surgical treatment or diagnostic procedures including any resulting complications, or when the outcome is not as planned or expected, including claims of medical malpractice; or

(13) travel in or descent from any aircraft, except as a fare-paying passenger on a regularly scheduled commercial flight on a licensed passenger aircraft carrier; or

(14) participation in the following activities: scuba diving, bungee jumping, base jumping, hang gliding, sail gliding, parasailing, parakiting, or mountain climbing; or

(15) riding or driving in any motor-driven vehicle in a race, stunt show or speed test; or

(16) practicing for or participating in any semi-professional or professional competitive athletics.

8. The provision entitled **When is proof of a loss resulting from a covered accident required?** in the **Claims** section of the certificate is amended in its entirety and replaced with the following:

**When is proof of a loss resulting from a covered accident required?**

Written proof of a loss resulting from a covered accident satisfactory to us must be provided to us within 180 days of the date of the loss. Failure to provide proof of the loss within this time will not invalidate or reduce a claim if it was not reasonably possible to provide proof within this 180 day period. However, proof must be provided within 1 year of the date it is otherwise required, except in the absence of legal capacity.

9. The provision entitled **When will the benefit be paid?** in the **Claims** section of the certificate is amended in its entirety and replaced with the following:

**When will the benefit be paid?**

We will pay a benefit for a loss resulting from a covered accident immediately upon receipt of written proof of the loss which meets all policy requirements and is satisfactory to us. You are responsible for all costs associated with claim form(s) completion, records, and the submission of your claim.

10. The provision entitled **Can your insurance coverage be contested?** in the **Additional Information** section of the certificate is hereby amended in its entirety and replaced with the following:

**Can your insurance coverage be contested?**

Yes. If an insured experiences a loss resulting from a covered accident within two years of the original effective date of coverage or increase in coverage, we will verify the accuracy of the information provided during the application process. If we discover a material misrepresentation, the affected coverage will be rescinded and an otherwise valid claim will be denied.
11. The third paragraph of the provision entitled **Who is eligible to continue insurance under this supplement?** in the *General Information* section of the Group Accident Insurance Portability Certificate Supplement is amended in its entirety and replaced with the following:

An insured child 26 or older is eligible to continue insurance under this supplement if he or she no longer meets the eligibility requirements of the certificate due to attaining an age limit or otherwise ceases to be an eligible dependent.

Secretary

President
This Certificate Endorsement is a part of the certificate of insurance describing the benefits available to you under Group Policy No. 76013, issued by Securian Life Insurance Company to Concordia Plan Services. This endorsement is subject to every term, condition, exclusion and provision of the certificate unless otherwise expressly provided for herein.

The following applies to you if you were a resident of the state of North Dakota at the time your coverage under this certificate became effective:

1. The definition of child or children in the Definitions section of the certificate is amended in its entirety and replaced with the following:

   child or children

   Your or your spouse’s natural, adopted, stepchild or foster child who is less than 26 years old. An adopted child includes a child legally placed for adoption with you. Eligibility begins at live birth (stillborn or unborn children are not eligible).

   Coverage for a child who reaches the limiting age does not terminate while the child continues to be both (1) incapable of self-sustaining employment by reason of a physical handicap or an intellectual disability; and (2) dependent on you for support and maintenance.

2. The provision entitled What is your agreement with us? under the General Information section of the certificate is amended in its entirety and replaced with the following:

   What is your agreement with us?

   If you meet the eligibility and enrollment requirements, you are insured under the group policy shown on the specifications page. Your application is deemed a part of this certificate. This certificate summarizes the principal provisions of the group policy that affect your insurance coverage. The provisions summarized in this certificate are subject in every respect to the group policy.

   Any statements made in your application as defined in this certificate will be considered representations and not warranties. Also, any statement made will not be used to void your insurance nor defend against a claim unless a copy of the instrument containing the statement is or has been furnished to you or, in the event of your death or incapacity, to your beneficiary or personal representative.

3. The provision entitled Are there any other exclusions that apply? under the Exclusions and Limitations section of the certificate is amended in its entirety and replaced with the following:

   Are there any other exclusions that apply?

   Yes. In no event will we pay benefits where the insured’s accident, injury or loss is caused directly or indirectly by, results in whole or in part from or during, or there is contribution from, any of the following:

   (1) Intentionally self-inflicted injury while sane; or
   (2) suicide or attempted suicide, while sane; or
   (3) your commission of, or your attempt to commit, a crime, or your being engaged in an illegal occupation; or
   (4) the use of alcohol; or
   (5) the use of prescription drugs, non-prescription drugs, illegal drugs, medications, poisons, gases, fumes or other substances taken, absorbed, inhaled, ingested or injected; or
   (6) motor vehicle collision or accident where you are the operator of the motor vehicle and your blood alcohol level meets or exceeds the level at which intoxication is defined in the state where the collision or accident occurred, regardless of any legal proceedings thereto; or
   (7) war or any act of war, whether declared or undeclared; or
   (8) bodily or mental infirmity, illness or disease; or
   (9) infection, other than infection occurring simultaneously with, and as a direct and independent result of, the injury; or
(10) repetitive stress syndromes including but not limited to rotator cuff syndrome, bursitis, tendonitis, carpal tunnel syndrome, ulnar nerve syndrome, stress fractures, neuropathy, epicondylitis or neuritis; or
(11) medical or surgical treatment or diagnostic procedures including any resulting complications, or when the outcome is not as planned or expected, including claims of medical malpractice; or
(12) travel in or descent from any aircraft, except as a fare-paying passenger on a regularly scheduled commercial flight on a licensed passenger aircraft carrier; or
(13) participation in the following activities: scuba diving, bungee jumping, base jumping, hang gliding, sail gliding, parasailing, parakiting, or mountain climbing; or
(14) riding or driving in any motor-driven vehicle in a race, stunt show or speed test; or
(15) practicing for or participating in any semi-professional or professional competitive athletics.

4. The provision entitled When will the benefit be paid? under the Claims section of the certificate is amended in its entirety and replaced with the following:

When will the benefit be paid?

We will pay a benefit for a loss resulting from a covered accident within 60 days after receipt at our home office of written proof of the loss which meets all policy requirements and is satisfactory to us. You are responsible for all costs associated with claim form(s) completion, records, and the submission of your claim.

5. The provision entitled Can your insurance coverage be contested? under the Additional Information section of the certificate is amended in its entirety and replaced with the following:

Can your insurance coverage be contested?

Yes. If an insured experiences a loss resulting from a covered accident within two years of the original effective date of coverage or increase in coverage, we will verify the accuracy of the information provided during the application process. If we discover a material misrepresentation, the affected coverage will be rescinded and an otherwise valid claim will be denied.

6. The provision entitled What is the policy interpretation right and authority? under the Additional Information section of the certificate is removed in its entirety.

Secretary

President
This Certificate Endorsement is a part of the certificate of insurance describing the benefits available to you under Group Policy No. 76013, issued by Securian Life Insurance Company to Concordia Plan Services. This endorsement is subject to every term, condition, exclusion and provision of the certificate unless otherwise expressly provided for herein.

The following applies to you if you were a resident of the state of Ohio at the time your coverage under this certificate became effective:

1. The definition of child or children in the Definitions section is amended in its entirety and replaced with the following:

   child or children

   Your or your spouse’s natural, adopted, stepchild or foster child who is less than 26 years old. An adopted child includes a child legally placed for adoption with you or in the process of placement for adoption. Eligibility begins at live birth (stillborn or unborn children are not eligible).

   Coverage for a child that reaches the limiting age does not terminate while the child continues to be both:

   (1) incapable of self-sustaining employment by reason of mental retardation or physical handicap; and
   (2) primarily dependent upon you for support and maintenance.

2. The provision entitled When is proof of a loss resulting from a covered accident required? in the Claims section is amended in its entirety and replaced with the following:

   When is proof of a loss resulting from a covered accident required?

   Written proof of a loss resulting from a covered accident satisfactory to us must be provided to us within 90 days of the date of the loss. Failure to provide proof of the loss within the time required will not invalidate or reduce a claim if it was not reasonably possible to provide proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

3. The provision entitled When will the benefit be paid? in the Claims section is amended in its entirety and replaced with the following:

   When will the benefit be paid?

   We will pay a benefit for a loss resulting from a covered accident within 30 days after receipt at our home office of written proof of the loss which meets all policy requirements and is satisfactory to us. You are responsible for all costs associated with claim form(s) completion, records, and the submission of your claim.
This Certificate Endorsement is a part of the certificate of insurance describing the benefits available to you under Group Policy No. 76013, issued by Securian Life Insurance Company to Concordia Plan Services. This endorsement is subject to every term, condition, exclusion and provision of the certificate unless otherwise expressly provided for herein.

The following applies to you if you were a resident of the state of Oklahoma at the time your coverage under this certificate became effective:

1. The following statement is added to page one of the certificate:

   **WARNING:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

2. Item (7) in the provision entitled **Are there any other exclusions that apply?** under the **Exclusions and Limitations** section of the certificate is amended in its entirety and replaced with the following:

   (7) war or any act of war, whether declared or undeclared while serving in the military or an auxiliary unit attached to the military or working in an area of war whether voluntarily or as required by an employer; or

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Secretary

President
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The following applies to you if you were a resident of the state of Oregon at the time your coverage under this certificate became effective:

1. The Definitions section of the certificate is amended to add the following definition:

   **domestic partner**
   
   A civil contract entered into in person between two individuals of the same sex who are at least 18 years of age, who are otherwise capable and at least one of whom is a resident of Oregon.

2. The definition of **spouse** under the Definitions section of the certificate is amended in its entirety and replaced with the following:

   **spouse**
   
   Your legally married spouse as recognized under the laws of the jurisdiction of celebration or your domestic partner.

   Spouse does not include any person who is eligible as an employee.

3. The provision entitled **What is your agreement with us?** under the General Information section of the certificate is amended in its entirety and replaced with the following:

   **What is your agreement with us?**
   
   If you meet the eligibility and enrollment requirements, you are insured under the group policy shown on the specifications page. Your application is deemed a part of this certificate. This certificate summarizes the principal provisions of the group policy that affect your insurance coverage. The provisions summarized in this certificate are subject in every respect to the group policy.

   Any statements made in your application will, in the absence of fraud, be considered representations and not warranties. Also, any statement made will not be used to void your insurance nor defend against a claim unless a copy of the instrument containing the statement is or has been provided to the policyholder, you or your beneficiary.

4. The provision entitled **Are there any other exclusions that apply?** under the Exclusions and Limitations section of the certificate is amended in its entirety and replaced with the following:

   **Are there any other exclusions that apply?**
   
   Yes. In no event will we pay benefits where the insured’s accident, injury or loss is caused directly or indirectly by, results in whole or in part from or during, or there is contribution from, any of the following:

   1. intentionally self-inflicted injury while sane; or
   2. suicide or attempted suicide while sane; or
   3. your commission of, or attempt to commit a felony, or your being engaged in an illegal occupation; or
   4. your being legally intoxicated; or
   5. the voluntary use of prescription drugs (unless administered on the advice of a physician in the prescribed manner); or
   6. the voluntary use of illegal drugs; or
   7. poisons, gases, fumes or other substances voluntarily taken, absorbed, inhaled, ingested or injected, except exposure during the course of employment; or
(8) motor vehicle collision or accident where you are the operator of the motor vehicle and your blood alcohol level meets or exceeds the level at which intoxication is defined in the state where the collision or accident occurred, regardless of any legal proceedings thereto; or
(9) war or any act of war, whether declared or undeclared; or
(10) bodily or mental infirmity, illness or disease; or
(11) infection, other than infection occurring simultaneously with, and as a direct and independent result of, the injury; or
(12) repetitive stress syndromes including but not limited to rotator cuff syndrome, bursitis, tendonitis, carpal tunnel syndrome, ulnar nerve syndrome, stress fractures, neuropathy, epicondylitis or neuritis; or
(13) medical or surgical treatment or diagnostic procedures including any resulting complications, or when the outcome is not as planned or expected, including claims of medical malpractice; or
(14) travel in or descent from any aircraft, except as a fare-paying passenger on a regularly scheduled commercial flight on a licensed passenger aircraft carrier; or
(15) participation in the following activities: scuba diving, bungee jumping, base jumping, hang gliding, sail gliding, parasailing, parakiting, or mountain climbing; or
(16) riding or driving in any motor-driven vehicle in a race, stunt show or speed test; or
(17) practicing for or participating in any semi-professional or professional competitive athletics.

5. The provision entitled **When will the benefit be paid?** under the **Claims** section of the certificate is amended in its entirety and replaced with the following:

**When will the benefit be paid?**

We will pay a benefit for a loss resulting from a covered accident within 30 days after receipt at our home office of written proof of the loss which meets all policy requirements and is satisfactory to us. You are responsible for all costs associated with claim form(s) completion, records, and the submission of your claim. Payment made by us in accordance with the terms of this certificate will fully discharge us to the extent of the payment.

6. The provision entitled **Can your insurance coverage be contested?** under the **Additional Information** section of the certificate is amended in its entirety and replaced with the following:

**Can your insurance coverage be contested?**

Yes. If an insured experiences a loss resulting from a covered accident within two years of the original effective date of coverage or increase in coverage, we will verify the accuracy of the information provided during the application process. If we discover a material misrepresentation, the affected coverage will be rescinded and an otherwise valid claim will be denied. This two year period will be extended by fraud.

7. The provision entitled **What is the policy interpretation right and authority?** under the **Additional Information** section of the certificate is deleted in its entirety.
Group Accident Insurance
Certificate Endorsement
Securian Life Insurance Company
400 Robert Street North • St. Paul, Minnesota 55101-2098

This Certificate Endorsement is a part of the certificate of insurance describing the benefits available to you under Group Policy No. 76013, issued by Securian Life Insurance Company to Concordia Plan Services. This endorsement is subject to every term, condition, exclusion and provision of the certificate unless otherwise expressly provided for herein.

The following applies to you if you were a resident of the state of South Carolina at the time your coverage under this certificate became effective:

1. The provision entitled Legal Actions on the cover page of the certificate is amended in its entirety and replaced with the following:

   No legal action may be brought to recover on this certificate within the first sixty days after written proof of loss has been given as required by this certificate. No such action may be brought after six years from the time written proof of loss is required to be given.

2. The provision entitled What is your agreement with us? under the General Information section of the certificate is amended in its entirety and replaced with the following:

   What is your agreement with us?

   If you meet the eligibility and enrollment requirements, you are insured under the group policy shown on the specifications page. Your application is deemed a part of this certificate. This certificate summarizes the principal provisions of the group policy that affect your insurance coverage. The provisions summarized in this certificate are subject in every respect to the group policy.

   Any statements made in your application will, in the absence of fraud, be considered representations and not warranties. Also, any statement made will not be used to void your insurance nor defend against a claim unless a copy of the instrument containing the statement is or has been furnished to the person or, in the event of the death or incapacity of the insured person, to the individual's beneficiary or personal representative.

3. The provision entitled When will the benefit be paid? under the Claims section of the certificate is amended in its entirety and replaced with the following:

   When will the benefit be paid?

   We will pay a benefit for a loss resulting from a covered accident within 60 days after receipt at our home office of written proof of the loss which meets all policy requirements and is satisfactory to us. You are responsible for all costs associated with claim form(s) completion, records, and the submission of your claim.

Secretary

President
This Certificate Endorsement is a part of the certificate of insurance describing the benefits available to you under Group Policy No. 76013, issued by Securian Life Insurance Company to Concordia Plan Services. This endorsement is subject to every term, condition, exclusion and provision of the certificate unless otherwise expressly provided for herein.

The following applies to you if you were a resident of the state of South Dakota at the time your coverage under this certificate became effective:

1. The definition of physician under the Definitions section of the certificate is amended in its entirety and replaced with the following:

   **physician**

   A medical doctor or other person recognized by law or regulation in the United States or United States territory where services are rendered as a physician. The person must be licensed as required by the United States jurisdiction where care is given and must be operating in the scope of his or her license.

   A physician cannot be a person who:

   (1) ordinarily resides in your household;
   (2) is a family member, unless he or she is the only doctor in the area provided that the doctor is acting within the scope of his or her practice.

2. The provision entitled Emergency Dental under the Emergency Care section of the certificate is deleted in its entirety.

3. The Initial Benefit in the provision entitled Hospital Stay under the Hospital Care section of the certificate is amended in its entirety and replaced with the following:

   **Initial Benefit**

   We will pay the initial benefit shown on the specifications page for the first day of a hospital stay provided the insured is receiving treatment for a covered accident in the hospital.

   The benefit payment will be based on the type of room and level of care the insured receives. The Intensive Care Unit (ICU) benefit is payable if the insured is receiving treatment in an ICU room of a hospital. The non-ICU benefit is payable if the insured is receiving treatment in a non-ICU room.

   This benefit is limited to one payment per insured per covered accident. In the event the insured receives treatment in both a non-ICU and an ICU room, the higher benefit will be payable as an initial benefit.

4. The provision entitled Are there any other exclusions that apply? under the Exclusions and Limitations section of the certificate is amended in its entirety and replaced with the following:

   **Are there any other exclusions that apply?**

   Yes. In no event will we pay benefits where the insured’s accident, injury or loss is caused directly or indirectly by, results in whole or in part from or during, or there is contribution from, any of the following:

   (1) intentionally self-inflicted injury while sane; or
   (2) suicide or attempted suicide, while sane; or
   (3) your commission of, or your attempt to commit, a felony, or to which a contributing cause was your being engaged in an illegal occupation; or
   (4) the use of medications, poisons, gases, fumes or other substances taken, absorbed, inhaled, ingested or injected. This does not include involuntary inhalation of poisonous gases; or
(5) war or any act of war, whether declared or undeclared; or
(6) bodily or mental infirmity, illness or disease; or
(7) infection, other than infection occurring simultaneously with, and as a direct and independent result of, the injury; or
(8) repetitive stress syndromes including but not limited to rotator cuff syndrome, bursitis, tendonitis, carpal tunnel syndrome, ulnar nerve syndrome, stress fractures, neuropathy, epicondylitis or neuritis; or
(9) medical or surgical treatment or diagnostic procedures including any resulting complications, or when the outcome is not as planned or expected, including claims of medical malpractice; or
(10) travel in or descent from any aircraft, except as a fare-paying passenger on a regularly scheduled commercial flight on a licensed passenger aircraft carrier; or
(11) participation in the following activities: scuba diving, bungee jumping, base jumping, hang gliding, sail gliding, parasailing, parakiting, or mountain climbing; or
(12) riding or driving in any motor-driven vehicle in a race, stunt show or speed test; or
(13) practicing for or participating in any semi-professional or professional competitive athletics.

5. The provision entitled **What is the policy interpretation right and authority?** under the **Additional Information** section of the certificate is deleted in its entirety.
This Certificate Endorsement is a part of the certificate of insurance describing the benefits available to you under Group Policy No. 76013, issued by Securian Life Insurance Company to Concordia Plan Services. This endorsement is subject to every term, condition, exclusion and provision of the certificate unless otherwise expressly provided for herein.

The following applies to you if you were a resident of the state of Texas at the time your coverage under this certificate became effective:

1. The following disclosure on the cover page is amended in its entirety and replaced with the following:

   **THIS CERTIFICATE IS NOT A MEDICARE SUPPLEMENT CONTRACT.** If you are eligible for Medicare, review the Guide to Health Insurance for people with Medicare available from us.

2. The definition of **child or children** under the **Definitions** section of the certificate is amended in its entirety and replaced with the following:

   **child or children**

   Your or your spouse’s natural, adopted, stepchild or foster child who is less than 26 years old. An adopted child includes a child legally placed for adoption with you. Eligibility begins at live birth (stillborn or unborn children are not eligible).

   Coverage for a child that reaches age 26 does not terminate while the child continues to be both:
   
   (1) incapable of self-sustaining employment by reason of a mental retardation or physical disability; and
   
   (2) chiefly dependent upon you for support and maintenance.

3. Item (1) under the provision entitled **Are there any other exclusions that apply?** under the **Exclusions and Limitations** section of the certificate is amended in its entirety and replaced with the following:

   (1) intentionally self-inflicted injury while sane; or

4. The provision entitled **When will the benefit be paid?** under the **Claims** section is amended in its entirety and replaced with the following:

   **When will the benefit be paid?**

   We will pay a benefit for a loss resulting from a covered accident not later than the 60th day after the date the proof of loss is received at our home office which meets all policy requirements and is satisfactory to us. You are responsible for all costs associated with claim form(s) completion, records, and the submission of your claim.

5. The provision entitled **Can this insurance be assigned?** under the **Additional Information** section of the certificate is amended in its entirety and replaced with the following:

   **Can this insurance be assigned?**

   Yes. However, we will not be bound by an assignment of the certificate or of any interest in it unless it is made as a written instrument, and you file the original instrument or a certified copy with us at our home office, and we send you an acknowledged copy. We are not responsible for the validity of any assignment. You are responsible for ensuring that the assignment is legal in your state and that it accomplishes your intended goals. If a claim is based on an assignment, we may require proof of interest of the claimant. A valid assignment will take precedence over any claim of a beneficiary.

   Secretary

   President
This Certificate Endorsement is a part of the certificate of insurance describing the benefits available to you under Group Policy No. 76013, issued by Securian Life Insurance Company to Concordia Plan Services. This endorsement is subject to every term, condition, exclusion and provision of the certificate unless otherwise expressly provided for herein.

The following applies to you if you were a resident of the state of Utah at the time your coverage under this certificate became effective:

1. The following notice is added to the cover page of the certificate:

**Notice to Buyer:** This is an accident only certificate and it does not pay benefits for loss from sickness. Review your certificate carefully.

2. The definition of **child or children** under the Definitions section of the certificate is amended in its entirety and replaced with the following:

   **child/children**

   Your or your spouse’s natural, adopted, stepchild, foster child, child in your or your spouse’s court-ordered custody, or child required to be covered due to a court or administrative order who is less than 26 years old. Coverage will continue in force through the last day of the month in which the child turns 26. An adopted child includes a child legally placed for adoption with you. Eligibility begins from the moment of birth (stillborn or unborn children are not eligible).

   The age limit does not apply to a child who is and continues to be both: (a) incapable of self-sustaining employment by reason of mental or physical impairment which can be expected to result in death, or which has lasted or can be expected to last for a continuous period of not less than 12 months; and (b) chiefly dependent on you for support and maintenance.

3. The definition of **physician** under the Definitions section of the certificate is amended in its entirety and replaced with the following:

   **physician**

   A medical doctor or other person recognized by law or regulation in the United States or United States territory, including a practitioner of the healing arts, where services are rendered as a physician. The person must be licensed as required by the United States jurisdiction where care is given and must be operating in the scope of his or her license.

   A physician cannot be a person who:

   (1) ordinarily resides in your household; or
   (2) is a family member.

4. The provision entitled **Burn Benefit** under the Injury Benefits section of the certificate is amended in its entirety and replaced with the following:

   **Burn Benefit**

   If an insured sustains a second or third degree burn in a covered accident, we will pay the appropriate amount shown on the specifications page based on the type of burn and the percentage of the body surface burned.

   The burn must be treated by a physician within 72 hours after the covered accident, or as soon as reasonably possible. If the burn meets more than one of the burn classifications shown on the specifications page, the amount we pay will be based on the burn classification that pays the highest benefit.

   We will pay the burn benefit no more than one time per insured per covered accident. No benefits are payable for sunburns or first degree burns.
5. The provision entitled **Concussion** under the **Injury Benefits** section of the certificate is amended in its entirety and replaced with the following:

**Concussion**

If an insured is injured in a covered accident and the injury causes a concussion, we will pay the amount shown on the specifications page. The insured must be treated by a physician within 72 hours of a covered accident, or as soon as reasonably possible, and the concussion must be diagnosed by a physician within 15 days of the covered accident.

Concussion refers to a disruption of brain function resulting from a traumatic blow to the head.

This benefit is limited to one payment per insured per covered accident per calendar year.

The concussion benefit is not payable if a traumatic brain injury benefit is payable under this certificate for the same accident.

6. The provision entitled **Lacerations** under the **Injury Benefits** section of the certificate is amended in its entirety and replaced with the following:

**Lacerations**

If an insured is injured in a covered accident and the injury results in a laceration, we will pay the appropriate amount shown on the specifications page based on the type of treatment provided.

The laceration must be treated by a physician within 72 hours after the covered accident, or as soon as reasonably possible. This benefit is limited to one payment per insured per covered accident. In no event will we pay more than one laceration benefit per calendar year.

7. The first paragraph of the **Paralysis** provision under the **Injury Benefits** section of the certificate is amended in its entirety and replaced with the following:

**Paralysis**

If an insured is injured in a covered accident and the injury causes paralysis which lasts more than 30 days we will pay the appropriate amount shown on the specifications page. Paralysis refers to the total, permanent, and irrevocable loss of movement. The paralysis must be diagnosed by a physician after the accident.

8. The provision entitled **Traumatic Brain Injury** under the **Injury Benefits** section of the certificate is amended in its entirety and replaced with the following:

**Traumatic Brain Injury**

If an insured is injured in a covered accident and the injury results in a traumatic brain injury, we will pay the amount shown on the specifications page.

Traumatic brain injury means only the following: intracranial hemorrhage, cerebral contusion or cerebral laceration.

The insured must be treated by a physician within 72 hours after the covered accident, or as soon as reasonably possible. The traumatic brain injury must be diagnosed within 30 days after the accident by computer tomography (CT) scan or magnetic resonance imaging (MRI). This benefit is payable only once per insured per covered accident. Scalp hematomas and scalp lacerations are not covered under this benefit.

9. The provision entitled **Ambulance** under the **Emergency Care** section of the certificate is amended in its entirety and replaced with the following:

**Ambulance**

If an insured is injured in a covered accident and requires transportation to a hospital (or between hospitals) we will pay the appropriate ambulance benefit shown on the specifications page. Ground or water transportation must be provided by a licensed professional ambulance service within 90 days of the covered accident, or as soon as reasonably possible. Air transportation must be provided by a licensed professional ambulance service within 72 hours, or as soon as reasonably possible. This benefit is limited to one payment per insured per covered accident. If an insured requires more than one ambulance transport, the highest benefit amount will be paid.
Ambulance means any publicly or privately owned surface, water or air vehicle, including a helicopter that is specifically designed and constructed or modified and equipped to be used, maintained or operated primarily for the transportation of individuals who are sick, injured or wounded.

Ambulance does not include a surface, water or air vehicle that is owned and operated to accommodate an incapacitated or disabled person who does not require medical monitoring, care or treatment during transport.

10. The provision entitled **Emergency Room Treatment** under the **Emergency Care** section of the certificate is amended in its entirety and replaced with the following:

**Emergency Room Treatment**

If an insured is injured in a covered accident and requires treatment in an emergency room, we will pay the emergency room treatment benefit shown on the specifications page. Treatment must occur within 72 hours of the covered accident, or as soon as reasonably possible.

This benefit is limited to one payment per insured per covered accident.

11. The provision entitled **Initial Physician’s Office Visit** under the **Emergency Care** section of the certificate is amended in its entirety and replaced with the following:

**Initial Physician’s Office Visit**

If an insured is injured in a covered accident, we will pay the initial physician’s office visit benefit shown on the specifications page.

Benefits are payable for the initial treatment received in a physician’s office or an urgent care center for injuries resulting from a covered accident. Treatment must occur within 72 hours of the covered accident, or as soon as reasonably possible. The maximum number of benefits per insured per calendar year is two. The benefit is not payable if the insured receives care in an emergency room within the same 72 hour period. Only one benefit is payable per covered accident.

12. The provision entitled **Abdominal or Pelvic Surgery** under the **Surgery Benefits** section of the certificate is amended in its entirety and replaced with the following:

**Abdominal or Pelvic Surgery**

If an insured is injured in a covered accident and requires abdominal or pelvic surgery to treat the injuries, we will pay the abdominal or pelvic surgery benefit shown on the specifications page. The surgery must be performed within 72 hours of the covered accident, or as soon as reasonably possible. This benefit is limited to one payment per insured per covered accident. Surgery required to treat a fracture or dislocation is payable under the fracture or dislocation benefit and is not covered under the abdominal or pelvic surgery benefit.

13. The provision entitled **Cranial Surgery** under the **Surgery Benefits** section of the certificate is amended in its entirety and replaced with the following:

**Cranial Surgery**

If an insured is injured in a covered accident and requires cranial surgery to treat the injuries, we will pay the cranial surgery benefit shown on the specifications page. The surgery must be performed within 72 hours of the covered accident, or as soon as reasonably possible. This benefit is limited to one payment per insured per covered accident. Surgery required to treat a skull fracture is payable under the fracture benefit and is not covered under the cranial surgery benefit.
14. The provision entitled **Thoracic Surgery** under the **Surgery Benefits** section of the certificate is amended in its entirety and replaced with the following:

**Thoracic Surgery**

If an insured is injured in a covered accident and requires thoracic surgery to treat the injuries, we will pay the thoracic surgery benefit shown on the specifications page. The surgery must be performed within 72 hours of the covered accident, or as soon as reasonably possible. This benefit is limited to one payment per insured per covered accident.

Surgery required to treat a fracture or dislocation is payable under the fracture or dislocation benefit and is not covered under the thoracic surgery benefit.

15. The provision entitled **Are there any other exclusions that apply?** under the **Exclusions** section of the certificate is amended in its entirety and replaced with the following:

**Are there any other exclusions that apply?**

Yes. In no event will we pay benefits where the insured’s accident, injury or loss is caused directly by, any of the following:

(1) intentionally self-inflicted injury while sane; or
(2) suicide or attempted suicide, while sane; or
(3) your voluntary participation in a felony; or
(4) your being intoxicated; or
(5) your being under the influence of narcotics, unless administered on the advice of a licensed physician; or
(6) the use of poisons, gases, fumes or illegal drugs taken, absorbed, inhaled, ingested or injected; or
(7) motor vehicle collision or accident where you are the operator of the motor vehicle and your blood alcohol level meets or exceeds the level at which intoxication is defined in the state where the collision or accident occurred, regardless of any legal proceedings thereto; or
(8) war or any act of war, whether declared or undeclared; or
(9) bodily or mental infirmity, illness or disease; or
(10) infection, other than infection occurring simultaneously with, and as a direct and independent result of, the injury; or
(11) repetitive stress syndromes including but not limited to rotator cuff syndrome, bursitis, tendonitis, carpal tunnel syndrome, ulnar nerve syndrome, stress fractures, neuropathy, epicondylitis or neuritis; or
(12) travel in or descent from any aircraft, except as a fare-paying passenger on a regularly scheduled commercial flight on a licensed passenger aircraft carrier; or
(13) participation in the following activities: scuba diving, bungee jumping, base jumping, hang gliding, sail gliding, parasailing, parakiting, or mountain climbing; or
(14) riding or driving in any motor-driven vehicle in a race, stunt show or speed test; or
(15) practicing for or participating in any semi-professional or professional competitive athletics.

16. The provision entitled **When is proof of a loss resulting from a covered accident required?** under the **Claims** section of the certificate is amended in its entirety and replaced with the following:

**When is proof of a loss resulting from a covered accident required?**

Written proof of a loss resulting from a covered accident satisfactory to us must be provided to us within 90 days of the date of the loss. Failure to provide proof of the loss within this time will not invalidate or reduce a claim if it was not reasonably possible to provide proof within this 90 day period. Failure to give notice or file proof of loss as required does not bar recovery under this certificate if we fail to show we were prejudiced by the failure.

17. The provision entitled **When does an insured dependent’s coverage terminate?** under the **Termination** section of the certificate is amended in its entirety and replaced with the following:

**When does an insured dependent’s coverage terminate?**

An insured dependent's coverage ends on the earliest of the following:
(1) the last day for which premium contributions have been paid following the date the dependent no longer meets the eligibility requirements; or
(2) 31 days (the grace period) after the due date of any premium contribution which is not paid; or
(3) the last day for which premium contributions have been paid following your written request that insurance on your eligible dependents be terminated; or
(4) the date you are no longer covered under the group policy.

You must notify us or your employer when you no longer have dependents eligible for coverage under this certificate so that premiums may be discontinued. All premiums paid for dependents who are no longer eligible for coverage under this certificate will be refunded without any payment of claim.

[Signature]
Secretary

[Signature]
President
This Certificate Endorsement is a part of the certificate of insurance describing the benefits available to you under Group Policy No. 76013, issued by Securian Life Insurance Company to Concordia Plan Services. This endorsement is subject to every term, condition, exclusion and provision of the certificate unless otherwise expressly provided for herein.

The following applies to you if you were a resident of the state of **West Virginia** at the time your coverage under this certificate became effective:

1. The face page of the Group Accident Certificate of Insurance is amended to include the following:

   **This is an accident-only certificate, and it does not pay benefits for loss from sickness.**

   **THIS PRODUCT PROVIDES LIMITED BENEFITS. THIS IS NOT MAJOR MEDICAL OR COMPREHENSIVE HEALTH INSURANCE. THIS PRODUCT DOES NOT PROVIDE THE MINIMUM ESSENTIAL COVERAGE NECESSARY TO AVOID PENALTY UNDER THE AFFORDABLE CARE ACT OF 2010 (ACA).**

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**Secretary**

**President**
This Certificate Endorsement is a part of the certificate of insurance describing the benefits available to you under Group Policy No. 76013, issued by Securian Life Insurance Company to Concordia Plan Services. This endorsement is subject to every term, condition, exclusion and provision of the certificate unless otherwise expressly provided for herein.

The following applies to you if you were a resident of the state of Wisconsin at the time your coverage under this certificate became effective:

1. The provision entitled **When is proof of a loss resulting from a covered accident required?** in the Claims section is amended in its entirety and replaced with the following:

   **When is proof of a loss resulting from a covered accident required?**

   Written proof of a loss resulting from a covered accident satisfactory to us must be provided to us within 90 days of the date of the loss. Failure to provide proof of the loss within this time will not invalidate or reduce a claim if it was not reasonably possible to provide proof within this 90 day period. However, proof must be provided within 1 year of the date it is otherwise required, except in the absence of legal capacity.

2. The provision entitled **When will the benefit be paid?** in the Claims section is amended in its entirety and replaced with the following:

   **When will the benefit be paid?**

   We will pay a benefit for a loss resulting from a covered accident within 30 days after receipt at our home office of written proof of the loss which meets all policy requirements and is satisfactory to us. If the benefit is not paid within the 30 day period, then we shall pay interest on the benefit from the date of the loss to the date when the benefit is paid at a rate of 12% per annum. You are responsible for all costs associated with claim form(s) completion, records, and the submission of your claim.

3. The Additional Information section is amended to add the following provision:

   **GRIEVANCE PROCEDURES**

   The following grievance procedures are available.

   **INTERNAL GRIEVANCE**

   You or your authorized representative may submit a grievance in writing to us at our home office. You also have the right to appear in person before our grievance panel to present written or oral information. We will mail a written acknowledgement of the grievance within 5 business days of its receipt in our home office. If the person requesting the review elects to appear in person, we will provide written notification of the time and place of the grievance meeting at least 7 calendar days before the meeting. We will also allow reasonable accommodations to allow the person to participate in the meeting. Our grievance panel will be made up of at least one person authorized to take corrective action on the grievance and may consult with the person who made the initial determination.

   We will resolve a grievance within 30 calendar days after its receipt in our home office. The grievance panel's decision will contain the disposition of the claim and any corrective action taken on the grievance. It will be signed by one voting member of the panel and include a written description of position titles of panel members involved in making the decision. If we are unable to resolve the grievance, we may extend the time another 30 calendar days. If extended, we will provide you or your authorized representative with a notice explaining that we have not resolved the grievance, when the resolution of the grievance may be expected and the reason additional time is needed.
INDEPENDENT REVIEW

You or your authorized representative may request an independent review of any adverse determination. You must request an independent review within four (4) months after we have reviewed the internal grievance and determined no further benefits are payable. You must exhaust the internal grievance before he or she may request an independent review. You are not required to exhaust the internal grievance before requesting an independent review if we and you agree that the matter may proceed directly to independent review. This may also apply if, along with the request for the independent review, you submit to the independent review organization selected, a request to bypass the internal grievance. If the independent review organization determines that your health condition is such that requiring you to use the internal grievance before proceeding to independent review would jeopardize your life or health or your ability to regain maximum function, they may waive the internal grievance. When the denial is made, we will provide you with information on how to request a review and the time within which the review must be requested. This information will include a current listing of certified independent review organizations from which you or your representative may choose from. You must submit your choice to us in writing along with a $25.00 check made payable to the independent review organization. Once we have received this request, we have five (5) business days to notify the commissioner of insurance and the independent review organization chosen. We will also send the following information to the independent review organization: any information submitted to us by you or your authorized representative in support of your position under the internal grievance; the contract provisions of our Group Critical Illness insurance; and any other relevant documents or information used by us in the internal grievance determination. The independent review organization has five (5) business days after receiving our information to request additional information from us. If requested, we must provide them with the information requested or an explanation of why the information is not being submitted within five (5) business days. The independent review organization has thirty (30) days to make a decision. They will send a copy of their decision to us and their decision is binding on both you and us.

EXPEDITED REVIEW

If the independent review organization determines that your health condition is such that the above steps would jeopardize your life or health or your ability to regain maximum function, the above procedures would apply with the following exceptions:

1. Once we have received the request for an independent review, we have (1) business day to notify the commissioner of insurance and the independent review organization chosen.

2. The independent review organization has two (2) business days after receiving our information to request additional information from us. If requested, we must provide them with the information requested or an explanation of why the information is not being submitted within two (2) business days.

3. The independent review organization has seventy-two (72) hours to make a decision. They will send a copy of their decision to us. Their decision is binding on both you and us.

DEFINITIONS

For the purposes of the above provisions, the following definitions apply.

adverse determination

A determination by us based on the information provided, where we denied payment of the claim.
**expedited grievance**

A grievance where:

1. the duration of the standard grievance resolution process will result in serious jeopardy to your life or health or your ability to regain maximum function; and

2. in the opinion of a physician with knowledge of your medical condition, you are subject to severe pain that cannot be adequately managed without the care or treatment that is the subject of the grievance; and

3. a physician with knowledge of your medical condition determines that the grievance shall be treated as an expedited grievance.

**grievance**

Any dissatisfaction with the provision of services or claims practices that is expressed in writing to us by, or on behalf of, you.

**independent review**

A review conducted by a certified independent review organization. The organization is certified by the Wisconsin Office of the Commissioner of Insurance.

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Signature: Secretary

Signature: President
NOTICE OF PROTECTION PROVIDED BY
ALASKA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This Notice provides a brief summary of the Alaska Life and Health Insurance Guaranty Association (Association) and the protection it provides for policyholders. This safety net was created under Alaska law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity, or health insurance company becomes financially unable to meet its obligations and is taken over by its insurance regulatory agency. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Alaska law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are:

Life Insurance
- $300,000 in death benefits
- $100,000 in net cash surrender or net cash withdrawal values

Health Insurance
- $500,000 in hospital, medical and surgical insurance benefits
- $300,000 for disability insurance and long-term care insurance
- $100,000 in other types of health insurance benefits

Annuities
- $250,000 in present value of annuity benefits including net cash surrender and net cash withdrawal values
- $5,000,000 for covered unallocated annuities that fund other plans

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000. Special rules may apply with regard to hospital, medical, and surgical insurance benefits.

The protections listed above apply only to the extent that benefits are payable under covered policy(s). In no event will the Association provide benefits greater than those given in the life, annuity, or health insurance policy or contract.

NOTE: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Alaska law.

A written complaint to allege violation of any provision of the Alaska Life and Health Insurance Guaranty Association Act must be filed with the Alaska Division of Insurance, 550 West Seventh Avenue, Suite 1560, Anchorage, Alaska, 99501-3567; telephone (907) 269-7900. Financial information for an insurance company, if the insurance information is not proprietary, is available at the same address and telephone number. The Association should not be contacted regarding the financial information of an insurance company.

To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website at www.aklifega.org, or contact:

Alaska Life and Health Insurance Guaranty Association
1007 West Third Avenue, Suite 400
Anchorage, AK 99501
(907) 243-2311

Alaska Division of Insurance
550 West Seventh Avenue, Suite 1560
Anchorage, AK 99501-3567
(907) 269-7900

Insurance companies and agents are not allowed by Alaska law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Alaska law, then Alaska law will control.
This notice is to advise you that should any questions arise regarding this insurance, you may contact the following:

Securian Life Insurance Company
Group Division
400 Robert Street North
St. Paul, Minnesota 55101-2098
TEL: 651-665-3500

If we at Securian Life Insurance Company fail to provide you with reasonable and adequate service, you should feel free to contact:

Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, Arkansas 72201-1904
TEL: (501) 371-2640
Toll-Free: (800) 852-5494
Residents of this state who purchase life insurance, annuities or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain 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 policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member 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 insurance companies that are well managed and financially stable.

DISCLAIMER

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") 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 this state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide you with 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 Arkansas Life and Health Insurance Guaranty Association

c/o The Liquidation Division
1023 West Capitol
Little Rock, AR 72201

Arkansas Insurance Department

1200 West Third Street
Little Rock, AR 72201-1904

The state law that provides for this safety-net coverage is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"). Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the Act; 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 Guaranty Association if they live in this state and hold a life, annuity or health insurance contract or policy, or if they are insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons owning such policies are NOT protected by the Guaranty 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 or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

• Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
• Any policy of reinsurance (unless an assumption certificate was issued);
• Interest rate yields that exceed an average rate;
• Dividends and voting rights and experience rating credits;
• Credits given in connection with the administration of a policy by 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);
• Unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC") (whether the FPBC is yet liable or not);
• Portions of an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution;
• Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal Law;
• Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
• Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliate benefit plan or its trustees).

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover. The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of $300,000 in life and annuity benefits and $500,000 in health insurance benefits - no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within these overall limits, the Association will not pay more than $300,000 in disability and long term care benefits, $500,000 in health insurance benefits, $300,000 in present value of annuity benefits, or $300,000 in life insurance death benefits or net cash surrender values - again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a $1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.
SUMMARY OF THE LIFE AND HEALTH INSURANCE PROTECTION ASSOCIATION ACT AND NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS

INTRODUCTION

Residents of Colorado 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 Life and Health Insurance Protection 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 Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in Colorado and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Association is limited, however. 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.

IMPORTANT DISCLAIMER

The Life and Health Insurance Protection Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require residency in Colorado. You should not rely on coverage by the Life and Health Insurance Protection 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.

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 Association to induce you to purchase any kind of insurance policy.

This Information is Provided By:

<table>
<thead>
<tr>
<th>Life and Health Insurance Protection Association</th>
<th>Colorado Division of Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>P.O. Box 36009</td>
<td>1560 Broadway, Suite 850</td>
</tr>
<tr>
<td>Denver, Colorado 80236</td>
<td>Denver, Colorado 80202</td>
</tr>
<tr>
<td>(303) 292-5022</td>
<td>(303) 894-7499</td>
</tr>
</tbody>
</table>

SUMMARY

The state law that provides for this safety-net coverage is called the Life and Health Insurance Protection Association Act. Below 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 Association.

COVERAGE

Generally, individuals will be protected by the Life and Health Insurance Protection Association if they live in this state and hold a life or health insurance contract, or an annuity, or if they hold certificates under a group life or health insurance contract or annuity, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state. Certain parties to structured settlement annuity contracts may be entitled to coverage benefits as well based on defined circumstances.

EXCLUSIONS FROM COVERAGE

Persons holding such policies or contracts are not protected by this Association if:

- they are not residents of the State of Colorado, except under certain very specific circumstances;
- the insurer was not authorized or licensed to do business in Colorado at the time the policy or contract was issued;
their policy was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, 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;
- any policy of reinsurance (unless an assumption certificate was issued);
- plans of employers, associations or similar entities to the extent they are self-funded or uninsured (that is, not insured by an insurance company, even if an insurance company administers them);
- interest rate yields, crediting rate yields or other factors employed in calculating returns, including but not limited to indexes or other external references stated in the policy or contract, that exceed an average rate specified in the Association Act;
- dividends;
- experience rating credits;
- credits given in connection with the administration of a policy or contract;
- any unallocated annuity;
- annuity contracts or group annuity certificates used by nonprofit insurance companies to provide retirement benefits for nonprofit educational institutions and their employees;
- policies, contracts, certificates or subscriber agreements issued by a prepaid dental care plan;
- sickness and accident insurance when written by a property and casualty insurer as part of an automobile insurance contract;
- unallocated annuity contracts issued to an employee benefit plan protected under the federal Pension Benefit Guaranty Corporation;
- policies or contracts issued by an insurer which was insolvent or unable to fulfill its contractual obligations as of July 1, 1991, except for annuity contracts issued by a member insurer which was placed into liquidation between July 1, 1991, and August 31, 1991;
- policies or contracts covering persons who are not citizens of the United States;
- any kind of insurance or annuity, the benefits of which are exclusively payable or determined by a separate account required by the terms of such insurance policy or annuity maintained by the insurer or by a separate entity.

**LIMITS ON AMOUNT OF COVERAGE**

The act also limits the amount the Association is obligated to pay out. The Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, no matter how many policies or contracts were issued by the same company, even if such contracts provided different types of coverages, the Association will pay a maximum of:

- $300,000 in net life insurance death benefits and no more than $100,000 in net cash surrender and net cash withdrawal values for life insurance;
- for health insurance benefits - $100,000 for coverages not defined as disability, basic hospital, medical and surgical; or major medical insurance, including any net cash surrender and net cash withdrawal values; $300,000 for disability insurance; or $500,000 for basic hospital, medical and surgical, or major medical insurance;
- $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values; or with respect to each payee of a structured settlement annuity, $250,000 in present value annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values; or
- $300,000 in long-term care benefits.

The Association shall not be liable to expend more than $300,000 in the aggregate, with respect to any one life except that with respect to benefits for basic hospital, medical and surgical and major medical insurance, the aggregate liability of the Association shall not exceed $500,000 with respect to any one individual.
Residents of the District of Columbia should know that licensed insurers who sell health insurance, life insurance, and annuities in the District of Columbia are members of the District of Columbia Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of the Guaranty Association is to provide statutorily-determined benefits associated with covered policies and contracts in the unlikely event that a member insurer is unable to meet its financial obligations and is found by a court of law to be insolvent. When a member insurer is found by a court to be insolvent, the Guaranty Association will assess the other member insurers to satisfy the benefits associated with any outstanding covered claims of persons residing in the District of Columbia. However, the protection provided through the Guaranty Association is subjected to certain statutory limits explained under "Coverage Limitations" section, below. In some cases, the Guaranty Association may facilitate the reassignment of policies or contracts to other licensed insurance companies to keep the coverage in-force, with no change in contractual rights or benefits.

**COVERAGE**


The insolvency protections provided by the Guaranty Association is generally conditioned on a person being 1) a resident of the District of Columbia and 2) the individual insured or owner under a health insurance, life insurance, or annuity contract issued by a member insurer, or insured under a group policy insurance contract issued by a member insurer. Beneficiaries, payees, or assignees of District insureds are also covered under the Act, even if they reside in another state.

**COVERAGE LIMITATIONS**

The Act also limits the amount the Guaranty Association is obligated to pay. The benefits for which the Guaranty Association may become liable shall be limited to the lesser of:

- The contractual obligations for which the insurer is liable or for which the insurer would have been liable if it were not an impaired or insolvent insurer; or

- With respect to any one life, regardless of the number of policies, contracts, or certificates:
  - $300,000 in life insurance death benefits for any one life; including net cash surrender or net cash withdrawal values;
  - $300,000 in the present value of annuity benefits, including net cash surrender or net cash withdrawal values;
  - $300,000 in the present value of structured settlement annuity benefits, including net cash surrender or net cash withdrawal values;
  - $300,000 for long-term care insurance benefits;
  - $300,000 for disability insurance benefits;
  - $500,000 for basic hospital, medical and surgical insurance, or major medical insurance benefits;
  - $100,000 for coverage not defined as disability insurance or basic hospital, medical and surgical insurance or major medical insurance or long term care insurance including any net cash surrender and net cash withdrawal values.
In no event is the Guaranty Association liable for more than $300,000 in benefits with respect to any one life ($500,000 in the event of basic hospital, medical and surgical insurance or major medical insurance).

Additionally, the Guaranty Association is not obligated to cover more than $5,000,000 for multiple non-group policies of life insurance with one owner of regardless of the number of policies owned.

**EXCLUSIONS FROM COVERAGE**

Policy or contract holders are not protected by this Guaranty 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 law protects insureds who live outside of that state); or
- their insurer was not authorized to do business in the District of Columbia; or
- their policy was issued by a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, a non-profit hospital or medical service organization, a health maintenance organization, or a risk retention group.

The Guaranty 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;
- any policy of reinsurance (unless an assumption certificate was issued);
- any plan or program of an employer or association that provides life, health, or annuity benefits to its employees or members and is self-funded;
- interest rate guarantees which exceed certain statutory limitations;
- dividends, experience rating credits, or fees for services in connection with a policy;
- credits given in connection with the administration of a policy by a group contract holder, or
- unallocated annuity contracts.

**CONSUMER PROTECTION**

To learn more about the above referenced protections, please visit the Guaranty Association’s website at www.dclifcga.org. Additional questions may be directed to the District of Columbia Department of Insurance, Securities and Banking (DISB) and they will respond to questions not specifically addressed in this disclosure document.

Policy or contract holders with additional questions may contact either:

**District of Columbia**
Department of Insurance, Securities and Banking
1050 First Street, N.E., Suite 801
Washington, DC  20002
(202) 727-8000

**District of Columbia**
Life and Health Guaranty Association
1200 G Street, N.W.
Washington, DC  20005
(202) 434-8771

Pursuant to the Act (D.C. Official Code § 31-5416), insurers are required to provide notice to policy and contract holders of the existence of the Guaranty Association and the amounts of coverage provided under the Act. Your insurer and agent are prohibited by law from using the existence of the Guaranty Association and the protection it provides to market insurance products. You should not rely on the insolvency protection provided under the Act when selecting an insurer or insurance product. If you have obtained this document from an agent in connection with the purchase of a policy or contract, you should be aware that such delivery does not guarantee that the Guaranty Association would cover your policy or contract. Any determination of whether a policy or contract will be covered will be determined solely by the coverage provisions of the Act.

This disclosure is intended to summarize the general purpose of the Act and does not address all the provisions of the Act. Moreover, the disclosure is not intended and should not be relied upon to alter any rights established in any policy or contract or under the Act.
If you have any questions regarding your coverage, or if you need assistance in resolving a complaint, you can contact us at:

Securian Life Insurance Company
400 Robert Street North
St. Paul, Minnesota  55101-2098

Telephone Number: 651-665-3500
Business hours 7am - 5pm Central Time Monday - Friday
Residents of Hawaii who purchase life insurance, annuities or disability insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Hawaii Life and Disability 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 Hawaii Life and Disability Insurance Guaranty Association 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 Hawaii. You should not rely on coverage by the Hawaii Life and Disability 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 Hawaii Life and Disability Insurance Guaranty Association
1132 Bishop Street, Suite 1590
Honolulu, Hawaii 96813

Department of Commerce & Consumer Affairs
Insurance Division
P.O. Box 3614
Honolulu, Hawaii 96811

The state law that provides for this safety-net coverage is called the Hawaii Life and Disability 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.
EXCLUSIONS FROM COVERAGE

Generally, individuals will be protected by the Hawaii Life and Disability Insurance Guaranty Association if they live in this state and hold a life or disability 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 the Guaranty 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); or

• the insurer was not a member insurer of the Guaranty Association. A nonprofit hospital or medical service organization (the "Blues"), an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or an insurance exchange are examples of nonmember insurers.

The Guaranty 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 an average rate;

• dividends;

• credits given in connection with the administration of a policy by 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).

LIMITS ON AMOUNT OF COVERAGE

The act limits the amount the Guaranty Association is obligated to pay out. The basic protections provided by the Association are:

• Life Insurance
  • $300,000 in death benefits
  • $100,000 in cash surrender or withdrawal values

• Health Insurance
  • $500,000 in hospital, medical and surgical insurance benefits
  • $300,000 in disability insurance benefits
  • $300,000 in long-term care insurance benefits
  • $100,000 in other types of health insurance benefits

• Annuities
  • $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000. Special rules may apply with regard to hospital, medical and surgical insurance benefits and with regard to one owner or multiple non-group policies of life insurance.
NOTICE OF PROTECTION PROVIDED BY
IOWA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a brief summary of the Iowa Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Iowa law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Iowa law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are:

- **Life Insurance**
  - $300,000 in death benefits
  - $100,000 in cash surrender and withdrawal values

- **Health Insurance**
  - $500,000 in basic hospital, medical-surgical or major medical insurance benefits
  - $300,000 in disability income protection insurance benefits
  - $300,000 in long-term care insurance benefits
  - $100,000 in other types of health insurance benefits

- **Annuities**
  - $250,000 in annuity benefits, cash surrender and withdrawal values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $350,000. Special rules may apply with regard to hospital, medical-surgical and major medical insurance benefits.

**NOTE:** Certain policies and contracts may not be covered or fully covered. If coverage is available, it will be subject to substantial limitations and exclusions. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements under Iowa law.

To learn more about the Association and the protections it provides, as well as those relating to group contracts or retirement plans, please visit the Association’s website at [www.iailfega.org](http://www.iailfega.org), or contact:

**Iowa Life and Health Insurance Guaranty Association**
700 Walnut Street, Suite 1600
Des Moines, IA 50309
(515) 248-5712

**Iowa Insurance Division**
330 Maple Street
Des Moines, IA 50319
(515) 281-5705

Information about the financial condition of insurers is available from a variety of sources, including financial rating agencies such as AM Best Company, Fitch Inc., Moody’s Investors Service, Inc., and Standard & Poor’s. That information may be accessed from the “Helpful Links & Information” page located on the website of the Iowa Insurance Division at [www.iid.state.ia.us](http://www.iid.state.ia.us).
The Association is subject to supervision and regulation by the Commissioner of the Iowa Insurance Division. Persons who desire to file a complaint to allege a violation of the laws governing the Association may contact the Iowa Insurance Division. State law provides that any suit against the Association shall be brought in the Iowa District Court in Polk County, Iowa.

Insurance companies and agents are not allowed by Iowa law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Iowa law, then Iowa law will control.
This notice is to advise you that should any complaints arise regarding this Insurance, you may contact the following:

Securian Life Insurance Company
400 Robert Street North
St. Paul, Minnesota 55101-2098
TEL: 651-665-3500

OR

Part 919 of the Rules of the Illinois Department of Insurance requires that our company advise you that, if you wish to take this matter up with the Illinois Department of Insurance, it maintains a Consumer Division in Chicago at 122 S. Michigan Ave., 19th Floor, Chicago, Illinois 60603 and in Springfield at 320 West Washington Street, Springfield, Illinois 62767.

You may also contact the Illinois Department of Insurance at http://insurance.illinois.gov/ 312-814-2420 or 217-782-4515.
This notice is required by the Illinois Religious Freedom Protection and Civil Union Act ("the Act"). Effective June 1, 2011 Securian Life Insurance Company is required to comply with the Act. We have implemented policies and procedures to comply with the Act.

You should be aware that the Act:

- Creates a legal relationship between two persons of the same or opposite sex who form a civil union. According to the Act, parties to a civil union are entitled to the same legal obligations, responsibilities, protections and benefits that are afforded or recognized by laws of Illinois to spouses.

- Provides that a party to a civil union shall be included in any definition or use of the terms "spouse," "family," "immediate family," "dependent," "next of kin," and other terms descriptive of spousal relationships as those terms are used throughout Illinois law. This includes the terms “marriage” or “married” or variations thereon.

- Requires recognition of civil unions or same sex civil unions or marriages legally entered into in other jurisdictions.

- Does not alter any current federal law.

For more information about existing Illinois law and the Act, please refer to the Consumer Fact Sheet available at the Illinois Department of Insurance website at [www.insurance.illinois.gov](http://www.insurance.illinois.gov).
GENERAL PURPOSES AND LIMITATIONS OF THE
KANSAS LIFE AND HEALTH
INSURANCE GUARANTY ASSOCIATION
K.S.A. 40-3001 et. seq

DISCLAIMER

THE KANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION MAY NOT PROVIDE COVERAGE FOR ALL OR A PORTION OF THIS POLICY. IF COVERAGE IS PROVIDED IT MAY BE SUBJECT TO SUBSTANTIAL LIMITATIONS OR EXCLUSIONS, AND IS CONDITIONED UPON RESIDENCY IN THIS STATE. THEREFORE YOU SHOULD NOT RELY UPON COVERAGE BY THE KANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION IN SELECTING AN INSURANCE COMPANY OR IN SELECTING AN INSURANCE POLICY. INSURANCE COMPANIES AND THEIR AGENTS ARE PROHIBITED BY LAW FROM USING THE EXISTENCE OF THE KANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION IN SELLING YOU ANY FORM OF AN INSURANCE POLICY, OR TO INDUCE YOU TO PURCHASE ANY FORM OF AN INSURANCE POLICY. EITHER THE KANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION OR THE KANSAS INSURANCE DEPARTMENT WILL RESPOND TO ANY QUESTIONS YOU MAY HAVE REGARDING THIS DOCUMENT.

KANSAS LIFE AND HEALTH
INSURANCE GUARANTY ASSOCIATION
2909 SW Maupin Lane
Topeka, KS  66614-5335

KANSAS INSURANCE DEPARTMENT
420 Southwest Ninth Street
Topeka, KS  66612-1678

This is a brief summary of the Kansas Life and Health Guaranty Association ("Association") and the protection it provides for policyholders. If there is any inconsistency between this notice and Kansas law, then Kansas law will control.

The Association was established to provide protection in the unlikely event that your life, annuity, or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Kansas law, with funding from assessments paid by other insurance companies. This safety net was created under Kansas law, which determines who and what is covered and the amounts of coverage. The basic protections provided by the Association are:

**Life Insurance**
- $300,000 in death benefits
- $100,000 in cash surrender or withdrawal values

**Health Insurance**
- $500,000 in hospital, medical and surgical insurance benefits
- $300,000 in disability insurance benefits
- $300,000 in long-term care insurance benefits
- $100,000 in other types of health insurance benefits

**Annuities**
- $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000. Special rules may apply with regard to hospital, medical and surgical insurance benefits, as well as certain aggregate limits.
NOTICE OF PROTECTION PROVIDED BY
MARYLAND LIFE AND HEALTH INSURANCE GUARANTY CORPORATION

This Notice provides a brief summary of the Maryland Life and Health Guaranty Corporation (the Corporation) and the protection it provides for policyholders. This safety net was created under Maryland law, which determines who and what is covered and the amount of coverage.

The Corporation is not a department or unit of the State of Maryland and the liabilities or debts of the Life and Health Insurance Guaranty Corporation are not liabilities or debts of the State or Maryland.

The Corporation was established to provide protection in the unlikely event that your life, annuity, or health insurance company becomes financially unable to meet its obligations and is taken over by its insurance department. If this should happen, the Corporation will typically arrange to continue coverage and pay claims, in accordance with Maryland law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Corporations are:

Life Insurance
- $300,000 in death benefits
- $100,000 in cash surrender or withdrawal values

Health Insurance
- $300,000 in health insurance benefits, including net cash surrenders and net cash withdrawal values
- $500,000 for basic hospital, medical, and surgical insurance or major medical insurance provided by health benefit plans
- $300,000 for disability insurance
- $300,000 for long-term care insurance
- $100,000 for a type of health insurance not listed above, including any net cash surrender and net cash withdrawal values under the types of health insurance listed above

Annuities
- $250,000 in the present value of annuity benefits, including net cash withdrawal values and net cash surrender values
- With respect to each payee under a structured settlement annuity, or beneficiary of the payee, $250,000 in present value annuity benefits, in the aggregate, including any net cash surrender and net cash withdrawal values.

The maximum amount of protection for each individual, regardless of the number of policies or contracts is:
- $300,000 in aggregate for all types of coverage listed above, with the exception of basic hospital, medical, and surgical insurance or major medical insurance
- $500,000 in aggregate for basic hospital, medical, and surgical insurance or major medical insurance

NOTE: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Maryland law.

To learn more about the above protections, please visit the Corporation's website at www.mdlifega.org, or contact:

Maryland Life and Health Insurance Guaranty Corporation
8817 Belair Road, Suite 208
Perry Hall, Maryland 21236
410-248-0407

Maryland Insurance Administration
200 St. Paul Place, Suite 2700
Baltimore, Maryland 21202
1-800-492-6116, ext. 2170

Insurance companies and agents are not allowed by Maryland law to use the existence of the Corporation or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Corporation coverage. If there is any inconsistency between this notice and Maryland law, then Maryland law will control.

THERESE M. GOLDSMITH
Insurance Commissioner
NOTICE CONCERNING POLICYHOLDER RIGHTS IN AN
INSOLVENCY UNDER THE MINNESOTA LIFE AND HEALTH
INSURANCE GUARANTY ASSOCIATION LAW

If the insurer who issued your life insurance, annuity or health insurance policy becomes impaired or insolvent, you are entitled to compensation for your policy from the assets of that insurer. The amount you recover will depend on the financial condition of the insurer.

In addition, residents of Minnesota who purchase life insurance, annuities or health insurance from insurance companies authorized to do business in Minnesota are protected, SUBJECT TO LIMITS AND EXCLUSIONS, in the event the insurer becomes financially impaired or insolvent. This protection is provided by the Minnesota Life and Health Insurance Guaranty Association.

The maximum amount the Guaranty Association will pay for all policies issued on one life by the same insurer is limited to $500,000. Subject to this $500,000 limit, the Guaranty Association will pay up to $500,000 in life insurance death benefits, but not more than $130,000 in net cash surrender and net cash withdrawal values for life insurance, $500,000 in health insurance benefits including any net cash surrender and net cash withdrawal values, $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values, $410,000 in present value of annuity benefits for annuities which are part of a structured settlement or for annuities in regard to which periodic annuity benefits, for a period of not less than the annuitant's lifetime or for a period certain of not less than ten years, have begun to be paid on or before the date of impairment or insolvency, or if no coverage limit has been specified for a covered policy or benefit, the coverage limit shall be $500,000 in present value. Unallocated annuity contracts issued to retirement plans, other than defined benefit plans, established under Section 401, 403(b) or 457 of the Internal Revenue Code of 1986, as amended through December 31, 1992, are covered up to $250,000 in net cash surrender and net cash withdrawal values, for Minnesota residents covered by the plan. If total claims exceed $10,000,000, the $10,000,000 shall be prorated among all claimants. These are the maximum claim amounts. Coverage by the Guaranty Association is also subject to other substantial limitations and exclusions and requires continued residency in Minnesota.

THE COVERAGE PROVIDED BY THE GUARANTY ASSOCIATION IS NOT A SUBSTITUTE FOR USING CARE IN SELECTING INSURANCE COMPANIES THAT ARE WELL MANAGED AND FINANCIALLY STABLE. IN SELECTING AN INSURANCE COMPANY OR POLICY, YOU SHOULD NOT RELY ON COVERAGE BY THE GUARANTY ASSOCIATION.

THIS NOTICE IS REQUIRED BY MINNESOTA STATE LAW TO ADVISE POLICYHOLDERS OF LIFE, ANNUITY OR HEALTH INSURANCE POLICIES OF THEIR RIGHTS IN THE EVENT THEIR INSURANCE CARRIER BECOMES FINANCIALLY INSOLVENT. THIS NOTICE IN NO WAY IMPLIES THAT THE COMPANY CURRENTLY HAS ANY TYPE OF FINANCIAL PROBLEMS. ALL LIFE, ANNUITY AND HEALTH INSURANCE POLICIES ARE REQUIRED TO PROVIDE THIS NOTICE.
NOTICE OF PROTECTION PROVIDED BY MISSISSIPPI LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a brief summary of the Mississippi Life and Health Insurance Guaranty Association (“the Association”) and the protection it provides for policyholders. This safety net was created by Mississippi law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurer becomes financially unable to meet its obligations. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Mississippi law, with funding from assessments paid by other insurance companies.

The maximum amount of protection with respect to any one (1) life, regardless of the number of policies or contracts, is:

**Life Insurance**
- $300,000 in death benefits
- $100,000 in net cash surrender and net cash withdrawal values

**Health Insurance**
- $500,000 in basic hospital, medical and surgical or major medical benefits
- $300,000 in disability benefits
- $300,000 in long-term care insurance benefits
- $100,000 in other types of health insurance benefits

**Annuities**
- $250,000 in net cash surrender and net cash withdrawal values

The Association may not cover this policy. If coverage is provided, it will be subject to substantial limitations and exclusions, and require continued residency in Mississippi. You should not rely on coverage by the Association when selecting an insurer.

To learn more about the above protections, limitations and exclusions, as well as protections relating to group contracts or retirement plans, please visit the Association’s website at www.mslifega.org or contact:

**Mississippi Life and Health Insurance Guaranty Association**
300 North Mart Plaza
Jackson, MS 39206-5327
601-981-0755

**Mississippi Insurance Department**
Woolfolk Building
501 N. West Street, Suite 1001
Jackson, MS 39201
601-359-3569

To file a complaint or seek information about the financial condition of an insurer, contact the Mississippi Insurance Department.

Your insurer is required by law to provide you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Association for the purpose of sales, solicitation or inducement to purchase any form of insurance.
APPENDIX ONE
NOTICE OF PROTECTION PROVIDED BY THE
MISSOURI LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a brief summary of the Missouri Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Missouri law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity, or health insurance company becomes financially unable to meet its obligations and is taken over by its insurance department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Missouri law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are as follows:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 in cash surrender and withdrawal values
- Health Insurance
  - $500,000 in hospital, medical, and surgical insurance benefits
  - $300,000 in disability insurance benefits
  - $300,000 in long-term care insurance benefits
  - $100,000 in other types of health insurance benefits
- Annuities
  - $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is as follows:

- $300,000 in aggregate for all types of coverage listed above, with the exception of basic hospital, medical, and surgical insurance or major medical insurance
- $500,000 in aggregate for basic hospital, medical, and surgical insurance or major medical insurance
- $5,000,000 to one policy owner of multiple nongroup policies of life insurance, whether the policy owner is an individual, firm, corporation, or other person, and whether the persons insured are officers, managers, employees, or other persons.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Missouri law.

To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association’s website at www.mo-iga.org, or contact:

Missouri Life and Health Insurance Guaranty Association
994 Diamond Ridge, Suite 102
Jefferson City, Missouri 65109
Phone: 573-634-8455
Fax: 573-634-8488

Missouri Department of Insurance, Financial Institutions and Professional Registration
301 West High Street, Room 530
Jefferson City, Missouri 65101
Phone: 573-522-6115

Insurance companies and agents are not allowed by Missouri law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Missouri law, then Missouri law will control.
In the event you need to contact someone regarding this policy, you may contact the insurance company issuing this policy at the following address and telephone number.

Securian Life Insurance Company
400 Robert Street North
St. Paul, MN 55101-2098

Telephone: (651) 665-3500
Residents of Nevada 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 Nevada Life and Health Insurance Guaranty Association ("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 Association assesses 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 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.

The Nevada Life and Health Insurance Guaranty Association may not provide coverage for a policy. If coverage is provided, it will be subject to substantial limitations or exclusions, and require continued residency in Nevada. A person should not rely on coverage by the Association when selecting an insurance company or when selecting an insurance policy.

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

Insurance companies are required by law to deliver this notice to you. However, insurance companies and their agents are prohibited by law from using the existence of the Association for sales, solicitation or to induce the purchase of any kind of insurance policy.

The state law that provides for this safety-net coverage is called the Nevada Life and Health Insurance Guaranty Association. On the back 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. Anyone may obtain additional information from the Association or file a complaint with the Commissioner of Insurance to allege a violation of any provision of the Nevada Life and Health Insurance Guaranty Association Act, at the applicable address listed below:

Nevada Life and Health Insurance Guaranty Association
4600 Kietzke Lane, Suite 0-269
Reno, Nevada 89502

Nevada Commissioner of Insurance
Department of Business and Industry
Division of Insurance
1818 E. College Parkway, Suite 103
Carson City, Nevada 89706
COVERAGE

Generally, individuals will be protected by the 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 the state);
- the insurer was not authorized to do business in this state; or
- their policy was issued by a nonprofit hospital or medical service organization, a health maintenance organization (HMO), a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, 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;
- interest rate yields that exceed an average rate;
- dividends;
- credits given in connection with the administration of a policy by 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); and
- unallocated annuity contracts (which give rights to group contractholders, not individuals) other than an annuity owned by a governmental retirement plan established under section 401, 403(b) or 457 of the Internal Revenue Code 26 U.S.C. §§ 401, 403(b) and 457, respectively, or trustees of such a plan; or
- Medicare or Medicare Advantage contracts.

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the Association is obligated to pay. The Association cannot pay more than what the insurance company would owe under a policy or contract. With respect to life insurance policies on any one insured life, the Association will pay a maximum of $300,000 -- regardless of how many policies and contracts there were with the same company, even if they provide different types of coverage. Within this overall $300,000 limit, the Association will not pay more than $100,000 in cash surrender values, or $300,000 in life insurance death benefits.

With respect to annuities, the Association will not pay more than $250,000 in the present value of benefits, including net cash surrender and withdrawal.

With respect to health insurance for any one life, the Association will not pay more than: (1) $100,000 for coverages other than disability insurance, basic hospital, medical and surgical insurance or major medical insurance, including any net cash for surrender or withdrawal; (2) $300,000 for disability insurance or long-term care insurance; or (3) $500,000 for basic hospital, medical and surgical insurance or major medical insurance.

With respect to each payee of a structured settlement annuity, or beneficiary or beneficiaries of the payee if deceased, the Association will not pay more than $250,000 in present values of benefits from the annuity in the aggregate, including any net cash for surrender or withdrawal.

With respect to any one life or person, in no event will the Association be obligated to cover more than: (1) an aggregate of $300,000 in benefits, excluding benefits for basic hospital, medical and surgical insurance or major medical insurance; or (2) an aggregate of $500,000 in benefits, including benefits for basic hospital, medical or surgical insurance or major medical insurance.

With respect to one owner of several non-group policies of life insurance, whether the owner is a natural person or an organization and whether the persons insured are officers, managers, employees or other persons, the Association will not pay more than $5,000,000 in benefits, regardless of the number of policies and contracts held by the owner.

FOR MORE INFORMATION AND ANSWERS TO THE MOST FREQUENTLY ASKED QUESTIONS, PLEASE VISIT THE ASSOCIATION’S WEB SITE: www.nvlifega.org
Residents of New Jersey 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 New Jersey 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 below, this protection is not a substitute for consumers’ care in selecting companies that are well-managed and financially stable.

The New Jersey Life and Health Insurance Guaranty Association 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 New Jersey. You should not rely on coverage by the New Jersey 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 New Jersey Life and Health Insurance Guaranty Association
One Gateway Center
9th Floor
Newark, NJ 07102

State of New Jersey Department of Banking and Insurance
20 West State Street
CN-325
Trenton, NJ 08625

The state law that provides for this safety-net coverage is called the New Jersey Life and Health Insurance Guaranty Association Act, N.J.S.A. 17B:32A-1, et seq (the "Act").

(please turn to back of page)
COVERAGE

The following is a brief summary of this law’s coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone’s rights or obligations under the act or the rights or obligations of the guaranty association.

Generally, individuals will be protected by the Life and Health Insurance Guaranty Association if they live in New Jersey and hold a life, health or long-term care insurance contract, annuity contract, 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;
- the policy is issued by an organization which is not a member of the New Jersey Life and Health Insurance Guaranty Association.

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 an average rate as more fully described in Section 3 of the Act;
- dividends;
- credits given in connection with the administration of a policy by 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).

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the Association is obligated to pay out. The Association cannot pay more than what the insurance company would owe under a policy or contract.

With respect to any one insured individual, regardless of the number of policies or contracts, the Association will pay not more than $500,000 in life insurance death benefits and present value annuity benefits, including net cash surrender and net cash withdrawal values. Within this overall limit, the Association will not pay more than $100,000 in cash surrender values for life insurance, $100,000 in cash surrender values for annuity benefits, $500,000 in life insurance death benefits or $500,000 in present value of annuities again no matter how many policies and contracts that were with the same company, and no matter how many different types of coverages.

The Association will not pay more than $2,000,000 in benefits to any one contractholder under any one unallocated annuity contract.

There are no limits on the benefits the Association will pay with respect to any one group, blanket or individual accident and health insurance policy.
NOTICE CONCERNING YOUR RIGHTS  
TO APPEAL DISPUTED CLAIMS

In the event of a claim where you are not satisfied with the claim decision, you may request a review of that decision by writing to our Internal Appeals Panel at the address listed below.

Internal Appeals Panel  
Attn: Station 21-3055  
Securian Life Insurance Company  
400 Robert Street North  
St. Paul, Minnesota 55101-2098  
Group Claims Telephone: 1-800-328-9442  
Telefax: 651-665-7979

Your appeal will be reviewed by our Securian Life Internal Appeals Panel.

Please include the following in your written notice to us:

1. Contract number  
2. Claim number  
3. Insured’s name  
4. Your name, address, telephone number and relationship to the insured  
5. The insured’s name, address and telephone number, if different from yours  
6. Your reason(s) to dispute the decision by our Claim Department  
7. Documentation to support your request

We will make a decision on your appeal within 10 business days of receiving your written request. Once we have made a decision, we will notify you within three working days.

If you are not satisfied with the final disposition of your claim and the response from Securian Life's Internal Appeals Panel, you have the right to contact the Office of the Insurance Claims Ombudsman at the address and phone listed below.

Office of Insurance Claims Ombudsman  
Department of Banking and Insurance  
P.O. Box 472  
Trenton, NJ 08625-0472  
Telephone: 1-800-446-7467  
Telefax: 609-292-2431  
E-mail: ombudsman@dobi.state.nj.us
If you have any questions regarding your insurance, or if you need assistance in resolving a complaint, you can contact us at:

Securian Life Insurance Company  
400 Robert Street North  
St. Paul, Minnesota 55101-2098  
Tel: 651-665-3500

If we at Securian Life Insurance Company fail to provide you with reasonable and adequate service, you should feel free to contact:

Consumer Inquiry and Case Preparation Unit  
20 West State Street  
P.O. Box 471  
9th Floor  
Trenton, New Jersey 08625  

Telephone: 609-292-7272 or 1-800-446-7467  
Fax: 609-777-0508  
Webpage: http://www.state.nj.us/dobi/consumer.htm
NOTICE OF PROTECTION PROVIDED BY
NEW MEXICO LIFE INSURANCE GUARANTY ASSOCIATION

This notice provides a brief summary of the New Mexico Life Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under New Mexico law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with New Mexico law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are:

- **Life Insurance**
  - $300,000 in death benefits
  - $100,000 in cash surrender or withdrawal values
- **Health Insurance**
  - $500,000 in hospital, medical and surgical insurance benefits
  - $300,000 in disability income insurance benefits
  - $300,000 in long-term care insurance benefits
  - $100,000 in other types of health insurance benefits
- **Annuities**
  - $250,000 in present value of annuity benefits

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000 ($500,000 for hospital, medical and surgical insurance policies).

**Note to benefit plan trustees or other holders of unallocated annuities covered under the act:** For unallocated annuities that fund certain governmental retirement plans, the limit is $250,000 in present value of annuity benefits per plan participant. For covered unallocated annuities that fund other plans, a special limit of $5,000,000 applies to each contract holder, regardless of the number of contracts held or number of persons covered.

**Note:** Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under New Mexico law.

To learn more about the above protections, please visit the Association’s website at [www.nmlifega.org](http://www.nmlifega.org) or contact:

**New Mexico Life Insurance Guaranty Association**
PO Box 2880
Santa Fe, NM 87504-2880
505-820-7355

**Insur¬ance Division**
Public Relations Commission
PO Box 1269
Santa Fe, NM 87504-1269
888-427-5772

Insurance companies and agents are not allowed by New Mexico law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and New Mexico law, then New Mexico law will control.
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 the 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.

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 27605-0218

North Carolina Department of Insurance, Consumer 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 an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, 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 by 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;
- a policy or contract commonly known as Medicare Part C or Part D or any regulations issued pursuant thereto.

LIMITS ON AMOUNT OF COVERAGE

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

1. The guaranty association cannot pay out more than the insurance company would owe under the policy or contract.
2. Except as provided in (3), (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. The guaranty association will pay a maximum of $500,000 with respect to basic hospital, medical and surgical insurance and major medical insurance.
4. The guaranty association will pay a maximum of $1,000,000 with respect to the payee of a structured settlement annuity.
5. The guaranty association will pay a maximum of $5,000,000 to any one unallocated annuity contract holder.
NOTICE OF PROTECTION PROVIDED BY THE NORTH DAKOTA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a brief summary of the North Dakota Life and Health Insurance Guaranty Association (“the Association”) and the protection it provides for policyholders. This safety net was created under North Dakota law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, health, or annuity insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with North Dakota law, with funding from assessments paid by other insurance companies.

The protections provided by the Association are based on contract obligations up to the following amounts:

- **Life Insurance**
  - $300,000 in death benefits
  - $100,000 in cash surrender or withdrawal values

- **Health Insurance**
  - $500,000 in hospital, medical and surgical insurance benefits
  - $300,000 in disability income insurance benefits
  - $300,000 in long-term care insurance benefits
  - $100,000 in other types of health insurance benefits

- **Annuities**
  - $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000; however, may be up to $500,000 with regard to hospital, medical, and surgical insurance benefits.

**Note:** Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. If coverage is available, it will be subject to substantial limitations. There are also various residency requirements and other limitations under North Dakota law. To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association’s website at [www.ndlifega.org](http://www.ndlifega.org) or contact:

**North Dakota Life and Health Insurance Guaranty Association**

P.O. Box 2422
Fargo, ND 58108

**North Dakota Insurance Department**

600 East Boulevard Avenue, Dept. 401
Bismarck, ND 58505

**COMPLAINTS AND COMPANY FINANCIAL INFORMATION**

A written complaint to allege a violation of any provision of the Life and Health Insurance Guaranty Association Act must be filed with the North Dakota Insurance Department, 600 East Boulevard Avenue, Dept. 401, Bismarck, North Dakota 58505; telephone (701) 328-2440. Financial information for an insurance company, if the information is not proprietary, is available at the same address and telephone number and on the Insurance Department website at [www.nd.gov/ndins](http://www.nd.gov/ndins).

Insurance companies and agents are not allowed by North Dakota law to use the existence of the Association or its coverage to sell, solicit or induce you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and North Dakota law, then North Dakota law will control.
NOTICE CONCERNING COVERAGE
LIMITATIONS AND EXCLUSIONS UNDER THE
OHIO LIFE AND HEALTH INSURANCE GUARANTY
ASSOCIATION ACT

Residents of Ohio 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 Ohio 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.

The Ohio Life and Health Insurance Guaranty Association 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 Ohio. You should not rely on coverage by the Ohio 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. You should check with your insurance company representative to determine if you are only covered in part or not covered at all.

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 Ohio Life and Health Insurance Guaranty Association
1840 MacKenzie Drive
Columbus, Ohio 43220

Ohio Department of Insurance
50 West Town Street
Third Floor, Suite 300
Columbus, Ohio 43215

The state law that provides for this safety-net coverage is called the Ohio 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.

(please turn to back of page)
COVERAGE

Generally, individuals will be protected by the life and health insurance guaranty association if they live in Ohio and hold a life or health insurance contract, annuity contract, unallocated annuity contract, 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 that state;
- their policy was issued by a medical, health or dental care corporation, an HMO, a fraternal benefit society, a mutual protective association or similar plan in which the policyholder 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 an average rate;
- dividends;
- credits given in connection with the administration of a policy by 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).

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the association is obligated to pay out: The association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the association will pay a maximum of $300,000, except as specified below, no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. The association will not pay more than $100,000 in cash surrender values, $500,000 in major medical insurance benefits, $300,000 in disability or long-term care insurance benefits, $100,000 in other health insurance benefits, $250,000 in present value of annuities, or $300,000 in life insurance death benefits. Again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages, the association will pay a maximum of $300,000, except for coverage involving major medical insurance benefits, for which the maximum of all coverages is $500,000.

For more information about the Ohio Life and Health Insurance Guaranty Association, visit our website at: www.olhiga.org.
NOTICE OF PROTECTION PROVIDED BY
OKLAHOMA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This Notice provides a brief summary of the Oklahoma Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Oklahoma law, which determines who and what is covered and the amounts of coverage. The Association was established to provide protection in the unlikely event that your life, annuity, or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Oklahoma law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are:

Life Insurance
- $300,000 in death benefits
- $100,000 in cash surrender or withdrawal values

Health Insurance
- $500,000 in hospital, medical and surgical insurance benefits
- $300,000 in disability income insurance benefits
- $300,000 in long-term care insurance benefits
- $100,000 in other types of health insurance benefits

Annuities
- $300,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000, except that with regard to hospital, medical and surgical insurance benefits, the maximum amount that will be paid is $500,000.

NOTE: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Oklahoma law.

To learn more about the above protections, please visit the Association's website at www.oklifega.org, or contact:

Oklahoma Life & Health Insurance Guaranty Association
201 Robert S. Kerr, Suite 600
Oklahoma City, OK 73102
Phone: (405) 272-9221

Oklahoma Department of Insurance
3625 NW 56th Street, Suite 100
Oklahoma City, OK 73112
1-800-522-0071 or (405) 521-2828

Insurance companies and agents are not allowed by Oklahoma law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Oklahoma law, then Oklahoma law will control.
KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

PROBLEMS WITH YOUR INSURANCE? - If you are having problems with your insurance company or agent, do not hesitate to contact the insurance company or agent to resolve your problem.

SECURIAN LIFE INSURANCE COMPANY
400 ROBERT STREET NORTH
ST PAUL MN 55101-2098
(651) 665-3500

You can also contact the DIRECTOR OF THE DEPARTMENT OF CONSUMER AND BUSINESS SERVICES, a state agency which enforces Oregon's insurance laws, and file a complaint. Assistance is available by writing to:

OREGON AGENCY
CONSUMER PROTECTION UNIT
350 WINTER STREET NE
ROOM 440-2
SALEM OR 97301-3883

by calling (503) 947-7984 or the toll free message line at (888) 877-4894; through the Internet at http://www.cbs.state.or.us/external/ins/; or by email at: DCBS.INSMAIL@STATE.or.us
A resident of Rhode Island who purchases life insurance, annuities, or accident and health insurance should know that an insurance company licensed in Rhode Island to write these types of insurance is a member of the Rhode Island Life and Health Insurance Guaranty Association ("Association"). The purpose of the Association is to assure that a policyholder will be protected within the statutory limits, if a member insurer becomes financially unable to meet its obligations. If this should happen, the Association will, within the statutory limits, pay the claims of insured persons who live in this state, and, in some cases, keep coverage in force. However, the protection provided through the Association is not unlimited. This protection is not a substitute for your care in selecting a company that is well managed and financially stable.

**IMPORTANT DISCLAIMER**

Rhode Island Life and Health Insurance Guaranty Association

235 Promenade Street #426, Providence, RI 02908
Telephone (401) 273-2921

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

The Life and Health Insurance Guaranty Association will respond to any questions you may have which are not answered by this document. Your insurer and agent are prohibited by law from using the existence of the association or its coverage to sell you an insurance policy.

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

Rhode Island Division of Insurance

1511 Pontiac Avenue, Cranston, RI 02920
Telephone (401) 462-9520

The full text of the state law that provides for this safety net coverage, Rhode Island Life and Health Insurance Guaranty Association Act ("the Act"), can be found beginning at R.I. Gen. Laws §27-34.3-1. A brief summary of the Act is provided below. This summary does not cover all provisions of the law, nor does it in any way change your rights or obligations or those of the Association under the Act.

**COVERAGE**

Generally, individuals will be protected by the Association if the individual lives in Rhode Island and: Holds a life or health insurance contract, long-term care contract, or annuity contract; or is 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 elsewhere.

**EXCLUSIONS FROM COVERAGE**

The Association does NOT protect a person holding a policy if:

- the individual is eligible for protection under a similar law of another state;
- the insurer was not authorized to do business in that state;
- the policy is issued by an organization that is not a member of the Association;
- the policy was issued by a nonprofit hospital or medical service organization (such as, the "Blues"), an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments or by an insurance exchange.
The Association does not provide coverage for:

- a policy or portion of a policy not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus; a policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed a rate specified by statute;
- dividends;
- credits given in connection with the administration of a policy by a group contract holder;
- an employer's plan to the extent that it is self-funded (that is, not insured by an insurance company, even if an insurance company administers the plan);
- an unallocated annuity contract issued to an employee benefit plan protected under the United States Pension Benefit Guaranty Corporation;
- that part of an unallocated annuity contract not issued to a specific employee, union, association of natural persons benefit plan, or a government lottery;
- certain contracts which establish benefits by reference to a portfolio of assets not owned by the insurer;
- any portion of a policy or contract to the extent that the required assessments are preempted by federal or state law;
- an obligation that does not arise under the express written terms of the policy or contract issued by the insurer.

The Act limits the amount the Association is obligated to pay. The Association cannot pay more than what the insurer would have owed under a policy or contract. Also, for any one insured life, no matter how many policies or contracts were in force with the same insurer, the Association will pay no more than:

- $300,000 in net life insurance death benefits and no more than $100,000 in net cash surrender and net cash withdrawal values for life insurance;
- $100,000 for health insurance benefits, coverages not defined as disability, basic hospital, medical, and surgical, or major medical insurance or long-term care insurance, including any net cash surrender and net cash withdrawal values;
- $300,000 or disability insurance;
- $300,000 for long-term care insurance;
- $500,000 for basic hospital, medical, and surgical insurance;
- $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal value;
- $250,000 in present value per payee with respect to a structured settlement annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values;
- $250,000, in the aggregate, of the present value of annuity benefits, including net cash surrender and net cash withdrawal values, with respect to an individual participating in a governmental retirement plan established under 26 U.S.C. §§ 401, 403(b), or 457 covered by an unallocated annuity contract, or to a beneficiary of the individual if the individual is deceased;
- $5,000,000 in unallocated annuity contract benefits, irrespective of the number of contracts with respect to the contract owner or plan sponsor whose plan owns, directly or in trust, one or more unallocated annuity contracts.

Note to benefit plan trustees or other holders of unallocated annuities (GICs, DACs, etc.) covered by the Act: for unallocated annuities that fund government retirement plans under sections 401, 403(b), or 457 of the Internal Revenue Code, the limit is $250,000 in present value of annuity benefits including net cash surrender and net cash withdrawal per participating individual. In no event shall the Association be liable to spend more than $300,000 in the aggregate per individual except hospital insurance up to $500,000 per individual. For covered unallocated annuities that fund other plans, a special limit of $5,000,000 applies to each contract holder, regardless of the number of contracts held with the same company or number of persons covered. In all cases, the contract limits also apply.

These general statements as to Limitations on Coverage are only summaries of the law. The actual limitations are set forth in R.I. Gen. Laws §27-34.3-3.

Any alleged violations of the provisions of the Rhode Island Life and Health Insurance Guaranty Association Act may be reported to the Rhode Island Division of Insurance at the address and telephone number above.

This information is provided by: The Association and by the Division of Insurance, whose respective addresses are provided in the Important Disclaimer above.
NOTICE CONCERNING COVERAGE
LIMITATIONS AND EXCLUSIONS UNDER THE SOUTH DAKOTA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of South Dakota 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 South Dakota 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.

The South Dakota Life and Health Insurance Guaranty Association does not provide coverage for all types of life, health, or annuity benefits, and the South Dakota Life and Health Guaranty Association 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 South Dakota. You should not rely on coverage by South Dakota 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 for the purpose of sales, solicitation, or inducement to purchase any kind of insurance policy.

The South Dakota Life and Health Insurance Guaranty Association
Charles D. Gullickson, Executive Director
206 West 14th Street
Sioux Falls, SD 57104
Tel. (605) 336-0177
www.sdlifega.org

South Dakota Division of Insurance
124 South Euclid Avenue, 2nd Floor
Pierre, SD 57501-5070
Tel. (605) 773-3563
www.dlr.sd.gov/insurance

The state law that provides for this safety-net coverage is called the South Dakota 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.

(Please Turn to Back of Page)
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 an insured certificateholder 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. Coverage is also provided by the Guaranty Association to persons eligible to receive payment under structured settlement annuities who are residents of this state and, under certain conditions, such persons even if they are not a resident of this state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by the Guaranty 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 an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The Guaranty 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;
- claims based on marketing materials or other documents which are not approved policy forms, claims based on misrepresentations of policy benefits, and other extra-contractual claims;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed an average rate specified by statute;
- dividends;
- credits given in connection with the administration of a policy by a group contract holder;
- 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);
- certain contracts which establish benefits by reference to a portfolio of assets not owned by the insurer; or
- policies providing health care benefits for Medicare Parts C or D coverage.

LIMITS ON AMOUNT OF COVERAGE

The Guaranty Association in no event will pay more than what an insurance company would owe under a policy or contract. In addition, state law limits the amount of benefits the Guaranty Association will pay for any one insured life, and no matter how many policies or contracts there are with the same company, as follows: (i) for life insurance, not more than $300,000 in death benefits and not more than $100,000 in net cash surrender and net cash withdrawal values; (ii) for health insurance, not more than $500,000 for basic hospital, medical and surgical insurance, not more than $300,000 for disability insurance and long term care insurance, and not more than $100,000 for other types of health insurance; and (iii) for annuities, not more than $250,000 in the present value benefits, including net cash surrender and net cash withdrawal values.

However, in no event will the Guaranty Association be obligated to cover more than an aggregate of $300,000 in benefits with respect to any one life except with respect to benefits for basic hospital, medical and surgical insurance, for which the aggregate liability of the Guaranty Association may not exceed $500,000. These general statements of the limits on coverage are only summaries and the actual limitation are set forth in South Dakota law.

ADDITIONAL INFORMATION

The statutes which govern the Guaranty Association are contained in SDCL Chapter 58-29C. Additional information about the Guaranty Association may be found at www.sdlifega.org which contains a link to SDCL Chapter 58-29C.

Information about the financial condition of insurers is available from a variety of sources, including financial rating agencies such as AM Best Company, Fitch Inc., Moody's Investors Service, Inc., and Standard & Poor's. Additional information about financial rating agencies may be obtained by clicking on "Useful Links" on the website of the South Dakota Division of Insurance at www.dlr.sd.gov/insurance.

The Guaranty Association is subject to supervision and regulation by the director of the South Dakota Division of Insurance. Persons who desire to file a complaint to allege a violation of the statutes governing the Guaranty Association may contract the Division of Insurance. State law provides that any suit against the Guaranty Association shall be brought in Hughes County, South Dakota.
In the event you need to contact someone regarding this policy, you may contact the insurance company issuing this policy at the following address and telephone number.

Securian Life Insurance Company  
400 Robert Street North  
St. Paul, MN  55101-2098  

Telephone: (651) 665-3500
NOTICE CONCERNING COVERAGE
UNDER THE LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of Tennessee 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 Tennessee 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 below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The state law that provides for this safety-net coverage is called the Tennessee Life and Health Insurance Guaranty Association Act. The following is a brief summary of this law's coverages, exclusions and limits. **This summary does not cover all provisions of the law or describe all of the conditions and limitations relating to coverage. This summary does not 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, an annuity, or if they are insured under a group insurance contract, issued by an insurer authorized to conduct business in Tennessee. Health insurance includes disability and long term care policies. 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 Guaranty 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 an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The Guaranty 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 an average rate;
- dividends;
- credits given in connection with the administration of a policy by 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).

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LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the Guaranty Association is obligated to pay out. The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. For any one insured life, the Guaranty Association guarantees payments up to a stated maximum no matter how many policies and contracts there were with the same company, even if they provided different types of coverage. These aggregate limits per life are as follows:

• $300,000 for policies and contracts of all types, except as described in the next point;
• $500,000 for basic hospital, medical and surgical insurance, and major medical insurance issued by companies that become insolvent after January 1, 2010.

With these overall limits, the Guaranty Association cannot guarantee payment of benefits greater than the following:

• life insurance death benefits - $300,000
• life insurance cash surrender value - $100,000
• present value of annuity benefits for companies insolvent before July 1, 2009 - $100,000
• present value of annuity benefits for companies insolvent after June 30, 2009 - $250,000
• health insurance benefits for companies declared insolvent before January 1, 2010 - $100,000
• health insurance benefits for companies declared insolvent on or after January 1, 2010:
  • $100,000 for limited benefits and supplemental health coverages
  • $300,000 for disability and long term care insurance
  • $500,000 for basic hospital, medical and surgical insurance, or major medical insurance

The Tennessee Life and Health Insurance Guaranty Association 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 Tennessee. You should not rely on coverage by the Tennessee 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.

Tennessee Life and Health Insurance Guaranty Association
1200 One Nashville Place
150 4th Avenue North
Nashville, TN 37219-2433

Tennessee Department of Commerce and Insurance
500 James Robertson Parkway
Nashville, TN 37243
Texas law establishes a system to protect Texas policyholders if their life or health insurance company fails. The Texas Life and Health Insurance Guaranty Association ("the Association") administers this protection system. Only the policyholders of insurance companies which are members of the Association are eligible for this protection which is subject to the terms, limitations, and conditions of the Association law. (The law is found in the Texas Insurance Code, Chapter 463.)

It is possible that the Association may not protect all or part of your policy because of statutory limitations.

Eligibility for Protection by the Association

When a member insurance company is found to be insolvent and placed under an order of liquidation by a court or designated as impaired by the Texas Commissioner of Insurance, the Association provides coverage to policyholders who are:

- Residents of Texas at that time (regardless of where the policyholder lived when the policy was issued)
- Residents of other states, ONLY if the following conditions are met:
  1) The policyholder has a policy with a company domiciled in Texas;
  2) The policyholder's state of residence has a similar guaranty association; and
  3) The policyholder is not eligible for coverage by the guaranty association of the policyholder's state of residence.

Limits of Protection by the Association

Accident, Accident and Health, or Health Insurance:

- For each individual covered under one or more policies: up to a total of $500,000 for basic hospital, medical-surgical, and major medical insurance, $300,000 for disability or long term care insurance, or $200,000 for other types of health insurance.

Life Insurance:

- Net cash surrender value or net cash withdrawal value up to a total of $100,000 under one or more policies on a single life; or
- Death benefits up to a total of $300,000 under one or more policies on a single life; or
- Total benefits up to a total of $5,000,000 to any owner of multiple non-group life policies.

Individual Annuities:

- Present value of benefits up to a total of $250,000 under one or more contracts on any one life.

Group Annuities:

- Present value of allocated benefits up to a total of $250,000 on any one life; or
- Present value of unallocated benefits up to a total of $5,000,000 for one contractholder regardless of the number of contracts.

Aggregate Limit:

- $300,000 on any one life with the exception of the $500,000 health insurance limit, the $5,000,000 multiple owner life insurance limit, and the $5,000,000 unallocated group annuity limit.

These limits are applied for each insolvent insurance company.

Insurance companies and agents are prohibited by law from using the existence of the association for the purpose of sales, solicitation, or inducement to purchase any form of insurance. When you are selecting an insurance company, you should not rely on Association coverage. For additional questions on Association protection or general information about an insurance company, please use the following contact information.

Texas Life and Health Insurance Guaranfy Association
515 Congress Avenue, Suite 1875
Austin, Texas 78701
800-982-6362 or www.txlifega.org

Texas Department of Insurance
P.O. Box 149104
Austin, Texas 78714-9104
800-252-3439 or www.tdi.texas.gov
NOTICE OF PROTECTION PROVIDED BY UTAH LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a brief summary of the Utah Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Utah law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, health, or annuity insurance company becomes financially unable to meet its obligations and is taken over by its insurance regulatory agency. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Utah law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are:

- **Life Insurance**
  - $500,000 in death benefits
  - $200,000 in cash surrender or withdrawal values

- **Health Insurance**
  - $500,000 in hospital, medical and surgical insurance benefits
  - $500,000 in long-term care insurance benefits
  - $500,000 in disability income insurance benefits
  - $500,000 in other types of health insurance benefits

- **Annuities**
  - $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $500,000. Special rules may apply with regard to hospital, medical and surgical insurance benefits.

**Note: Certain policies and contracts may not be covered or fully covered.** For example, coverage does not extend to any portion of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. Coverage is conditioned on residency in this state and there are substantial limitations and exclusions. For a complete description of coverage, consult Utah Code, Title 31A, Chapter 28.

Insurance companies and agents are prohibited by Utah law to use the existence of the Association or its coverage to encourage you to purchase insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between Utah law and this notice, Utah law will control.

To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association’s website at [www.utlifega.org](http://www.utlifega.org) or contact:

**Utah Life and Health Insurance Guaranty Association**  
60 East South Temple, Suite 500  
Salt Lake City, UT 84111  
(801) 320-9955

**Utah Insurance Department**  
3110 State Office Building  
Salt Lake City, UT 84114-6901  
(801) 538-3800

A written complaint about misuse of this Notice or the improper use of the existence of the Association may be filed with the Utah Insurance Department at the above address.
IMPORTANT INFORMATION REGARDING YOUR INSURANCE

In the event you need to contact someone about this insurance for any reason please contact your agent. If no agent was involved in the sale of this insurance, or if you have additional questions, you may contact the insurance company issuing this insurance at the following address and telephone number:

Securian Life Insurance Company
400 Robert Street North
St. Paul, MN  55101-2098
Telephone: 651-665-3500

If you have been unable to contact or obtain satisfaction from the company or the agent, you may contact the Virginia State Corporation Commission’s Bureau of Insurance at:

Life and Health Division
Bureau of Insurance
P.O. Box 1157
Richmond, VA  23218
Telephone: 804-371-9741

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your agent, the company, or the Bureau of Insurance, have your policy number available.
NOTICE OF PROTECTION PROVIDED BY
VIRGINIA LIFE, ACCIDENT AND SICKNESS INSURANCE GUARANTY ASSOCIATION

This Notice provides a brief summary of the Virginia Life, Accident and Sickness Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Virginia law, which determines who and what is covered and the amounts of coverage. The Association was established to provide protection in the unlikely event that a life, annuity, or health insurance company licensed in the Commonwealth of Virginia becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Virginia law, with funding from assessments paid by other insurance companies licensed in the Commonwealth of Virginia.

The basic protections provided by the Association are:

Life Insurance
   • $300,000 in death benefits
   • $100,000 in cash surrender or withdrawal values

Health Insurance
   • $500,000 in hospital, medical and surgical insurance benefits
   • $300,000 in disability income insurance benefits
   • $300,000 in long-term care insurance benefits
   • $100,000 in other types of health insurance benefits

Annuities
   • $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $350,000, except for hospital, medical and surgical insurance benefits, for which the limit is increased to $500,000.

NOTE: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Virginia law.

To learn more about the above protections, please visit the Association’s website at www.valifega.org, or contact:

VIRGINIA LIFE, ACCIDENT AND SICKNESS INSURANCE GUARANTY ASSOCIATION
   c/o APM Management Services, Inc.
   1503 Santa Rosa Road, Suite 101
   Henrico, VA 23229
   804-282-2240

STATE CORPORATION COMMISSION
   Bureau of Insurance
   P.O. Box 1157
   Richmond, VA 23218
   804-371-9741
   Toll Free Virginia only: 1-800-552-7945

Insurance companies and agents are not allowed by Virginia law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Virginia law, then Virginia law will control.
Residents of West Virginia 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 West Virginia 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.

The West Virginia Life and Health Insurance Guaranty Association 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 West Virginia. You should not rely on coverage by the West Virginia Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy. For a complete description of coverage, consult Article 26A, Chapter 33 of the West Virginia Code.

Coverage is NOT provided for any portion OF YOUR CONTRACT that is not guaranteed by the insurer or for which you have assumed the risk.

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 Guaranty Association or the West Virginia Insurance Commission will respond to questions you may have which are not answered by this document. Policyholders with additional questions may contact:

West Virginia Life and Health Insurance Guaranty Association
P. O. Box 816
Huntington, West Virginia 25712

West Virginia Insurance Commissioner
Consumer Services Division
1124 Smith Street, RM 309
P. O. Box 50540
Charleston, West Virginia 25305-0540
(304) 558-3386
Toll Free 1-888-879-9842
TDD 1-800-435-7381

The state law that provides for this safety-net coverage is called the West Virginia 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 West Virginia Life and Health Insurance Guaranty Association if they live in West Virginia and hold a life or health insurance contract, annuity contract, unallocated annuity contract, or if they are insured under a group life, health or annuity insurance contract, issued by a member insurer. Member insurer also includes non-profit service corporations (W. Va. Code §33-24) and health care corporations (W. Va. Code §33-25). 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;
- the policy was issued at a time when the insurer was not licensed or authorized to do business in the state;
- their policy was issued by an HMO, a fraternal benefit society, mandatory state pooling plan, a mutual protective association or similar plan in which the policyholder is subject to future assessments, an insurance exchange, or any entity similar to the above.

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 or contractholder has assumed the risk;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed an average rate;
- dividends;
- credits given in connection with the administration of a policy by a group contractholder;
- employer or association plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them) or uninsured, including:
  - multiple employer welfare arrangement;
  - minimum premium group insurance plan;
  - stop loss group insurance plan; or
  - administrative services only contract.
- any unallocated annuity contract issued to an employee benefit plan protected under the federal pension guaranty corporation;
- any portion of any unallocated contract which is not issued to or in connection with a specific employee, union or association’s benefit plan or a governmental lottery;
- any policy or contract providing any hospital, medical, prescription drug or other health care benefits pursuant to Medicare Part C and D.
- an obligation that does not arise under the written terms of the policy, including claims based on marketing materials; claims based on side letters or riders not approved by the Commissioner; misrepresentations regarding policy benefits; extracural claims for penalties or consequential or incidental damages;
- a contractual agreement that establishes the member insurer’s obligation to provide a book value guaranty for defined contribution benefit plan participants by reference to a portfolio of assets that is owned by the benefit plan or trustee, which is not an affiliate of the insurer.

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the association is obligated to pay out: The association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, regardless of the number of policies or contracts the association will only pay:

- $300,000 in life insurance benefits, but no more than $100,000 in net cash surrender and net cash withdrawal values;
- $300,000 for disability insurance;
- $300,000 for long term care insurance;
- $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values;
- $500,000 for basic major hospital medical and surgical insurance or major medical insurance, and;
- $100,000 for all other types of accident and sickness insurance than those listed above (disability, long term care, and major medical).

Also, for any one insured life, the association will only pay a maximum of $300,000 - no matter how many policies or contracts there were with the same company for all policies or contracts other than major medical insurance, in which case the aggregate limit shall not exceed $500,000 with respect to any one individual.

Note to benefit plan trustees or other holders of unallocated annuities (GICs, DACs, etc.) covered by the act: for unallocated annuities that fund governmental retirement plans under §§401(k), 403(b) or 457 of the Internal Revenue Code, the limit is $250,000 in present value of annuity benefits including net cash surrender and net cash withdrawal per participating individual. In no event shall the association be liable to spend more than $300,000 in the aggregate per individual; for covered unallocated annuities that fund other plans, a special limit of $5,000,000 applies to each contractholder, regardless of the number of contracts held with the same company or number of persons covered. In all cases, of course, the contract limits also apply.
KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

PROBLEMS WITH YOUR INSURANCE? If you are having problems with your insurance company or agent, do not hesitate to contact the insurance company or agent to resolve your problem.

SECURIAN LIFE INSURANCE COMPANY
400 ROBERT STREET NORTH
ST PAUL MN 55101-2098
(651) 665-3500

You can also contact the OFFICE OF THE COMMISSIONER OF INSURANCE, a state agency which enforces Wisconsin's insurance laws, and file a complaint. You can contact the OFFICE OF THE COMMISSIONER OF INSURANCE by writing to:

OFFICE OF THE COMMISSIONER OF INSURANCE
COMPLAINTS DEPARTMENT
PO BOX 7873
MADISON WI 53707-7873

or, you can call 1-800-236-8517 outside of Madison or 266-0103 in Madison, and request a complaint form.
GROUP ACCIDENT CERTIFICATE OF INSURANCE

POLICYHOLDER: Concordia Plan Services

POLICY NUMBER: 76013

Notice of the California Consumer Affairs Unit
If you have questions or concerns regarding your certificate, please contact us, our agent or other representative at the address shown above. The phone number for customer service is: 855-750-1906.

If we, our agent or representative fail to satisfactorily resolve your questions or concerns, you may contact the California Department of Insurance. The address of the Department’s Consumer Services Division is:

300 S. Spring Street
Los Angeles, CA 90013

The phone number for callers inside the State of California is: 1-800-927-HELP. The phone number for callers outside the State of California is: 1-(213) 897-8921.

THIS CERTIFICATE IS NOT MAJOR MEDICAL INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL INSURANCE. IT DOES NOT QUALIFY AS MINIMUM ESSENTIAL HEALTH COVERAGE UNDER THE FEDERAL AFFORDABLE CARE ACT. THIS CERTIFICATE DOES NOT SATISFY THE FEDERAL REQUIREMENT THAT YOU HAVE HEALTH INSURANCE COVERAGE, WHICH BECAME EFFECTIVE JANUARY 1, 2014.

THIS IS A LIMITED BENEFIT CERTIFICATE: This certificate provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses. Read your certificate carefully.

THIS CERTIFICATE IS NOT A MEDICARE SUPPLEMENT CONTRACT. If you are eligible for Medicare, review the Guide to Health Insurance for people with Medicare available from us.

If you are 65 or older, you have the right to return this certificate, by mail or other delivery method, within 30 days after its receipt. If you do so, this certificate will be void from its inception, and we will refund the full premium paid.

Read Your Certificate Carefully
If you meet the eligibility and enrollment requirements herein, you are insured under the group policy shown on the specifications page. This certificate summarizes the principal provisions of the group policy that affect you. The provisions summarized in this certificate are subject in every respect to the group policy. You may examine the group policy at the principal office of the policyholder during regular working hours.

Legal Actions
No action at law or in equity shall be brought to recover on this certificate prior to the expiration of sixty days after written proof of loss has been furnished in accordance with the requirements of this certificate. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

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GROUP ACCIDENT CERTIFICATE OF INSURANCE
15-32401.4

Securian Life 1
EdF91293 03-2018
GENERAL INFORMATION

POLICYHOLDER: Concordia Plan Services
POLICY NUMBER: 76013
ASSOCIATED COMPANIES: All subsidiaries and affiliates reported to Securian Life by the policyholder for inclusion in the policy.
POLICY SITUS: The policy was issued and delivered in Missouri.
POLICY EFFECTIVE DATE: January 1, 2019.

This certificate and/or certificate specifications page replaces any and all certificates and/or certificate specifications pages previously issued to you under the group policy. Please replace any certificate and/or certificate specifications page previously issued to you with this new certificate and/or specifications page.

GROUP: The group is composed of all active employees of the policyholder and its associated companies working in the United States in the following classes:

Class 1: Active employees working at least 20 hours per week.

All new employees of the employer will be added to such group and classes for which they become eligible.

NO DOUBLE COVERAGE: A person cannot be covered under more than one class. A person cannot be covered as both an active employee and a retiree. Any person who is eligible as an employee or retiree under the policy, or insured under the portability provisions, is not eligible as a dependent. Only one person can insure an eligible dependent child.

ENROLLMENT PERIOD: 90 days from the first day of eligibility for contributory insurance.
WAITING PERIOD: None
MINIMUM HOURS PER WEEK REQUIREMENT: 20 hours per week

PLAN OF INSURANCE

EMPLOYEE BENEFIT SCHEDULE

EMPLOYEE GROUP ACCIDENT INSURANCE:

Supplemental Group Accident Insurance

<table>
<thead>
<tr>
<th>Eligible Class</th>
<th>Employee Supplemental Group Accident Insurance Benefit Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class 1</td>
<td>Low Plan or High Plan as elected by the employee.</td>
</tr>
</tbody>
</table>
GENERAL PROVISIONS FOR EMPLOYEE INSURANCE

RETIREMENT REDUCTIONS: All insurance terminates at retirement, except as otherwise provided for under any applicable certificate supplement.

CONTRIBUTORY/NONCONTRIBUTORY: Supplemental insurance is contributory insurance.

PORTABILITY BENEFIT: Low Plan or High Plan as elected by the employee.

DEPENDENT BENEFIT SCHEDULE

An employee must be insured in order to elect dependent group accident insurance.

SPOUSE GROUP ACCIDENT INSURANCE

Supplemental Group Accident Insurance

<table>
<thead>
<tr>
<th>Eligible Class</th>
<th>Spouse Supplemental Group Accident Insurance Benefit Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class 1</td>
<td>Spouse benefit plan will match the employee’s Supplemental Group Accident Benefit Plan.</td>
</tr>
</tbody>
</table>

CHILD GROUP ACCIDENT INSURANCE

Supplemental Group Accident Insurance

<table>
<thead>
<tr>
<th>Eligible Class</th>
<th>Child Supplemental Group Accident Insurance Benefit Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class 1</td>
<td>Child benefit plan will match the employee’s supplemental Group Accident Benefit Plan.</td>
</tr>
</tbody>
</table>

GENERAL PROVISIONS FOR DEPENDENT INSURANCE

CONTRIBUTORY/NONCONTRIBUTORY: Supplemental insurance is contributory insurance.

SPOUSE AND CHILD PORTABILITY BENEFIT: Spouse benefit plan will match the employee’s Group Accident Benefit Plan. Child benefit plan will match the employee’s Group Accident Benefit Plan.

COVERED BENEFITS

Refer to the Injury Benefits, Emergency Care, Hospital Care, Surgery Benefits, Follow-up Care and Support Care sections of the Certificate for additional benefit details.

<table>
<thead>
<tr>
<th>INJURY BENEFITS</th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burn Benefit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2nd degree burns</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 10% of the body</td>
<td>$100</td>
<td>$300</td>
</tr>
<tr>
<td>Between 10% and 20% of the body</td>
<td>$250</td>
<td>$750</td>
</tr>
<tr>
<td>20% or more of the body</td>
<td>$500</td>
<td>$1,500</td>
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<tr>
<td>3rd degree burns</td>
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</tr>
<tr>
<td>Less than 10% of the body</td>
<td>$1,000</td>
<td>$3,000</td>
</tr>
<tr>
<td>Between 10% and 20% of the body</td>
<td>$2,500</td>
<td>$7,500</td>
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<tr>
<td>20% or more of the body</td>
<td>$5,000</td>
<td>$15,000</td>
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<tr>
<td>Child Organized Sports Injury</td>
<td>$50</td>
<td>$100</td>
</tr>
<tr>
<td>INJURY BENEFITS</td>
<td>LOW PLAN</td>
<td>HIGH PLAN</td>
</tr>
<tr>
<td>---------------------------------------</td>
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</tr>
<tr>
<td>Concussion</td>
<td>$100</td>
<td>$200</td>
</tr>
<tr>
<td>Dislocation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Principal Amount (Surgical)</td>
<td>$2,000</td>
<td>$5,000</td>
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<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>% of Principal Amount</td>
<td>% of Principal Amount</td>
</tr>
<tr>
<td>Hip/Thigh</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Foot</td>
<td>40%</td>
<td>40%</td>
</tr>
<tr>
<td>Ankle</td>
<td>40%</td>
<td>40%</td>
</tr>
<tr>
<td>Knee</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Hand or wrist (excluding fingers)</td>
<td>Hand: 20%</td>
<td>Hand: 20%</td>
</tr>
<tr>
<td></td>
<td>Wrist: 30%</td>
<td>Wrist: 30%</td>
</tr>
<tr>
<td>Lower jaw</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Shoulder</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Collarbone</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Ribs</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Finger</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Toe</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Elbow</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Non-surgical</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Partial dislocation</td>
<td></td>
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<tr>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>50% of surgical benefit</td>
<td>50% of surgical benefit</td>
</tr>
<tr>
<td>Eye Injury - with Surgery</td>
<td>$120</td>
<td>$300</td>
</tr>
<tr>
<td>Eye Injury – Removal of Foreign Object without Surgery</td>
<td>$30</td>
<td>$75</td>
</tr>
<tr>
<td>Fracture</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Principal Amount (Surgical)</td>
<td>$2,000</td>
<td>$5,000</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>% of Principal Amount</td>
<td>% of Principal Amount</td>
</tr>
<tr>
<td>Hip/Thigh</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Vertebral body</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Vertebral processes</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Pelvis</td>
<td>75%</td>
<td>75%</td>
</tr>
<tr>
<td>Sternum</td>
<td>75%</td>
<td>75%</td>
</tr>
<tr>
<td>Coccyx</td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td>Skull – non depressed</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Skull – depressed</td>
<td>150%</td>
<td>150%</td>
</tr>
<tr>
<td>Lower leg</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Foot</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Ankle</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Kneecap</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Upper arm</td>
<td>35%</td>
<td>35%</td>
</tr>
<tr>
<td>Facial excluding lower jaw</td>
<td>35%</td>
<td>35%</td>
</tr>
<tr>
<td>Forearm</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Hand or wrist (except fingers)</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Lower jaw</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Shoulder blade</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Collarbone</td>
<td>15%</td>
<td>15%</td>
</tr>
<tr>
<td>Ribs</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Finger</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Toe</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Nose</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Non-surgical</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>50% of surgical benefit</td>
<td>50% of surgical benefit</td>
</tr>
<tr>
<td>Chip fracture</td>
<td>25% of non-surgical benefit</td>
<td>25% of non-surgical benefit</td>
</tr>
<tr>
<td>INJURY BENEFITS</td>
<td>LOW PLAN</td>
<td>HIGH PLAN</td>
</tr>
<tr>
<td>----------------</td>
<td>----------</td>
<td>-----------</td>
</tr>
<tr>
<td><strong>Lacerations</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>With stitches or staples</td>
<td>$100</td>
<td>$500</td>
</tr>
<tr>
<td>Without stitches or staples</td>
<td>25% of benefit provided with stitches or staples</td>
<td>25% of benefit provided with stitches or staples</td>
</tr>
<tr>
<td><strong>Paralysis</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Principal Amount</td>
<td>$20,000</td>
<td>$60,000</td>
</tr>
<tr>
<td>% of Principal Amount</td>
<td>% of Principal Amount</td>
<td></td>
</tr>
<tr>
<td>Quadriplegia</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Paraplegia</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Hemiplegia</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Uniplegia</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td><strong>Traumatic Brain Injury</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$200</td>
<td>$400</td>
</tr>
<tr>
<td><strong>EMERGENCY CARE</strong></td>
<td>LOW PLAN</td>
<td>HIGH PLAN</td>
</tr>
<tr>
<td><strong>Ambulance</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ground or water</td>
<td>$100</td>
<td>$200</td>
</tr>
<tr>
<td>Air</td>
<td>$500</td>
<td>$1,000</td>
</tr>
<tr>
<td>Blood, Plasma or Platelets Transfusion</td>
<td>$300</td>
<td>$600</td>
</tr>
<tr>
<td><strong>Emergency Dental</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crown</td>
<td>$150</td>
<td>$300</td>
</tr>
<tr>
<td>Extraction</td>
<td>$50</td>
<td>$100</td>
</tr>
<tr>
<td><strong>Emergency Room Treatment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$100</td>
<td>$300</td>
</tr>
<tr>
<td><strong>Initial Physician's Office Visit</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$50</td>
<td>$100</td>
</tr>
<tr>
<td><strong>Hospital Stay</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initial benefit, non-ICU</td>
<td>$400</td>
<td>$1,200</td>
</tr>
<tr>
<td>Initial benefit, ICU</td>
<td>$800</td>
<td>$2,400</td>
</tr>
<tr>
<td>Daily benefit, non-ICU</td>
<td>$100</td>
<td>$300</td>
</tr>
<tr>
<td>Daily benefit, ICU</td>
<td>$200</td>
<td>$600</td>
</tr>
<tr>
<td><strong>SURGERY</strong></td>
<td>LOW PLAN</td>
<td>HIGH PLAN</td>
</tr>
<tr>
<td><strong>Abdominal or Pelvic Surgery</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$1,000</td>
<td>$2,000</td>
</tr>
<tr>
<td><strong>Cranial Surgery</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$1,000</td>
<td>$2,000</td>
</tr>
<tr>
<td><strong>Knee Cartilage Surgery</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Open</td>
<td>$500</td>
<td>$1,000</td>
</tr>
<tr>
<td>Arthroscopic</td>
<td>$250</td>
<td>$500</td>
</tr>
<tr>
<td><strong>Ruptured Disc Surgery</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$500</td>
<td>$1,000</td>
</tr>
<tr>
<td><strong>Tendon, Ligament or Rotator Cuff Surgery</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Open</td>
<td>$500</td>
<td>$1,000</td>
</tr>
</tbody>
</table>
### INJURY BENEFITS

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Low Plan</th>
<th>High Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arthroscopic</td>
<td>$250</td>
<td>$500</td>
</tr>
<tr>
<td>Thoracic Surgery</td>
<td>$1,000</td>
<td>$2,000</td>
</tr>
</tbody>
</table>

### FOLLOW-UP CARE

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Low Plan</th>
<th>High Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adaptive Home and Vehicle Benefit</td>
<td>$500</td>
<td>$1,000</td>
</tr>
<tr>
<td>Appliances</td>
<td>$50</td>
<td>$250</td>
</tr>
<tr>
<td>Follow-Up Physician’s Office Visit</td>
<td>$50</td>
<td>$100</td>
</tr>
<tr>
<td>Prosthetics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>One prosthesis</td>
<td>$500</td>
<td>$1,000</td>
</tr>
<tr>
<td>Two or more prosthetics</td>
<td>2x one prosthetic</td>
<td>2x one prosthetic</td>
</tr>
<tr>
<td>Transportation</td>
<td>$200 per visit</td>
<td>$500 per visit</td>
</tr>
</tbody>
</table>

### SUPPORT CARE

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Low Plan</th>
<th>High Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Companion Lodging</td>
<td>$75 per day</td>
<td>$150 per day</td>
</tr>
</tbody>
</table>

### ADDITIONAL INFORMATION

#### ANNUAL OPEN ENROLLMENTS:

During the policyholder’s annual open enrollment an employee may elect or change employee and dependent accident insurance benefit plans.

Coverage will be effective on the January 1 following the annual enrollment, subject to the actively at work requirement for employees and the hospitalization/non-confinement provision for dependents (this does not apply to a newborn child).

**Special Enrollment Periods:** Upon mutual agreement between the Policyholder and Securian, one or more special enrollment periods may be offered to eligible employees. These special enrollment periods (if offered) will be in addition to the annual enrollment opportunities described above. In the event that a special enrollment period is offered, the details of the special enrollment, including enrollment dates, allowed changes, and evidence of insurability requirements, will be communicated to you in advance of the special enrollment period and documented in the group policy on file with the policyholder and Securian.

#### QUALIFIED STATUS CHANGES:

An employee who experiences a Qualified Status Changes as defined below may elect or change employee and dependent accident insurance benefit plans provided enrollment is made within 60 days of the status change.

- An active employee may elect accident insurance for the first time or increase coverage from the low plan to the high plan.
- An active employee may elect dependent coverage.

Coverage will be effective on the date of the election. All increases are subject to the actively at work requirement for employees and the hospitalization/non-confinement provision for dependents (this does not apply to a newborn child).

A qualified status change for the purpose of waiving the evidence of insurability requirement means marriage, birth or adoption.
SUPPLEMENTS TO THE CERTIFICATE

Portability
Definitions

Any use in this certificate of a term defined in this section is to be given the meaning defined in this section unless otherwise defined in another provision of this certificate.

accident

An act or event which is:

(1) unintended, unexpected and unforeseen; and
(2) results in bodily injury to the insured.

application

Your application or enrollment for insurance under the group policy.

associated company

Any company which is a subsidiary or affiliate of the policyholder which is designated by the policyholder and agreed to by us to participate under the group policy.

child or children

Your or your spouse’s natural, adopted, stepchild or foster child who is less than 26 years old. An adopted child includes a child legally placed for adoption with you. Eligibility begins at live birth (stillborn or unborn children are not eligible).

The limiting age does not apply to a child who is and continues to be both: (a) incapable of self-sustaining employment by reason of an intellectual disability or physical handicap; and (b) chiefly dependent on you for support and maintenance.

ccontributory insurance

Insurance for which you are required to make premium contributions.

covered accident

An accident which:

(1) is not excluded under the Exclusions and Limitations section or any other terms of this certificate; and
(2) occurs while the insured’s coverage is in force; and
(3) occurs in the United States or a United States territory.

dependent

Your children or spouse.

If both parents of a child qualify as eligible employees under the group policy, the child shall be considered a dependent of only one parent for purposes of this certificate.

If any child qualifies as an eligible employee under the group policy, he or she is not eligible to be insured as a dependent child.

emergency room

A department of a hospital or a satellite emergency center that is designated for persons requiring immediate medical care. This area must be staffed and equipped to handle trauma, be supervised and provide treatment by physicians, and provide care seven days per week, 24 hours per day.

A satellite emergency center is a licensed facility providing outpatient care under the direction of a licensed physician on a 24-hour basis. Available services must include:

(1) diagnostic care, including laboratory services and diagnostic x-rays; and
(2) treatment or medical care, including availability of the means for stabilization of emergency medical conditions.

A satellite emergency center does not include a hospital or an office maintained by a licensed physician for the practice of medicine or dentistry.

employee

An individual who is employed by the policyholder or by an associated company. A sole proprietor will be considered the employee of the proprietorship. A partner in a partnership will be considered an employee so long as the partner’s principal work is the conduct of the partnership’s business. The term employee does not include temporary employees nor corporate directors who are not otherwise employees.

employer

The policyholder or any designated associated companies.

family member

A parent, spouse, child, sibling, grandparent, aunt, uncle, first cousin, niece or nephew. This includes adopted, in-law and step relatives.

hospital

A short-term, acute care general facility that:

(1) is legally licensed and operated as a hospital;
(2) provides overnight care of injured and sick people;
(3) requires that every patient be supervised by a physician;
(4) provides 24 hour nursing service by or under the supervision of a registered nurse;
(5) has on-site or pre-arranged use of x-ray equipment, laboratory, and surgical facilities; and
(6) maintains permanent medical history records.
A hospital is not a rehabilitation center, nursing home, rest home, extended-care facility, convalescent home, a place for alcoholics or drug addicts or a mental institution, even if such facilities are affiliated with or adjoined to a hospital.

**injury or injuries**

A bodily injury which is sustained as a result of a covered accident.

**insured**

An employee, spouse or child covered for insurance under this certificate.

**noncontributory insurance**

Insurance for which you are not required to make premium contributions.

**non-work day**

A day on which you are not regularly scheduled to work, including scheduled time off for vacations, personal holidays, weekends and holidays, and approved leaves of absence for non-medical reasons.

Non-work day does not include time off for medical leave of absence, temporary layoff, employer suspension of operations in total or in part, strike, and any time off due to sickness or injury including sick days, short-term disability, or long term disability.

**physician**

A medical doctor or other person recognized by law or regulation in the United States or United States territory where services are rendered as a physician. The person must be licensed as required by the United States jurisdiction where care is given and must be operating in the scope of his or her license.

A physician cannot be a person who:

(1) ordinarily resides in your household; or

(2) is a family member

**policyholder**

The owner of the group policy as shown on the specifications page.

**specifications page**

The summary of the plan specifics available under the group policy.

**spouse**

Your legally married spouse, as recognized under the laws of the jurisdiction of celebration.

Spouse does not include any person who is eligible as an employee.

**surgery**

Medical treatment in which a physician cuts into someone’s body in order to repair or remove damaged parts as a result of a covered accident. The surgery must be performed solely because of injuries sustained in a covered accident.

**urgent care center**

A health care facility that is separate from a hospital or a separate unit within a hospital and whose primary purpose is the offering and provision of immediate, short term medical care, without appointment, for urgent care.

**waiting period**

The period, if any, of continuous employment with the employer that the employee must satisfy prior to becoming eligible for coverage under this certificate. You are not eligible to become insured until the first day following the waiting period. Any such waiting period is shown on the specifications page.

**we, our, us**

Securian Life Insurance Company.

**you, your, certificate holder**

An insured employee.

### Entire Contract; Changes

This certificate, certificate supplements, and attached papers, if any, including the application if attached, constitutes the entire contract of insurance between the parties, and no statement made by the employer or by any employee whose eligibility has been accepted by the insurer shall avoid the insurance or reduce the benefits under this certificate or be used in a defense to a claim hereunder. No change in this certificate shall be valid unless approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this certificate or to waive any of its provisions.

### Who is eligible for insurance?

You are eligible for group accident insurance if you:

(1) are a member of the eligible group and of an eligible class as defined on the specifications page; and

(2) work for the employer for at least the number of hours per week shown as the minimum hours per week requirement on the specifications page; and

(3) have satisfied the waiting period as shown on the specifications page; and
Are your dependents eligible for insurance?

Yes. If you are insured for group accident coverage, your dependents are eligible for insurance.

Are employees of associated companies eligible for insurance under the group policy?

Yes. Employees of associated companies may be eligible for insurance under the group policy. The policyholder represents any associated company in all transactions pertaining to the group policy. The policyholder’s acts or omissions and every notice given by us to the policyholder shall be binding on every associated company. When an associated company ceases its participation under the policy, the policy shall be considered to be terminated for all employees of the associated company. All provisions related to policy termination will apply to such employees.

What is the actively at work requirement?

To be eligible to become insured or to receive an increase in the benefit amount, you must be actively at work, fully performing your customary duties for your regularly scheduled number of hours at the employer’s normal place of business, or at other places the employer’s business requires you to travel.

If you are not working due to illness or injury, you do not meet the actively at work requirement. If you are receiving sick pay, short-term disability benefits or long-term disability benefits, you do not meet the actively at work requirement.

If you are not actively at work on the date coverage would otherwise begin, or on the date an increase in your benefit amount would otherwise be effective, you will not be eligible for the coverage or increase until you return to active work. However, if the absence is on a non-work day, coverage will not be delayed provided you were actively at work on the work day immediately preceding the non-work day.

Except as otherwise provided for in this certificate, you are eligible to continue to be insured only while you remain actively at work.

Any insurance or increase in insurance which is elected or put in force while you are not actively at work will not be eligible for claim payment. You or your beneficiary will receive a refund of premium for any contributory insurance for which you were not eligible.

What is the dependent non-confinement requirement?

If a dependent is hospitalized or confined because of illness or disease on the date his or her insurance would otherwise become effective, his or her effective date shall be delayed until he or she is released from such hospitalization or confinement.

This does not apply to a newborn child. In no event will insurance on a dependent be effective before your insurance is effective.

Can your coverage be continued during sickness, injury, leave of absence or temporary layoff?

Yes. Insurance may be continued on an insured employee who is not actively at work due to sickness, injury, leave of absence or temporary layoff, subject to the employer’s practices and procedures, including the employer’s limits on the length of continuation allowed for the type of absence. Continuation is contingent upon continued premium payment.

Coverage during a leave of absence and upon return from a leave of absence shall meet all state and federal requirements.

Enrollment

When can you elect or make changes to your insurance?

You must enroll in order to be insured for contributory coverage under the group policy. You can enroll for coverage within 90 days of when you first become eligible. After that period, you can only enroll for coverage or make changes during your annual open enrollment or within 60 days of a qualified status change event, as defined by the state and federal rules and regulations.

When does your insurance become effective?

Your insurance becomes effective on the date all of the following conditions have been met:

1. you meet all eligibility requirements, including the actively at work requirement; and
2. for contributory coverage, application is made in accordance with the application methods agreed upon by the policyholder and us

When does insurance for a dependent become effective?

Insurance on a dependent becomes effective on the date when all of the following conditions have been met:

1. your insurance becomes effective;
2. the dependent meets all eligibility requirements; and
3. for contributory insurance, you apply for dependent coverage on forms which are approved by us.

When will changes in your coverage amount be effective?

Requested changes in the amount of your contributory insurance are effective on the first day of the month following receipt of your request for a change.
However, elections made during an enrollment period will not become effective prior to the effective date for that enrollment.

## Premiums

**When and how often are your premium contributions due?**

Unless the policyholder and we have agreed to some other premium payment procedure, any premium contributions you are required to make for contributory insurance are to be paid by you to the policyholder on a periodic basis. Premium rates are subject to change in accordance with the group policy.

**How is the premium determined?**

The premium will be the applicable premium rate in force on the date premiums are due. The premium may also be computed by any other method on which the policyholder and we agree.

Premium rates are subject to change according to the provisions of the group policy.

## Grace Period

The group policy has a 31-day grace period. If a premium is not paid on or before the date it is due, that premium may be paid during the 31-day period following the due date. The insurance under the group policy will remain in effect during the 31-day grace period.

## Injury Benefits

### Burn Benefit

If an insured sustains a second or third degree burn in a covered accident, we will pay the appropriate amount shown on the specifications page based on the type of burn and the percentage of the body surface burned.

The burn must be treated by a physician within 72 hours after the covered accident. If the burn meets more than one of the burn classifications shown on the specifications page, the amount we pay will be based on the burn classification that pays the highest benefit.

We will pay the burn benefit no more than one time per insured per covered accident. No benefits are payable for sunburns or first degree burns.

### Child Organized Sports Injury

The child organized sports injury benefit is subject to the following conditions:

1. the insured dependent child suffers an injury in a covered accident while participating in an organized sport; and
2. a benefit is payable for the insured dependent child under another provision of the group policy for the same covered accident; and
3. the insured dependent child has not attained 19 years of age and is insured on the date the covered accident occurs;

A child organized sport refers to a sport activity that is governed by an organization and requires formal registration to participate. Adult supervision of practice and competition is required. Proof of registration must be submitted with claims.

The child organized sports injury benefit amount is shown on the specifications page.

This benefit is limited to one payment per insured dependent child per calendar year.

### Concussion

If an insured is injured in a covered accident and the injury causes a concussion, we will pay the amount shown on the specifications page. The insured must be treated by a physician within 72 hours of a covered accident and the concussion must be diagnosed by a physician within 15 days of the covered accident.

Concussion refers to a disruption of brain function resulting from a traumatic blow to the head.

This benefit is limited to one payment per insured per covered accident per calendar year.

The concussion benefit is not payable if a traumatic brain injury benefit is payable under this certificate for the same accident.

### Dislocation

If a joint is dislocated in a covered accident, and it is diagnosed and treated by a physician within 90 days after the covered accident, we will pay the amount shown on the specifications page. The amount varies based on the joint that is dislocated, whether the dislocation is a full or a partial dislocation, and whether surgery is required to treat the dislocation.

A full dislocation refers to a completely separated joint due to a covered accident. A partial dislocation means the joint is misaligned but not completely dislocated, as diagnosed by a physician.

If more than one dislocation benefit is payable resulting from the same covered accident, we will pay the lesser of:

1. the total of the benefit amounts shown for each applicable dislocation on the specifications page; or
2. 2 times the highest dislocation benefit that would otherwise be payable for any one of the dislocations involved.
Eye Injury – with Surgery

If an insured is injured in a covered accident and the injury results in an eye injury that requires surgery, we will pay the amount shown on the specifications page. The insured must be seen by a physician within 60 days of the covered accident and surgery must be performed within 180 days of the covered accident. This benefit is limited to one payment per eye per insured per covered accident.

Eye Injury – Removal of Foreign Object without Surgery

If an insured is injured in a covered accident and the injury results in an eye injury that requires removal of a foreign object, but does not require surgery, we will pay the amount shown on the specifications page. The insured must be seen by a physician within 60 days of the covered accident and removal of the foreign object must be performed within 180 days of the covered accident. This benefit is limited to one payment per eye per insured per covered accident.

Fracture

If a bone is fractured in a covered accident, and it is diagnosed and treated by a physician within 90 days after the covered accident, we will pay the amount shown on the specifications page. The amount varies based on the bone that is fractured, whether or not the fracture is a chip fracture, and whether surgery is required to treat the fracture.

Fracture refers to a break in a bone that can be seen by x-ray. A chip fracture is a fracture in which a small fragment of the bone is broken off.

If more than one fracture benefit is payable resulting from the same covered accident, we will pay the lesser of:

1. the total of the benefit amounts shown for each applicable fracture on the specifications page; or
2. 3 times the highest fracture benefit that would otherwise be payable for any one of the bones involved.

We will pay no more than one fracture benefit per bone, per covered accident per insured. In no event will multiple fracture benefits be paid for the same fracture benefit shown on the specifications page unless it is a bi-lateral fracture. Bi-lateral fracture means the fracture of the same bone on both the left and right sides of the body.

Lacerations

If an insured is injured in a covered accident and the injury results in a laceration, we will pay the appropriate amount shown on the specifications page based on the type of treatment provided.

The laceration must be treated by a physician within 72 hours after the covered accident. This benefit is limited to one payment per insured per covered accident.

In no event will we pay more than one laceration benefit per calendar year.

Paralysis

If an insured is injured in a covered accident and the injury causes paralysis which lasts more than 180 days we will pay the appropriate amount shown on the specifications page. Paralysis refers to the total, permanent, and irrevocable loss of movement. The paralysis must be diagnosed by a physician within 180 days after the accident.

The amount payable will be based on the the type of paralysis, as follows:

Quadriplegia refers to paralysis of both upper limbs (from the shoulder down including total paralysis of both hands) and both lower limbs (from the waist down including total paralysis of both feet).

Paraplegia refers to paralysis of both lower limbs (from the waist down including total paralysis of both feet).

Hemiplegia refers to paralysis of both the upper limb (from the shoulder down including total paralysis of the hand) and lower limb (from the waist down including total paralysis of the foot) on one side of the body.

Uniplegia refers to paralysis of one limb (from the shoulder down including total paralysis of the hand if claiming an upper limb and from the waist down including total paralysis of the foot if claiming a lower limb).

We will pay no more than one paralysis benefit per covered accident per insured. In the event that an insured qualifies under multiple types of paralysis, the highest benefit amount will be paid.

Traumatic Brain Injury

If an insured is injured in a covered accident and the injury results in a traumatic brain injury, we will pay the amount shown on the specifications page.

Traumatic brain injury means only the following: intracranial hemorrhage, cerebral contusion or cerebral laceration.

The insured must be treated by a physician within 72 hours after the covered accident. The traumatic brain injury must be diagnosed within 30 days after the accident by computer tomography (CT) scan or magnetic resonance imaging (MRI). This benefit is payable only once per insured per covered accident. Scalp hematomas and scalp lacerations are not covered under this benefit.

Emergency Care

Ambulance

If an insured is injured in a covered accident and requires transportation to a hospital (or between hospitals) we will pay the appropriate ambulance benefit shown on the
specifications page. Ground or water transportation must be provided by a licensed professional ambulance service within 90 days of the covered accident. Air transportation must be provided by a licensed professional ambulance service within 72 hours. This benefit is limited to one payment per insured per covered accident. If an insured requires more than one ambulance transport, the highest benefit amount will be paid.

Ambulance means any publicly or privately owned surface, water or air vehicle, including a helicopter that is specifically designed and constructed or modified and equipped to be used, maintained or operated primarily for the transportation of individuals who are sick, injured or wounded.

Ambulance does not include a surface, water or air vehicle that is owned and operated to accommodate an incapacitated or disabled person who does not require medical monitoring, care or treatment during transport.

Blood, Plasma or Platelets Transfusion

If an insured is injured in a covered accident and requires a blood, plasma or platelets transfusion, we will pay the blood/plasma/platelets transfusion benefit shown on the specifications page. The transfusion must occur within 90 days of the covered accident. This benefit is limited to one payment per insured per covered accident.

Emergency Dental

If an insured has an injury to sound natural teeth as a result of a covered accident, we will pay the appropriate emergency dental benefit shown on the specifications page. A benefit is payable for a broken tooth repaired with crown(s) or a broken tooth requiring extraction. Treatment must occur within 60 days of the covered accident. The maximum number of crown benefits payable per insured per covered accident is two. The maximum number of extraction benefits payable per insured per covered accident is two.

Proof of the soundness of the injured tooth must be submitted with claims. Injuries resulting from biting or chewing are not covered under this benefit.

Sound natural teeth are defined as teeth that are free of active or chronic clinical decay, have at least 50% bone support and are functional in the arch.

Emergency Room Treatment

If an insured is injured in a covered accident and requires treatment in an emergency room, we will pay the emergency room treatment benefit shown on the specifications page. Treatment must occur within 72 hours of the covered accident.

This benefit is limited to one payment per insured per covered accident.

Initial Physician’s Office Visit

If an insured is injured in a covered accident, we will pay the initial physician’s office visit benefit shown on the specifications page. Benefits are payable for the initial treatment received in a physician’s office or an urgent care center for injuries resulting from a covered accident. Treatment must occur within 72 hours of the covered accident. The maximum number of benefits per insured per calendar year is two. The benefit is not payable if the insured receives care in an emergency room within the same 72 hour period. Only one benefit is payable per covered accident.

Hospital Care

Hospital Stay

If an insured is injured in a covered accident and requires treatment in a hospital for the injury within 180 days of a covered accident, we will pay the hospital stay benefit shown on the specifications page subject to the following.

Initial Benefit

We will pay the initial benefit shown on the specifications page for the first day of a hospital stay provided the insured is receiving treatment for a covered accident in the hospital for a minimum of 18 continuous hours.

The benefit payment will be based on the type of room and level of care the insured receives. The Intensive Care Unit (ICU) benefit is payable if the insured is receiving treatment in an ICU room of a hospital. The non-ICU benefit is payable if the insured is receiving treatment in a non-ICU room.

This benefit is limited to one payment per insured per covered accident. In the event the insured receives treatment in both a non-ICU and an ICU room, the higher benefit will be payable as an initial benefit.

Daily Benefit

If an initial benefit is payable, the insured will also receive a daily benefit for each day he or she is treated in the hospital, including the first day. The amount payable for the daily benefit is shown on the specifications page.

The daily benefit payment will be based on the type of room and level of care the insured receives. The ICU benefit is payable if the insured is receiving treatment in an ICU room of a hospital. The non-ICU benefit is payable if the insured is receiving treatment in a non-ICU room.

The ICU daily benefit will be limited to a maximum of 15 days per insured per covered accident.
The combination of the both ICU and non-ICU benefits will be limited to a cumulative maximum of 120 days per insured per covered accident.

If an insured is released from the hospital and subsequently requires treatment in a hospital for injuries sustained in the same covered accident, the subsequent treatment will be considered a continuation of the same hospital stay for purposes of determining the cumulative maximum daily benefit so long as the treatment occurs within two years of the date of the covered accident.

Intensive Care Unit (ICU) refers to a specifically designated part of a hospital that provides the highest level of medical care and is restricted to patients who are critically ill or injured and who require intensive comprehensive observation and care. Hospital Intensive Care Units must be:

1. separate and apart from the surgical recovery room;
2. separate and apart from rooms, beds, and wards customarily used for patient confinement; and
3. permanently equipped with special life-saving equipment to care for the critically ill or injured; and
4. under constant and continuous observation by nursing staffs assigned to the Intensive Care Unit.

Surgery Benefits

Abdominal or Pelvic Surgery

If an insured is injured in a covered accident and requires abdominal or pelvic surgery to treat the injuries, we will pay the abdominal or pelvic surgery benefit shown on the specifications page. The surgery must be performed within 72 hours of the covered accident. This benefit is limited to one payment per insured per covered accident. Surgery required to treat a fracture or dislocation is payable under the fracture or dislocation benefit and is not covered under the abdominal or pelvic surgery benefit.

Cranial Surgery

If an insured is injured in a covered accident and requires cranial surgery to treat the injuries, we will pay the cranial surgery benefit shown on the specifications page. The surgery must be performed within 72 hours of the covered accident. This benefit is limited to one payment per insured per covered accident.

Knee Cartilage Surgery

If an insured is injured in a covered accident and requires knee cartilage surgery to treat the injury, we will pay the knee cartilage surgery benefit shown on the specifications page. The insured must be treated by a physician within 60 days of the covered accident and surgery must be performed within 180 days of the covered accident. This benefit is limited to one payment per insured per covered accident.

Ruptured Disc Surgery

If an insured is injured in a covered accident and requires surgery for one or more ruptured discs to treat the injury, we will pay the ruptured disc surgery benefit shown on the specifications page. The insured must be treated by a physician within 60 days of the covered accident and surgery must be performed within 180 days of the covered accident. This benefit is limited to one payment per insured per covered accident.

Tendon, Ligament or Rotator Cuff Surgery

If an insured is injured in a covered accident and requires tendon, ligament or rotator cuff surgery to treat the injuries, we will pay the tendon, ligament or rotator cuff surgery benefit shown on the specifications page. The insured must be treated by a physician within 60 days of the covered accident and surgery must be performed within 180 days of the covered accident. This benefit is limited to one payment per insured per covered accident.

Thoracic Surgery

If an insured is injured in a covered accident and requires thoracic surgery to treat the injuries, we will pay the thoracic surgery benefit shown on the specifications page. The surgery must be performed within 72 hours of the covered accident. This benefit is limited to one payment per insured per covered accident.

Surgery required to treat a fracture or dislocation is payable under the fracture or dislocation benefit and is not covered under the thoracic surgery benefit.

Follow-Up Care

Adaptive Home and Vehicle Benefit

If an insured is injured in a covered accident and requires adaptive modifications to his or her primary residence or private vehicle to be made drivable or rideable, we will pay the adaptive home and vehicle benefit shown on the specifications page subject to the following conditions:

1. a benefit is payable under the paralysis benefit of the Injury Benefits section of this certificate; and
(2) the modification must take place within two years of the covered accident; and
(3) such home alterations are made by a person or persons with experience in such alterations and recommended by a recognized organization associated with the injury; and
(4) such vehicle modifications are carried out by a person or persons with experience in such matters and approved by the Motor Vehicle Department.

This benefit is limited to one payment per insured per covered accident.

**Appliances**

If an insured is injured in a covered accident and a medical appliance is prescribed by a physician for mobility, we will pay the appliance benefit shown on the specifications page. The order for the appliance must be placed within 180 days of the covered accident. This benefit is limited to payment for two covered appliances per insured per covered accident.

Covered appliances means only the following: crutches, canes, walkers, wheelchairs/scooters, leg braces and back braces. This benefit does not cover replacement appliances.

**Follow-Up Physician’s Office Visit**

If an insured is injured in a covered accident and follow-up care for the injury is ordered by the treating physician, we will pay the follow-up physician’s office visit benefit shown on the specifications page. The follow-up visit(s) must occur within 180 days of the covered accident. This benefit is limited to three payments per insured per covered accident. Follow-up at an urgent care center is not covered under this benefit.

**Prosthetics**

If an insured is injured in a covered accident and sustains the loss of a limb, hand, foot or sight in an eye, we will pay the prosthetic benefit shown on the specifications page, subject to the following:

(1) this benefit is limited to payment for two prosthetic devices per insured per covered accident; and
(2) the prosthetic device(s) must be prescribed by a physician and ordered within 180 days after the covered accident.

Prosthetic device refers to an artificial device that replaces a missing limb, hand, foot or an eye. For purposes of this benefit, the term prosthetic device does not include corrective lenses or other cosmetic prostheses.

In addition, this benefit does not provide coverage for damaged prosthetics; more than one prosthetic device for the same limb, hand, foot or eye; the replacement of a prosthetic device; or a joint replacement.

**Transportation**

If an insured receives follow-up treatment ordered by a physician for an injury sustained in a covered accident and is required to travel more than 100 miles (one way) from the insured’s primary residence to a hospital or other treatment facility, we will pay the transportation benefit shown on the specifications page subject to the following:

(1) a benefit is payable under this certificate for the same injury; and
(2) the follow-up treatment is ordered by a physician and is not available within 100 miles (one way) of the insured’s primary residence; and
(3) the Ambulance benefit is not payable for the same trip.

Mileage is measured from the insured’s primary residence to the hospital or treatment facility where the follow-up treatment is provided.

This benefit is limited to two payments per insured per covered accident.

**Support Care**

**Adult Companion Lodging**

If an insured is injured in a covered accident, we will pay the adult companion lodging benefit shown on the specifications page for each day the insured is receiving treatment in a hospital or rehabilitative facility for the injury, and for the 24 hours following the last day the insured is receiving treatment in a hospital or rehabilitative facility for the injury subject to the following conditions:

(1) a companion who accompanies the insured stays in lodging for which a charge is made; and
(2) either the hospital stay benefit or rehabilitative therapy (inpatient) benefit is payable for the same day the adult companion lodging benefit is payable; and
(3) the companion is 18 or older.

Lodging refers to an establishment licensed under the laws applicable to where it is located, such as a motel, hotel, or other facility that provides sleeping accommodations to the general public in exchange for a fee and is located at least 100 miles from the insured’s primary residence.

This benefit is limited to 30 days per covered accident. Proof must be provided that the companion incurred an expense for staying at a lodging.
Exclusions and Limitations

Are there any other exclusions that apply?

Yes. In no event will we pay benefits where the insured’s accident, injury or loss is caused from any of the following:

(1) intentionally self-inflicted injury while sane; or
(2) suicide or attempted suicide, while sane; or
(3) your commission of, or your attempt to commit, a felony, or your engagement in an illegal occupation; or
(4) your being intoxicated; or
(5) your being under the influence of any narcotic, unless administered on the advice of a physician; or
(6) poisons, gases, fumes or other substances voluntarily taken, absorbed, inhaled, ingested or injected, unless as a direct result of an occupational accident; or
(7) war or any act of war, whether declared or undeclared; or
(8) bodily or mental infirmity, illness or disease; or
(9) repetitive stress syndromes including rotator cuff syndrome, bursitis, tendonitis, carpal tunnel syndrome, ulnar nerve syndrome, stress fractures, neuropathy, epicondylitis or neuritis; or
(10) aviation, other than as a fare-paying passenger; or
(11) participation in the following activities: scuba diving, bungee jumping, base jumping, hang gliding, sail gliding, parasailing, parakiting, or mountain climbing; or
(12) riding or driving in any motor-driven vehicle in a race, stunt show or speed test; or
(13) practicing for or participating in any semi-professional or professional competitive athletics.

Are there any additional limitations that apply?

Yes. Benefits are not payable for any care, treatment or diagnostic measures which were received outside of the United States or United States territory.

Notice of Claim

Written notice of claim must be given to us within 20 days after the occurrence or commencement of any loss covered by the certificate or as soon thereafter as reasonably possible. Notice given by or on behalf of the claimant to us at our home office or to any authorized agent of ours, with information sufficient to identify the insured, shall be deemed notice to us.

Claim Forms

When we receive written notice of claim, we will furnish to the claimant such forms as are usually furnished by us for filing proofs of loss.

If such forms are not furnished within 15 days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of this certificate as to proof of a loss upon submitting, within the time fixed in this certificate for filing proofs of loss, written proof of the occurrence, character and extent of the loss for which claim is made.

Proof of Loss

Proof of a loss must be furnished to us within 90 days after the date of loss. However, failure to provide such notice and proof within the time provided will not invalidate or reduce a claim if it was not reasonably possible to provide proof within that time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the employee, later than one year from the time proof is otherwise required.

Time of Payment of Claims

We will pay a benefit for a loss resulting from a covered accident immediately after receipt at our home office of written proof of the loss which meets all policy requirements. You are responsible for all costs associated with claim form(s) completion, records, and the submission of your claim.

Payment of Claims

To whom will benefits be paid?

All benefits including dependent's benefits will be paid to you, if you are living.

Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to your estate.

Any other accrued indemnities unpaid at your death may, at the option of the Insurer, be paid either to such beneficiary or to such estate.

Physical Examination and Autopsy

We, at our own expense, shall have the right and opportunity to examine the person of any individual whose injury is the basis of a claim when and as often as we may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death, where it is not forbidden by law.

Termination

When does your coverage terminate?

Coverage ends on the earliest of the following:
(1) the date you no longer meet the eligibility requirements; or
(2) 31 days (the grace period) after the due date of any premium which is not paid; or
(3) the last day for which premium contributions have been paid following your request to cancel your coverage; or
(4) the date the group policy ends.

When does an insured dependent’s coverage terminate?

An insured dependent’s coverage ends on the earliest of the following:

(1) the date the dependent no longer meets the eligibility requirements; or
(2) 31 days (the grace period) after the due date of any premium contribution which is not paid; or
(3) the last day for which premium contributions have been paid following your written request that insurance on your eligible dependents be terminated; or
(4) the date you are no longer covered under the group policy.

You must notify us or your employer when you no longer have dependents eligible for coverage under this certificate so that premiums may be discontinued.

All premiums paid for dependents who are no longer eligible for coverage under this certificate will be refunded without any payment of claim.

Time Limit on Certain Defenses

After this certificate has been in force for a period of three years, no statements of the employer contained in the application, and no statement relating to insurability made by any employee eligible for coverage under this certificate shall be used to deny a claim or in contesting the validity of the insurance with respect to which such statement was made after the insurance has been in force prior to the contest for a period of three years during the lifetime of the person with respect to whom any such statement was made.

Additional Information

Is the policyholder required to maintain records?

Yes. The policyholder is required to maintain adequate records of any information necessary for us to administer the policy, and shall provide access to such records when required for us to administer the policy. If a clerical error is made in keeping records on the insurance under the group policy, it will not affect otherwise valid insurance.

A clerical error does not continue insurance which is otherwise stopped, make insurance effective when it should not have been or change the benefit amount provided by the provisions of the policy and no claim shall be paid on amounts affected by a clerical error. If an error causes a change in premium payment, a fair adjustment will be made.

Will the provisions of this certificate conform with applicable state law?

Yes. If any provision in this certificate, or in the provisions of the group policy, is in conflict with the applicable laws of the state governing the certificates or the group policy, the provision will be deemed to be amended to conform to such laws.

What if an insured’s age has been misstated?

If an insured’s age has been misstated, all amounts payable will be adjusted to that amount which the premium would have purchased at the correct age. This will be determined by applying the ratio of the paid premium over the required premium to the initial benefit amount.

Can this insurance be assigned?

No. Insurance coverage under the group policy cannot be assigned.

Can this certificate be amended?

Yes. We retain the right to amend this certificate at any time without your consent. Any amendment will be without prejudice to any claim incurred for benefits prior to the date of the amendment.
General Information

This certificate supplement is subject to every term, condition, exclusion, limitation and provision of the certificate unless otherwise expressly provided for herein.

What does this supplement provide?

This supplement provides for continuation of insurance if an insured no longer meets the eligibility requirements of the certificate, except as provided for herein.

To continue insurance the insured must make a written request and make the first premium payment within 31 days after insurance provided by the group policy would otherwise terminate. Coverage provided by this supplement will then be deemed effective retroactive to the beginning of the 31-day period. This date is considered to be the insured's portability date and the insured is then considered to have portability status.

Who is eligible to continue insurance under this supplement?

An insured employee is eligible to continue group accident insurance under the terms of this supplement if he or she no longer meets the eligibility requirements of the certificate due to any of the following:

1. the employee terminates employment, including retirement; or
2. the employee is no longer in a class eligible for insurance or is on a leave or layoff; or
3. a class or group of employees insured under the policy are no longer considered eligible and there is no successor plan for that class or group. Successor plan means an insurance policy or policies provided by us or another insurer that replaces insurance provided under this policy.

Regardless of whether an insured is otherwise eligible under this supplement to continue, an insured will not be eligible to request coverage under this supplement if he or she:

1. has attained the age of 70; or
2. is an employee and was not actively at work due to sickness or injury on the date immediately preceding his or her portability date; or
3. loses eligibility due to a class or group of employees no longer being eligible under the policy and there is a successor plan for that class or group of employees; or
4. loses eligibility due to termination of the group policy.

What insurance can be continued under this supplement?

Group accident insurance may be continued under this supplement. If an employee elects to continue his or her own coverage according to the provisions of this supplement, he or she may also elect to continue insurance for any other individual insured under his or her certificate.

What benefit amounts can be continued under this supplement?

The benefit amounts that can be continued under this supplement shall be the amounts shown on the specifications page applicable to the insured based on the benefit plan selected by the insured employee.

Can an insured request a change in the benefit plan continued under this supplement?

Yes. The insured employee may change the benefit plan to one that provides lower benefit amounts, but may not change the benefit plan to one that provides higher benefit amounts.

How will premiums be paid?

Premiums will be paid directly to us on a monthly, quarterly, semi-annual, or annual basis and will be subject to an administrative charge per billing period.

Can the premium rate change?

Yes. The premium rates for ported coverage may be different than the premium rates for active employees, and are not subject to the premium rate provision of the policy.

What happens if an insured again becomes eligible under the certificate?

If an insured is continuing coverage under the terms of this supplement, and again meets the eligibility requirements of the certificate the insured shall no longer be considered to have portability status. Insurance may be continued only under the terms of the certificate, not including this supplement, unless and until the insured no longer meets the eligibility requirements of the certificate and again returns to portability status as provided for herein.

What happens to insurance provided under this supplement when the group policy terminates?

Any insurance continued under the terms of this supplement will remain in force until terminated by the provisions of the section entitled “When will insurance continued under this supplement terminate?”
No individual may elect coverage under this supplement on or after the date of termination of the group policy.

**When will insurance continued under this supplement terminate?**

An insured’s insurance being continued under this supplement will terminate on the earliest of the following:

1. the insured’s 70th birthday;
2. the date the insured again meets the eligibility requirements of the certificate, not including the terms of this supplement;
3. in the case of a dependent child or a spouse, the date your coverage is no longer being continued under this supplement or the date the spouse or child ceases to be eligible as defined under the terms of your certificate; or
4. the date the group policy is terminated; or
5. 31 days after the due date of any premium contribution which is not made.

Secretary President
IT IS IMPORTANT TO US THAT YOU ARE SATISFIED WITH THIS POLICY AND THE SERVICE YOU RECEIVE FROM US.

IF YOU HAVE AN UNRESOLVED COMPLAINT, THE CALIFORNIA INSURANCE DEPARTMENT SUGGESTS THAT YOU NOTIFY THEIR CONSUMER AFFAIRS OFFICE. CONTACT SHOULD BE MADE ONLY AFTER COMMUNICATIONS BETWEEN YOU AND US (THE AGENT OR OTHER REPRESENTATIVE) HAVE FAILED TO PRODUCE A SATISFACTORY SOLUTION TO THE PROBLEM.

CONTACT : YOUR AGENT
OR
SECURIAN LIFE INSURANCE COMPANY
400 ROBERT STREET NORTH
ST. PAUL, MN 55101-2098
651-665-3500

QUESTIONS ABOUT THIS NOTICE OR ANY UNRESOLVED COMPLAINT MAY BE DIRECTED TO:

DEPARTMENT OF INSURANCE
CONSUMER AFFAIRS DEPARTMENT
300 SOUTH SPRING STREET
LOS ANGELES, CA  90013
213-897-8921

TOLL FREE TELEPHONE FOR CALIFORNIA ONLY:
800-927-4357

OFFICE HOURS:  9 A.M. TO 5 P.M.

THIS NOTICE PROVIDES CONTACT INFORMATION ONLY AND IS NOT A CONDITION OF THE POLICY.
NOTICE OF PROTECTION PROVIDED BY CALIFORNIA LIFE AND HEALTH INSURANCE GUARANTEE ASSOCIATION

This notice provides a brief summary regarding the protections provided to policyholders by the California Life and Health Insurance Guarantee Association ("the Association"). The purpose of the Association is to assure that policyholders will be protected, within certain limits, in the unlikely event that a member insurer of the Association becomes financially unable to meet its obligations. Insurance companies licensed in California to sell life insurance, health insurance, annuities and structured settlement annuities are members of the Association. The protection provided by the Association is not unlimited and is not a substitute for consumers' care in selecting insurers. This protection was created under California law, which determines who and what is covered and the amounts of coverage.

Below is a brief summary of the coverage, exclusions and limits provided by the Association. This summary does not cover all provisions of the law; nor does it in any way change anyone's right or obligations or the rights or obligations of the Association.

COVERAGE

Persons Covered

Generally, an individual is covered by the Association if the insurer was a member of the Association and the individual lives in California at the time the insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payees or assignees, whether or not they live in California.

Amounts of Coverage

The basic coverage protections provided by the Association are as follows:

- **Life Insurance, Annuities and Structured Settlement Annuities**

  For life insurance policies, annuities and structured settlement annuities, the Association will provide the following:

  - **Life Insurance**
    - 80% of death benefits but not to exceed $300,000
    - 80% of cash surrender or withdrawal values but not to exceed $100,000
  
  - **Annuities and Structured Settlement Annuities**
    - 80% of the present value of annuity benefits, including net cash withdrawal and net cash surrender values but not to exceed $250,000

  The maximum amount of protection provided by the Association to an individual, for all life insurance, annuities and structured settlement annuities is $300,000, regardless of the number of policies or contracts covering the individual.

- **Health Insurance**

  The maximum amount of protection provided by the Association to an individual, as of July 1, 2016, is $546,741. This amount will increase or decrease based upon changes in the health care cost component of the consumer price index to the date on which an insurer becomes an insolvent insurer. Changes to this amount will be posted on the Association's website www.califega.org.
COVERAGE LIMITATIONS AND EXCLUSIONS FROM COVERAGE

The Association may not provide coverage for this policy. Coverage by the Association generally requires residency in California. You should not rely on coverage by the Association in selecting an insurance company or in selecting an insurance policy.

The following policies and persons are among those that are excluded from Association coverage:

- A policy or contract issued by an insurer that was not authorized to do business in California when it issued the policy or contract.
- A policy issued by a health care service plan (HMO), a hospital or medical service organization, a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society.
- If a person is provided coverage by the guaranty association of another state.
- Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which do not guaranty annuity benefits to an individual.
- Employer and association plans, to the extent they are self-funded or uninsured;
- A policy or contract providing any health care benefits under Medicare Part C or Part D.
- An annuity issued by an organization that is only licensed to issue charitable gift annuities.
- 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 certain investment elements of a variable life insurance policy or a variable annuity contract.
- Any policy of reinsurance unless an assumption certificate was issued;
- Interest rate yields (including implied yields) that exceed limits that are specified in Insurance Code Section 1607.02(b)(2)(C).

NOTICES

Insurance companies or their agents are required by law to give or send you this notice. Policyholders with additional questions should first contact their insurer or agent. To learn more about coverage provided by the Association, please visit the Association's website at www.califega.org, or contact either of the following:

**California Life and Health Insurance Guarantee Association**
P.O. Box 16860
Beverly Hills, CA 90209-3319
(323) 782-0182

**California Department of Insurance**
Consumer Communications Bureau
300 South Spring Street
Los Angeles, CA 90013
(800) 927-4357

Insurance companies and agents are not allowed by California law to use the existence of the Association or its coverage to solicit, induce or encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and California law, then California law will control.
Securian Life Insurance Company • A Stock Company
400 Robert Street North • St. Paul, Minnesota 55101-2098

GROUP ACCIDENT CERTIFICATE OF INSURANCE
Group Accident Insurance
Outline of Coverage
Securian Life Insurance Company • A Stock Company
400 Robert Street North • St. Paul, Minnesota  55101-2098

Applies to Residents of Idaho

THIS CERTIFICATE PROVIDES LIMITED BENEFITS. BENEFITS PROVIDED ARE SUPPLEMENTAL AND NOT INTENDED TO COVER ALL MEDICAL EXPENSES.

(1) Read Your Certificate Carefully - This Outline of Coverage accompanies Group Accident Insurance Certificate of Insurance, form 15-32401. It provides a very brief description of the important features of your certificate. This is not the insurance contract and only the actual certificate provisions shall control. The certificate sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR CERTIFICATE CAREFULLY!

(2) ACCIDENT COVERAGE is designed to provide, to persons insured, coverage for certain losses resulting from a covered accident ONLY, subject to any limitations contained in the certificate. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

(3) BENEFITS – The benefit amount payable will depend on whether the insured is enrolled in the Low Plan or High Plan, the number of benefits you qualify for, the care you receive and the terms and conditions of the policy.

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<thead>
<tr>
<th>INJURY BENEFITS</th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
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<tbody>
<tr>
<td><strong>Burn Benefit</strong></td>
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<td>2nd degree burns</td>
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<tr>
<td>Less than 10% of the body</td>
<td>$100</td>
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<td><strong>Concussion</strong></td>
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**Dislocation**

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<td>Wrist: 30%</td>
<td></td>
<td>Wrist: 30%</td>
</tr>
<tr>
<td>Lower jaw</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Shoulder</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Collarbone</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Ribs</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Finger</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Toe</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Elbow</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Non-surgical</td>
<td>50% of surgical benefit</td>
<td>50% of surgical benefit</td>
</tr>
<tr>
<td>Partial dislocation</td>
<td>25% of non-surgical benefit</td>
<td>25% of non-surgical benefit</td>
</tr>
<tr>
<td>INJURY BENEFITS</td>
<td>LOW PLAN</td>
<td>HIGH PLAN</td>
</tr>
<tr>
<td>----------------</td>
<td>----------</td>
<td>-----------</td>
</tr>
<tr>
<td>Eye Injury - with Surgery</td>
<td>$120</td>
<td>$300</td>
</tr>
<tr>
<td>Eye Injury – Removal of Foreign Object without Surgery</td>
<td>$30</td>
<td>$75</td>
</tr>
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**Fracture**

<table>
<thead>
<tr>
<th>Fracture</th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Principal Amount (Surgical)</td>
<td>$2,000</td>
<td>$5,000</td>
</tr>
<tr>
<td>% of Principal Amount</td>
<td>% of Principal Amount</td>
<td></td>
</tr>
<tr>
<td>Hip/Thigh</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Vertebral body</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Vertebral processes</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Pelvis</td>
<td>75%</td>
<td>75%</td>
</tr>
<tr>
<td>Sternum</td>
<td>75%</td>
<td>75%</td>
</tr>
<tr>
<td>Coccyx</td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td>Skull – non depressed</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Skull – depressed</td>
<td>150%</td>
<td>150%</td>
</tr>
<tr>
<td>Lower leg</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Foot</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Ankle</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Kneecap</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Upper arm</td>
<td>35%</td>
<td>35%</td>
</tr>
<tr>
<td>Facial excluding lower jaw</td>
<td>35%</td>
<td>35%</td>
</tr>
<tr>
<td>Forearm</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Hand or wrist (except fingers)</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Lower jaw</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Shoulder blade</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Collarbone</td>
<td>15%</td>
<td>15%</td>
</tr>
<tr>
<td>Ribs</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Finger</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Toe</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Nose</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Non-surgical</td>
<td>50% of surgical benefit</td>
<td>50% of surgical benefit</td>
</tr>
<tr>
<td>Chip fracture</td>
<td>25% of non-surgical benefit</td>
<td>25% of non-surgical benefit</td>
</tr>
</tbody>
</table>

**Lacerations**

<table>
<thead>
<tr>
<th>Lacerations</th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>With stitches or staples</td>
<td>$100</td>
<td>$500</td>
</tr>
<tr>
<td>Without stitches or staples</td>
<td>25% of benefit provided with stitches or staples</td>
<td>25% of benefit provided with stitches or staples</td>
</tr>
</tbody>
</table>

**Paralysis**

<table>
<thead>
<tr>
<th>Paralysis</th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Principal Amount</td>
<td>$20,000</td>
<td>$60,000</td>
</tr>
<tr>
<td>% of Principal Amount</td>
<td>% of Principal Amount</td>
<td></td>
</tr>
<tr>
<td>Quadriplegia</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Paraplegia</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Hemiplegia</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Uniplegia</td>
<td>25%</td>
<td>25%</td>
</tr>
</tbody>
</table>

**Traumatic Brain Injury**

<table>
<thead>
<tr>
<th>Traumatic Brain Injury</th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>$200</td>
<td>$400</td>
<td></td>
</tr>
</tbody>
</table>

**EMERGENCY CARE**

<table>
<thead>
<tr>
<th>Ambulance</th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ground or water</td>
<td>$100</td>
<td>$200</td>
</tr>
<tr>
<td>Air</td>
<td>$500</td>
<td>$1,000</td>
</tr>
<tr>
<td>INJURY BENEFITS</td>
<td>LOW PLAN</td>
<td>HIGH PLAN</td>
</tr>
<tr>
<td>-----------------------------------------------------</td>
<td>----------</td>
<td>-----------</td>
</tr>
<tr>
<td>Blood, Plasma or Platelets Transfusion</td>
<td>$300</td>
<td>$600</td>
</tr>
<tr>
<td>Emergency Dental</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crown</td>
<td>$150</td>
<td>$300</td>
</tr>
<tr>
<td>Extraction</td>
<td>$50</td>
<td>$100</td>
</tr>
<tr>
<td>Emergency Room Treatment</td>
<td>$100</td>
<td>$300</td>
</tr>
<tr>
<td>Initial Physician’s Office Visit</td>
<td>$50</td>
<td>$100</td>
</tr>
<tr>
<td>HOSPITAL CARE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Stay</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initial benefit, non-ICU</td>
<td>$400</td>
<td>$1,200</td>
</tr>
<tr>
<td>Initial benefit, ICU</td>
<td>$800</td>
<td>$2,400</td>
</tr>
<tr>
<td>Daily benefit, non-ICU</td>
<td>$100</td>
<td>$300</td>
</tr>
<tr>
<td>Daily benefit, ICU</td>
<td>$200</td>
<td>$600</td>
</tr>
<tr>
<td>SURGERY</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abdominal or Pelvic Surgery</td>
<td>$1,000</td>
<td>$2,000</td>
</tr>
<tr>
<td>Cranial Surgery</td>
<td>$1,000</td>
<td>$2,000</td>
</tr>
<tr>
<td>Knee Cartilage Surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Open</td>
<td>$500</td>
<td>$1,000</td>
</tr>
<tr>
<td>Arthroscopic</td>
<td>$250</td>
<td>$500</td>
</tr>
<tr>
<td>Ruptured Disc Surgery</td>
<td>$500</td>
<td>$1,000</td>
</tr>
<tr>
<td>Tendon, Ligament or Rotator Cuff Surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Open</td>
<td>$500</td>
<td>$1,000</td>
</tr>
<tr>
<td>Arthroscopic</td>
<td>$250</td>
<td>$500</td>
</tr>
<tr>
<td>Thoracic Surgery</td>
<td>$1,000</td>
<td>$2,000</td>
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<tr>
<td>FOLLOW-UP CARE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adaptive Home and Vehicle Benefit</td>
<td>$500</td>
<td>$1,000</td>
</tr>
<tr>
<td>Appliances</td>
<td>$50</td>
<td>$250</td>
</tr>
<tr>
<td>Follow-Up Physician’s Office Visit</td>
<td>$50</td>
<td>$100</td>
</tr>
<tr>
<td>FOLLOW-UP CARE</td>
<td>LOW PLAN</td>
<td>HIGH PLAN</td>
</tr>
<tr>
<td>----------------</td>
<td>----------</td>
<td>-----------</td>
</tr>
<tr>
<td>Prosthetics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>One prosthetic</td>
<td>$500</td>
<td>$1,000</td>
</tr>
<tr>
<td>Two or more prosthetics</td>
<td>2x one prosthetic</td>
<td>2x one prosthetic</td>
</tr>
<tr>
<td>Transportation</td>
<td>$200 per visit</td>
<td>$500 per visit</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SUPPORT CARE</th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Companion Lodging</td>
<td>$75 per day</td>
<td>$150 per day</td>
</tr>
</tbody>
</table>

(4) EXCLUSIONS AND LIMITATIONS - In no event will we pay benefits where the insured’s accident, injury or loss is caused directly or indirectly by, results in whole or in part from or during, or there is contribution from, any of the following:

1. intentionally self-inflicted injury while sane; or
2. suicide or attempted suicide while sane; or
3. your participation in a felony; or
4. alcoholism; or
5. drug addiction; or
6. war or any act of war, whether declared or undeclared; or
7. bodily or mental infirmity, illness or disease; or
8. infection, other than infection occurring simultaneously with, and as a direct and independent result of, the injury; or
9. travel in or descent from any aircraft, except as a fare-paying passenger on a regularly scheduled commercial flight on a licensed passenger aircraft carrier; or
10. practicing for or participating in any professional competitive athletics.

(5) RENEWABILITY - The group policy will continue in force until it is canceled by either the group policyholder or Securian Life. Subject to the termination section of the certificate, the certificate may be renewed by making the required premium payments.

(6) PREMIUMS – We reserve the right to change premium rates on any premium due date, but not more than once in each 12-month period. We will provide at least 60 days advance notice of any change in premium rates.

(7) TERMINATION - Please refer to the Termination section of your certificate for information about when coverage will end. In the event that you lose eligibility under the group policy, you may continue your coverage according to the terms of the Continuation of Insurance Certificate Supplement.

Secretary

President
Group Accident Certificate of Insurance

Securian Life Insurance Company • A Stock Company
400 Robert Street North • St. Paul, Minnesota 55101-2098

Applies to Residents of Idaho

POLICYHOLDER: Concordia Plan Services

POLICY NUMBER: 76013

THIS CERTIFICATE IS NOT MAJOR MEDICAL INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL INSURANCE. IT DOES NOT QUALIFY AS MINIMUM ESSENTIAL HEALTH COVERAGE UNDER THE FEDERAL AFFORDABLE CARE ACT. THIS CERTIFICATE DOES NOT SATISFY THE FEDERAL REQUIREMENT THAT YOU HAVE HEALTH INSURANCE COVERAGE, WHICH BECAME EFFECTIVE JANUARY 1, 2014.

THIS IS A LIMITED BENEFIT CERTIFICATE: This certificate provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses. Read your certificate carefully.

THIS CERTIFICATE IS NOT A MEDICARE SUPPLEMENT CONTRACT. If you are eligible for Medicare, review the Guide to Health Insurance for people with Medicare available from us.

The following contact information is provided should you wish to contact the Idaho Department of Insurance for assistance: Idaho Department of Insurance, Consumer Affairs, 700 W State Street, 3rd Floor, PO Box 83720, Boise ID 83720-0043, 1-800-721-3272 or www.DOI.Idaho.gov

Read Your Certificate Carefully

If you meet the eligibility and enrollment requirements herein, you are insured under the group policy shown on the specifications page. This certificate summarizes the principal provisions of the group policy that affect you. The provisions summarized in this certificate are subject in every respect to the group policy. You may examine the group policy at the principal office of the policyholder during regular working hours.

Legal Actions

No legal action may be brought to recover on this certificate within the first sixty days after written proof of loss has been given as required by this certificate. No such action may be brought after three years from the time written proof of loss is required to be given.

Secretary

President

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GROUP ACCIDENT CERTIFICATE OF INSURANCE
GENERAL INFORMATION

POLICYHOLDER: Concordia Plan Services

POLICY NUMBER: 76013

ASSOCIATED COMPANIES: All subsidiaries and affiliates reported to Securian Life by the policyholder for inclusion in the policy.

POLICY SITUS: The policy was issued and delivered in Missouri.

POLICY EFFECTIVE DATE: January 1, 2019.

This certificate and/or certificate specifications page replaces any and all certificates and/or certificate specifications pages previously issued to you under the group policy. Please replace any certificate and/or certificate specifications page previously issued to you with this new certificate and/or specifications page.

GROUP:

The group is composed of all active employees of the policyholder and its associated companies working in the United States in the following classes:

Class 1: Active employees working at least 20 hours per week.

All new employees of the employer will be added to such group and classes for which they become eligible.

NO DOUBLE COVERAGE:

A person cannot be covered under more than one class. A person cannot be covered as both an active employee and a retiree. Any person who is eligible as an employee or retiree under the policy, or insured under the portability provisions, is not eligible as a dependent. Only one person can insure an eligible dependent child.

ENROLLMENT PERIOD: 90 days from the first day of eligibility for contributory insurance.

WAITING PERIOD: None

MINIMUM HOURS PER WEEK REQUIREMENT: 20 hours per week

PLAN OF INSURANCE

EMPLOYEE BENEFIT SCHEDULE

EMPLOYEE GROUP ACCIDENT INSURANCE:

Supplemental Group Accident Insurance

<table>
<thead>
<tr>
<th>Eligible Class</th>
<th>Employee Supplemental Group Accident Insurance Benefit Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class 1</td>
<td>Low Plan or High Plan as elected by the employee.</td>
</tr>
</tbody>
</table>
GENERAL PROVISIONS FOR EMPLOYEE INSURANCE

RETIREMENT REDUCTIONS: All insurance terminates at retirement, except as otherwise provided for under any applicable certificate supplement.

CONTRIBUTORY/NONCONTRIBUTORY: Supplemental insurance is contributory insurance.

PORTABILITY BENEFIT: Low Plan or High Plan as elected by the employee.

DEPENDENT BENEFIT SCHEDULE

An employee must be insured in order to elect dependent group accident insurance.

SPOUSE GROUP ACCIDENT INSURANCE

Supplemental Group Accident Insurance

<table>
<thead>
<tr>
<th>Eligible Class</th>
<th>Spouse Supplemental Group Accident Insurance Benefit Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class 1</td>
<td>Spouse benefit plan will match the employee’s Supplemental Group Accident Benefit Plan</td>
</tr>
</tbody>
</table>

CHILD GROUP ACCIDENT INSURANCE

Supplemental Group Accident Insurance

<table>
<thead>
<tr>
<th>Eligible Class</th>
<th>Child Supplemental Group Accident Insurance Benefit Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class 1</td>
<td>Child benefit plan will match the employee’s supplemental Group Accident Benefit Plan</td>
</tr>
</tbody>
</table>

GENERAL PROVISIONS FOR DEPENDENT INSURANCE

CONTRIBUTORY/NONCONTRIBUTORY: Supplemental insurance is contributory insurance.

SPOUSE AND CHILD PORTABILITY BENEFIT: Spouse benefit plan will match the employee’s Group Accident Benefit Plan. Child benefit plan will match the employee’s Group Accident Benefit Plan

COVERED BENEFITS

Refer to the Injury Benefits, Emergency Care, Hospital Care, Surgery Benefits, Follow-up Care and Support Care sections of the Certificate for additional benefit details.

<table>
<thead>
<tr>
<th>INJURY BENEFITS</th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burn Benefit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2nd degree burns</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 10% of the body</td>
<td>$100</td>
<td>$300</td>
</tr>
<tr>
<td>Between 10% and 20% of the body</td>
<td>$250</td>
<td>$750</td>
</tr>
<tr>
<td>20% or more of the body</td>
<td>$500</td>
<td>$1,500</td>
</tr>
<tr>
<td>3rd degree burns</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 10% of the body</td>
<td>$1,000</td>
<td>$3,000</td>
</tr>
<tr>
<td>Between 10% and 20% of the body</td>
<td>$2,500</td>
<td>$7,500</td>
</tr>
<tr>
<td>20% or more of the body</td>
<td>$5,000</td>
<td>$15,000</td>
</tr>
<tr>
<td>Child Organized Sports Injury</td>
<td>$50</td>
<td>$100</td>
</tr>
<tr>
<td>INJURY BENEFITS</td>
<td>LOW PLAN</td>
<td>HIGH PLAN</td>
</tr>
<tr>
<td>----------------</td>
<td>----------</td>
<td>-----------</td>
</tr>
<tr>
<td>Concussion</td>
<td>$100</td>
<td>$200</td>
</tr>
<tr>
<td>Dislocation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Principal Amount (Surgical)</td>
<td>$2,000</td>
<td>$5,000</td>
</tr>
<tr>
<td>% of Principal Amount</td>
<td>% of Principal Amount</td>
<td></td>
</tr>
<tr>
<td>Hip/Thigh</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Foot</td>
<td>40%</td>
<td>40%</td>
</tr>
<tr>
<td>Ankle</td>
<td>40%</td>
<td>40%</td>
</tr>
<tr>
<td>Knee</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Hand or wrist (excluding fingers)</td>
<td>Hand: 20%</td>
<td>Hand: 20%</td>
</tr>
<tr>
<td>Wrist: 30%</td>
<td>Wrist: 30%</td>
<td></td>
</tr>
<tr>
<td>Lower jaw</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Shoulder</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Collarbone</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Ribs</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Finger</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Toe</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Elbow</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Non-surgical</td>
<td>50% of surgical benefit</td>
<td>50% of surgical benefit</td>
</tr>
<tr>
<td>Partial dislocation</td>
<td>25% of non-surgical benefit</td>
<td>25% of non-surgical benefit</td>
</tr>
<tr>
<td>Eye Injury - with Surgery</td>
<td>$120</td>
<td>$300</td>
</tr>
<tr>
<td>Eye Injury – Removal of Foreign Object without Surgery</td>
<td>$30</td>
<td>$75</td>
</tr>
<tr>
<td>Fracture</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Principal Amount (Surgical)</td>
<td>$2,000</td>
<td>$5,000</td>
</tr>
<tr>
<td>% of Principal Amount</td>
<td>% of Principal Amount</td>
<td></td>
</tr>
<tr>
<td>Hip/Thigh</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Vertebral body</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Vertebral processes</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Pelvis</td>
<td>75%</td>
<td>75%</td>
</tr>
<tr>
<td>Sternum</td>
<td>75%</td>
<td>75%</td>
</tr>
<tr>
<td>Coccyx</td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td>Skull – non depressed</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Skull – depressed</td>
<td>150%</td>
<td>150%</td>
</tr>
<tr>
<td>Lower leg</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Foot</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Ankle</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Kneecap</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Upper arm</td>
<td>35%</td>
<td>35%</td>
</tr>
<tr>
<td>Facial excluding lower jaw</td>
<td>35%</td>
<td>35%</td>
</tr>
<tr>
<td>Forearm</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Hand or wrist (except fingers)</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Lower jaw</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Shoulder blade</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Collarbone</td>
<td>15%</td>
<td>15%</td>
</tr>
<tr>
<td>Ribs</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Finger</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Toe</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Nose</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Non-surgical</td>
<td>50% of surgical benefit</td>
<td>50% of surgical benefit</td>
</tr>
<tr>
<td>Chip fracture</td>
<td>25% of non-surgical Benefit</td>
<td>25% of non-surgical benefit</td>
</tr>
<tr>
<td>LACERATIONS</td>
<td>LOW PLAN</td>
<td>HIGH PLAN</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>----------</td>
<td>-----------</td>
</tr>
<tr>
<td>With stitches or staples</td>
<td>$100</td>
<td>$500</td>
</tr>
<tr>
<td>Without stitches or staples</td>
<td>25% of benefit provided with stitches or staples</td>
<td>25% of benefit provided with stitches or staples</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PARALYSIS</th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Principal Amount</td>
<td>$20,000</td>
<td>$60,000</td>
</tr>
<tr>
<td>Quadriplegia</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Paraplegia</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Hemiplegia</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Uniplegia</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Traumatic Brain Injury</td>
<td>$200</td>
<td>$400</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EMERGENCY CARE</th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ground or water</td>
<td>$100</td>
<td>$200</td>
</tr>
<tr>
<td>Air</td>
<td>$500</td>
<td>$1,000</td>
</tr>
<tr>
<td>Blood, Plasma or Platelets Transfusion</td>
<td>$300</td>
<td>$600</td>
</tr>
<tr>
<td>Emergency Dental</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crown</td>
<td>$150</td>
<td>$300</td>
</tr>
<tr>
<td>Extraction</td>
<td>$50</td>
<td>$100</td>
</tr>
<tr>
<td>Emergency Room Treatment</td>
<td>$100</td>
<td>$300</td>
</tr>
<tr>
<td>Initial Physician's Office Visit</td>
<td>$50</td>
<td>$100</td>
</tr>
<tr>
<td>Hospital Stay</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initial benefit, non-ICU</td>
<td>$400</td>
<td>$1,200</td>
</tr>
<tr>
<td>Initial benefit, ICU</td>
<td>$800</td>
<td>$2,400</td>
</tr>
<tr>
<td>Daily benefit, non-ICU</td>
<td>$100</td>
<td>$300</td>
</tr>
<tr>
<td>Daily benefit, ICU</td>
<td>$200</td>
<td>$600</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SURGERY</th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal or Pelvic Surgery</td>
<td>$1,000</td>
<td>$2,000</td>
</tr>
<tr>
<td>Cranial Surgery</td>
<td>$1,000</td>
<td>$2,000</td>
</tr>
<tr>
<td>Knee Cartilage Surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Open</td>
<td>$500</td>
<td>$1,000</td>
</tr>
<tr>
<td>Arthroscopic</td>
<td>$250</td>
<td>$500</td>
</tr>
<tr>
<td>Ruptured Disc Surgery</td>
<td>$500</td>
<td>$1,000</td>
</tr>
<tr>
<td>Tendon, Ligament or Rotator Cuff Surgery</td>
<td>$500</td>
<td>$1,000</td>
</tr>
</tbody>
</table>
### INJURY BENEFITS

<table>
<thead>
<tr>
<th></th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arthroscopic</td>
<td>$250</td>
<td>$500</td>
</tr>
<tr>
<td>Thoracic Surgery</td>
<td>$1,000</td>
<td>$2,000</td>
</tr>
</tbody>
</table>

### FOLLOW-UP CARE

<table>
<thead>
<tr>
<th></th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adaptive Home and Vehicle Benefit</td>
<td>$500</td>
<td>$1,000</td>
</tr>
<tr>
<td>Appliances</td>
<td>$50</td>
<td>$250</td>
</tr>
<tr>
<td>Follow-Up Physician’s Office Visit</td>
<td>$50</td>
<td>$100</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prosthetics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>One prosthesis</td>
<td>$500</td>
<td>$1,000</td>
</tr>
<tr>
<td>Two or more prosthetics</td>
<td>2x one prosthetic</td>
<td>2x one prosthetic</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transportation</td>
<td>$200 per visit</td>
<td>$500 per visit</td>
</tr>
</tbody>
</table>

### SUPPORT CARE

<table>
<thead>
<tr>
<th></th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Companion Lodging</td>
<td>$75 per day</td>
<td>$150 per day</td>
</tr>
</tbody>
</table>

### ADDITIONAL INFORMATION

#### ANNUAL OPEN ENROLLMENTS:

During the policyholder’s annual open enrollment an employee may elect or change employee and dependent accident insurance benefit plans.

Coverage will be effective on the January 1 following the annual enrollment, subject to the actively at work requirement for employees and the hospitalization/non-confinement provision for dependents (this does not apply to a newborn child).

#### Special Enrollment Periods:

Upon mutual agreement between the Policyholder and Securian, one or more special enrollment periods may be offered to eligible employees. These special enrollment periods (if offered) will be in addition to the annual enrollment opportunities described above. In the event that a special enrollment period is offered, the details of the special enrollment, including enrollment dates, allowed changes, and evidence of insurability requirements, will be communicated to you in advance of the special enrollment period and documented in the group policy on file with the policyholder and Securian.

#### QUALIFIED STATUS CHANGES:

An employee who experiences a Qualified Status Changes as defined below may elect or change employee and dependent accident insurance benefit plans provided enrollment is made within 60 days of the status change.

- An active employee may elect accident insurance for the first time or increase coverage from the low plan to the high plan.
- An active employee may elect dependent coverage.

Coverage will be effective on the date of the election. All increases are subject to the actively at work requirement for employees and the hospitalization/non-confinement provision for dependents (this does not apply to a newborn child)

A qualified status change for the purpose of waiving the evidence of insurability requirement means marriage, birth or adoption.
SUPPLEMENTS TO THE CERTIFICATE

Portability
Definitions

Any use in this certificate of a term defined in this section is to be given the meaning defined in this section unless otherwise defined in another provision of this certificate.

accident
An act or event which is:

1. unintended, unexpected and unforeseen; and
2. directly results in bodily injury to the insured.

application
Your application or enrollment for insurance under the group policy.

associated company
Any company which is a subsidiary or affiliate of the policyholder which is designated by the policyholder and agreed to by us to participate under the group policy.

child or children
Your or your spouse’s natural, adopted, stepchild or foster child who is less than 26 years old. An adopted child includes a child legally placed for adoption with you. Eligibility begins at live birth (stillborn or unborn children are not eligible). Children age 26 or older are also eligible so long as they are physically or mentally incapable of self-support, were incapable of self-support prior to age 26 and remain financially dependent on you for more than one-half of their support and maintenance.

contributory insurance
Insurance for which you are required to make premium contributions.

covered accident
An accident which:

1. is not excluded under the Exclusions and Limitations section or any other terms of this certificate; and
2. occurs while the insured’s coverage is in force; and
3. occurs in the United States or a United States territory.

dependent
Your children or spouse.

If both parents of a child qualify as eligible employees under the group policy, the child shall be considered a dependent of only one parent for purposes of this certificate. If any child qualifies as an eligible employee under the group policy, he or she is not eligible to be insured as a dependent child.

emergency room
A department of a hospital or a satellite emergency center that is designated for persons requiring immediate medical care. This area must be staffed and equipped to handle trauma, be supervised and provide treatment by physicians, and provide care seven days per week, 24 hours per day.

A satellite emergency center is a licensed facility providing outpatient care under the direction of a licensed physician on a 24-hour basis. Available services must include:

1. diagnostic care, including laboratory services and diagnostic x-rays; and
2. treatment or medical care, including availability of the means for stabilization of emergency medical conditions.

A satellite emergency center does not include a hospital or an office maintained by a licensed physician for the practice of medicine or dentistry.

employee
An individual who is employed by the policyholder or by an associated company. A sole proprietor will be considered the employee of the proprietorship. A partner in a partnership will be considered an employee so long as the partner’s principal work is the conduct of the partnership’s business. The term employee does not include temporary employees nor corporate directors who are not otherwise employees.

employer
The policyholder or any designated associated companies.

family member
A parent, spouse, child, sibling, grandparent, aunt, uncle, first cousin, niece or nephew. This includes adopted, in-law and step relatives.

hospital
A short-term, acute care general facility that:

1. is legally licensed and operated as a hospital;
2. provides overnight care of injured and sick people;
3. requires that every patient be supervised by a physician;
4. provides 24 hour nursing service by or under the supervision of a registered nurse;
5. has on-site or pre-arranged use of x-ray equipment, laboratory, and surgical facilities; and
6. maintains permanent medical history records.

A hospital is not a rehabilitation center, nursing home, rest home, extended-care facility, convalescent home, a place for alcoholics or drug addicts or a mental institution, even if such facilities are affiliated with or adjoining to a hospital.

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injury or injuries
A bodily injury which is sustained as a direct result of a covered accident.

insured
An employee, spouse or child covered for insurance under this certificate.

noncontributory insurance
Insurance for which you are not required to make premium contributions.

non-work day
A day on which you are not regularly scheduled to work, including scheduled time off for vacations, personal holidays, weekends and holidays, and approved leaves of absence for non-medical reasons.

Non-work day does not include time off for medical leave of absence, temporary layoff, employer suspension of operations in total or in part, strike, and any time off due to sickness or injury including sick days, short-term disability, or long term disability.

physician
A medical doctor or other person recognized by law or regulation in the United States or United States territory where services are rendered as a physician. The person must be licensed as required by the United States jurisdiction where care is given and must be operating in the scope of his or her license.

A physician cannot be a person who:
(1) ordinarily resides in your household; or
(2) is a family member.

policyholder
The owner of the group policy as shown on the specifications page.

specifications page
The summary of the plan specifics available under the group policy.

spouse
Your legally married spouse as recognized under the laws of the jurisdiction of celebration.

Spouse does not include any person who is eligible as an employee.

surgery
Medical treatment in which a physician cuts into someone's body in order to repair or remove damaged parts as a result of a covered accident. The surgery must be performed solely because of injuries sustained in a covered accident.

urgent care center
A health care facility that is separate from a hospital or a separate unit within a hospital and whose primary purpose is the offering and provision of immediate, short term medical care, without appointment, for urgent care.

we, our, us
Securian Life Insurance Company.

you, your, certificate holder
An insured employee.

General Information

What is your agreement with us?
If you meet the eligibility and enrollment requirements, you are insured under the group policy shown on the specifications page. Your application is deemed a part of this certificate. This certificate summarizes the principal provisions of the group policy that affect your insurance coverage. The provisions summarized in this certificate are subject in every respect to the group policy.

Any statements made in your application will, in the absence of fraud, be considered representations and not warranties. Also, any statement made will not be used to void your insurance nor defend against a claim unless the statement is contained in the application.

Can this certificate be amended?
Yes. We retain the right to amend this certificate at any time without your consent. Any amendment will be without prejudice to any claim incurred for benefits prior to the date of the amendment.

Who is eligible for insurance?
You are eligible for group accident insurance if you:
(1) are a member of the eligible group and of an eligible class as defined on the specifications page; and
(2) work for the employer for at least the number of hours per week shown as the minimum hours per week requirement on the specifications page; and
(3) have satisfied the waiting period as shown on the specifications page; and
(4) meet the actively at work requirement described in the “What is the actively at work requirement?” provision of this section.
Are your dependents eligible for insurance?
Yes. If you are insured for group accident coverage, your dependents are eligible for insurance.

Are employees of associated companies eligible for insurance under the group policy?
Yes. Employees of associated companies may be eligible for insurance under the group policy. The policyholder represents any associated company in all transactions pertaining to the group policy. The policyholder's acts or omissions and every notice given by us to the policyholder shall be binding on every associated company. When an associated company ceases its participation under the policy, the policy shall be considered to be terminated for all employees of the associated company. All provisions related to policy termination will apply to such employees.

What is the actively at work requirement?
To be eligible to become insured or to receive an increase in the benefit amount, you must be actively at work, fully performing your customary duties for your regularly scheduled number of hours at the employer's normal place of business, or at other places the employer's business requires you to travel.

If you are not working due to illness or injury, you do not meet the actively at work requirement. If you are receiving sick pay, short-term disability benefits or long-term disability benefits, you do not meet the actively at work requirement.

If you are not actively at work on the date coverage would otherwise begin, or on the date an increase in your benefit amount would otherwise be effective, you will not be eligible for the coverage or increase until you return to active work. However, if the absence is on a non-work day, coverage will not be delayed provided you were actively at work on the work day immediately preceding the non-work day.

Except as otherwise provided for in this certificate, you are eligible to continue to be insured only while you remain actively at work.

Any insurance or increase in insurance which is elected or put in force while you are not actively at work will not be eligible for claim payment. You or your beneficiary will receive a refund of premium for any contributory insurance for which you were not eligible.

What is the dependent non-confinement requirement?
If a dependent is hospitalized or confined because of illness or disease on the date his or her insurance would otherwise become effective, his or her effective date shall be delayed until he or she is released from such hospitalization or confinement. This does not apply to a newborn child.

In no event will insurance on a dependent be effective before your insurance is effective.

Can your coverage be continued during sickness, injury, leave of absence or temporary layoff?
Yes. Insurance may be continued on an insured employee who is not actively at work due to sickness, injury, leave of absence or temporary layoff, subject to the employer's practices and procedures, including the employer's limits on the length of continuation allowed for the type of absence. Continuation is contingent upon continued premium payment.

Coverage during a leave of absence and upon return from a leave of absence shall meet all state and federal requirements.

Enrollment

When can you elect or make changes to your insurance?
You must enroll in order to be insured for contributory coverage under the group policy. You can enroll for coverage within 90 days of when you first become eligible. After that period, you can only enroll for coverage or make changes during your annual open enrollment or within 60 days of a qualified status change event, as defined by the state and federal rules and regulations.

When does your insurance become effective?
Your insurance becomes effective on the date all of the following conditions have been met:

1. you meet all eligibility requirements, including the actively at work requirement; and
2. for contributory coverage, application is made in accordance with the application methods agreed upon by the policyholder and us

When does insurance for a dependent become effective?
Insurance on a dependent becomes effective on the date when all of the following conditions have been met:

1. your insurance becomes effective;
2. the dependent meets all eligibility requirements; and
3. for contributory insurance, you apply for dependent coverage on forms which are approved by us.

When will changes in your coverage amount be effective?
Requested changes in the amount of your contributory insurance are effective on the first day of the month following receipt of your request for a change.
However, elections made during an enrollment period will not become effective prior to the effective date for that enrollment.

**Premiums**

*When and how often are your premium contributions due?*

Unless the policyholder and we have agreed to some other premium payment procedure, any premium contributions you are required to make for contributory insurance are to be paid by you to the policyholder on a periodic basis. Premium rates are subject to change in accordance with the group policy.

*How is the premium determined?*

The premium will be the applicable premium rate in force on the date premiums are due. The premium may also be computed by any other method on which the policyholder and we agree.

Premium rates are subject to change according to the provisions of the group policy.

*Can a premium be paid after the date it is due?*

Yes. The group policy has a 31-day grace period. If a premium is not paid on or before the date it is due, that premium may be paid during the 31-day period following the due date. The insurance under the group policy will remain in effect during the 31-day grace period.

**Injury Benefits**

*Burn Benefit*

If an insured sustains a second or third degree burn in a covered accident, we will pay the appropriate amount shown on the specifications page based on the type of burn and the percentage of the body surface burned.

The burn must be treated by a physician within 72 hours after the covered accident. If the burn meets more than one of the burn classifications shown on the specifications page, the amount we pay will be based on the burn classification that pays the highest benefit.

We will pay the burn benefit no more than one time per insured per covered accident. No benefits are payable for sunburns or first degree burns.

*Child Organized Sports Injury*

The child organized sports injury benefit is subject to the following conditions.

1. the insured dependent child suffers an injury in a covered accident while participating in an organized sport; and
2. a benefit is payable for the insured dependent child under another provision of the group policy for the same covered accident; and
3. the insured dependent child has not attained 19 years of age and is insured on the date the covered accident occurs;

A child organized sport refers to a sport activity that is governed by an organization and requires formal registration to participate. Adult supervision of practice and competition is required. Proof of registration must be submitted with claims.

The child organized sports injury benefit amount is shown on the specifications page.

This benefit is limited to one payment per insured dependent child per calendar year.

*Concussion*

If an insured is injured in a covered accident and the injury causes a concussion, we will pay the amount shown on the specifications page. The insured must be treated by a physician within 72 hours of a covered accident and the concussion must be diagnosed by a physician within 15 days of the covered accident.

Concussion refers to a disruption of brain function resulting from a traumatic blow to the head.

This benefit is limited to one payment per insured per covered accident per calendar year.

The concussion benefit is not payable if a traumatic brain injury benefit is payable under this certificate for the same accident.

*Dislocation*

If a joint is dislocated in a covered accident, and it is diagnosed and treated by a physician within 90 days after the covered accident, we will pay the amount shown on the specifications page. The amount varies based on the joint that is dislocated, whether the dislocation is a full or a partial dislocation, and whether surgery is required to treat the dislocation.

A full dislocation refers to a completely separated joint due to a covered accident. A partial dislocation means the joint is misaligned but not completely dislocated, as diagnosed by a physician.

If more than one dislocation benefit is payable resulting from the same covered accident, we will pay the lesser of:

1. the total of the benefit amounts shown for each applicable dislocation on the specifications page; or
2. 2 times the highest dislocation benefit that would otherwise be payable for any one of the dislocations involved.
Eye Injury – with Surgery

If an insured is injured in a covered accident and the injury results in an eye injury that requires surgery, we will pay the amount shown on the specifications page. The insured must be seen by a physician within 60 days of the covered accident and surgery must be performed within 180 days of the covered accident. This benefit is limited to one payment per eye per insured per covered accident.

Eye Injury – Removal of Foreign Object without Surgery

If an insured is injured in a covered accident and the injury results in an eye injury that requires removal of a foreign object, but does not require surgery, we will pay the amount shown on the specifications page. The insured must be seen by a physician within 60 days of the covered accident and removal of the foreign object must be performed within 180 days of the covered accident. This benefit is limited to one payment per eye per insured per covered accident.

Fracture

If a bone is fractured in a covered accident, and it is diagnosed and treated by a physician within 90 days after the covered accident, we will pay the amount shown on the specifications page. The amount varies based on the bone that is fractured, whether or not the fracture is a chip fracture, and whether surgery is required to treat the fracture.

Fracture refers to a break in a bone that can be seen by x-ray. A chip fracture is a fracture in which a small fragment of the bone is broken off.

If more than one fracture benefit is payable resulting from the same covered accident, we will pay the lesser of:

1. the total of the benefit amounts shown for each applicable fracture on the specifications page; or
2. 3 times the highest fracture benefit that would otherwise be payable for any one of the bones involved.

We will pay no more than one fracture benefit per bone, per covered accident per insured. In no event will multiple fracture benefits be paid for the same fracture shown on the specifications page unless it is a bilateral fracture. Bi-lateral fracture means the fracture of the same bone on both the left and right sides of the body.

Lacerations

If an insured is injured in a covered accident and the injury results in a laceration, we will pay the appropriate amount shown on the specifications page based on the type of treatment provided.

The laceration must be treated by a physician within 72 hours after the covered accident. This benefit is limited to one payment per insured per covered accident.

In no event will we pay more than one laceration benefit per calendar year.

Paralysis

If an insured is injured in a covered accident and the injury causes paralysis which lasts more than 180 days we will pay the appropriate amount shown on the specifications page. Paralysis refers to the total, permanent, and irrevocable loss of movement. The paralysis must be diagnosed by a physician within 180 days after the accident.

The amount payable will be based on the type of paralysis, as follows:

Quadriplegia refers to paralysis of both upper limbs (from the shoulder down including total paralysis of both hands) and both lower limbs (from the waist down including total paralysis of both feet).

Paraplegia refers to paralysis of both lower limbs (from the waist down including total paralysis of both feet).

Hemiplegia refers to paralysis of both the upper limb (from the shoulder down including total paralysis of both hands) and lower limb (from the waist down including total paralysis of the foot) on one side of the body.

Uniplegia refers to paralysis of one limb (from the shoulder down including total paralysis of the hand if claiming an upper limb and from the waist down including total paralysis of the foot if claiming a lower limb).

We will pay no more than one paralysis benefit per covered accident per insured. In the event that an insured qualifies under multiple types of paralysis, the highest benefit amount will be paid.

Traumatic Brain Injury

If an insured is injured in a covered accident and the injury results in a traumatic brain injury, we will pay the amount shown on the specifications page.

Traumatic brain injury means only the following: intracranial hemorrhage, cerebral contusion or cerebral laceration.

The insured must be treated by a physician within 72 hours after the covered accident. The traumatic brain injury must be diagnosed within 30 days after the accident by computer tomography (CT) scan or magnetic resonance imaging (MRI). This benefit is payable only once per insured per covered accident. Scalp hematomas and scalp lacerations are not covered under this benefit.

Emergency Care

Ambulance

If an insured is injured in a covered accident and requires transportation to a hospital (or between hospitals) we will pay the appropriate ambulance benefit shown on the
specifications page. Ground or water transportation must be provided by a licensed professional ambulance service within 90 days of the covered accident. Air transportation must be provided by a licensed professional ambulance service within 72 hours. This benefit is limited to one payment per insured per covered accident. If an insured requires more than one ambulance transport, the highest benefit amount will be paid.

Ambulance means any publicly or privately owned surface, water or air vehicle, including a helicopter that is specifically designed and constructed or modified and equipped to be used, maintained or operated primarily for the transportation of individuals who are sick, injured or wounded.

Ambulance does not include a surface, water or air vehicle that is owned and operated to accommodate an incapacitated or disabled person who does not require medical monitoring, care or treatment during transport.

Blood, Plasma or Platelets Transfusion

If an insured is injured in a covered accident and requires a blood, plasma or platelets transfusion, we will pay the blood/plasma/platelets transfusion benefit shown on the specifications page. The transfusion must occur within 90 days of the covered accident. This benefit is limited to one payment per insured per covered accident.

Emergency Dental

If an insured has an injury to sound natural teeth as a result of a covered accident, we will pay the appropriate emergency dental benefit shown on the specifications page. A benefit is payable for a broken tooth repaired with crown(s) or a broken tooth requiring extraction. Treatment must occur within 60 days of the covered accident. The maximum number of crown benefits payable per insured per covered accident is two. The maximum number of extraction benefits payable per insured per covered accident is two.

Proof of the soundness of the injured tooth must be submitted with claims. Injuries resulting from biting or chewing are not covered under this benefit.

Sound natural teeth are defined as teeth that are free of active or chronic clinical decay, have at least 50% bone support and are functional in the arch.

Emergency Room Treatment

If an insured is injured in a covered accident and requires treatment in an emergency room, we will pay the emergency room treatment benefit shown on the specifications page. Treatment must occur within 72 hours of the covered accident. This benefit is limited to one payment per insured per covered accident.

Initial Physician’s Office Visit

If an insured is injured in a covered accident, we will pay the initial physician’s office visit benefit shown on the specifications page. Benefits are payable for the initial treatment received in a physician’s office or an urgent care center for injuries resulting from a covered accident. Treatment must occur within 72 hours of the covered accident. The maximum number of benefits per insured per calendar year is two. The benefit is not payable if the insured receives care in an emergency room within the same 72 hour period. Only one benefit is payable per covered accident.

Hospital Care

Hospital Stay

If an insured is injured in a covered accident and requires treatment in a hospital for the injury within 180 days of a covered accident, we will pay the hospital stay benefit shown on the specifications page subject to the following.

Initial Benefit

We will pay the initial benefit shown on the specifications page for the first day of a hospital stay provided the insured is receiving treatment for a covered accident in the hospital for a minimum of 18 continuous hours.

The benefit payment will be based on the type of room and level of care the insured receives. The Intensive Care Unit (ICU) benefit is payable if the insured is receiving treatment in an ICU room of a hospital. The non-ICU benefit is payable if the insured is receiving treatment in a non-ICU room.

This benefit is limited to one payment per insured per covered accident. In the event the insured receives treatment in both a non-ICU and an ICU room, the higher benefit will be payable as an initial benefit.

Daily Benefit

If an initial benefit is payable, the insured will also receive a daily benefit for each day he or she is treated in the hospital, including the first day. The amount payable for the daily benefit is shown on the specifications page.

The daily benefit payment will be based on the type of room and level of care the insured receives. The ICU benefit is payable if the insured is receiving treatment in an ICU room of a hospital. The non-ICU benefit is payable if the insured is receiving treatment in a non-ICU room.

The ICU daily benefit will be limited to a maximum of 15 days per insured per covered accident.
The combination of the both ICU and non-ICU benefits will be limited to a cumulative maximum of 120 days per insured per covered accident.

If an insured is released from the hospital and subsequently requires treatment in a hospital for injuries sustained in the same covered accident, the subsequent treatment will be considered a continuation of the same hospital stay for purposes of determining the cumulative maximum daily benefit so long as the treatment occurs within two years of the date of the covered accident.

Intensive Care Unit (ICU) refers to a specifically designated part of a hospital that provides the highest level of medical care and is restricted to patients who are critically ill or injured and who require intensive comprehensive observation and care. Hospital Intensive Care Units must be:

1. separate and apart from the surgical recovery room; and
2. separate and apart from rooms, beds, and wards customarily used for patient confinement; and
3. permanently equipped with special life-saving equipment to care for the critically ill or injured; and
4. under constant and continuous observation by nursing staffs assigned to the Intensive Care Unit.

### Surgery Benefits

#### Abdominal or Pelvic Surgery

If an insured is injured in a covered accident and requires abdominal or pelvic surgery to treat the injuries, we will pay the abdominal or pelvic surgery benefit shown on the specifications page. The surgery must be performed within 72 hours of the covered accident. This benefit is limited to one payment per insured per covered accident. Surgery required to treat a fracture or dislocation is payable under the fracture or dislocation benefit and is not covered under the abdominal or pelvic surgery benefit.

#### Cranial Surgery

If an insured is injured in a covered accident and requires cranial surgery to treat the injuries, we will pay the cranial surgery benefit shown on the specifications page. The surgery must be performed within 72 hours of the covered accident. This benefit is limited to one payment per insured per covered accident. Surgery required to treat a skull fracture is payable under the paralysis benefit and is not covered under the cranial surgery benefit.

#### Knee Cartilage Surgery

If an insured is injured in a covered accident and requires knee cartilage surgery to treat the injury, we will pay the knee cartilage surgery benefit shown on the specifications page. The insured must be treated by a physician within 60 days of the covered accident and surgery must be performed within 180 days of the covered accident. This benefit is limited to one payment per insured per covered accident.

If both open and arthroscopic surgeries are required for the same injury, only the open benefit will be paid.

#### Tendon, Ligament or Rotator Cuff Surgery

If an insured is injured in a covered accident and requires tendon, ligament or rotator cuff surgery to treat the injuries, we will pay the tendon, ligament or rotator cuff surgery benefit shown on the specifications page. The surgery must be performed within 60 days of the covered accident and surgery must be performed within 180 days of the covered accident. This benefit is limited to one payment per insured per covered accident.

If both open and arthroscopic surgeries are required, only the open benefit will be paid.

#### Thoracic Surgery

If an insured is injured in a covered accident and requires thoracic surgery to treat the injuries, we will pay the thoracic surgery benefit shown on the specifications page. The surgery must be performed within 72 hours of the covered accident. This benefit is limited to one payment per insured per covered accident.

Surgery required to treat a fracture or dislocation is payable under the fracture or dislocation benefit and is not covered under the thoracic surgery benefit.

#### Follow-Up Care

#### Adaptive Home and Vehicle Benefit

If an insured is injured in a covered accident and requires adaptive modifications to his or her primary residence or private vehicle to be made drivable or rideable, we will pay the adaptive home and vehicle benefit shown on the specifications page subject to the following conditions:

1. a benefit is payable under the paralysis benefit of the Injury Benefits section of this certificate; and
(2) the modification must take place within two years of the covered accident; and
(3) such home alterations are made by a person or persons with experience in such alterations and recommended by a recognized organization associated with the injury; and
(4) such vehicle modifications are carried out by a person or persons with experience in such matters and approved by the Motor Vehicle Department.

This benefit is limited to one payment per insured per covered accident.

**Appliances**

If an insured is injured in a covered accident and a medical appliance is prescribed by a physician for mobility, we will pay the appliance benefit shown on the specifications page. The order for the appliance must be placed within 180 days of the covered accident. This benefit is limited to payment for two covered appliances per insured per covered accident.

Covered appliances means only the following: crutches, canes, walkers, wheelchairs/scooters, leg braces and back braces. This benefit does not cover replacement appliances.

**Follow-Up Physician’s Office Visit**

If an insured is injured in a covered accident and follow-up care for the injury is ordered by the treating physician, we will pay the follow-up physician’s office visit benefit shown on the specifications page. The follow-up visit(s) must occur within 180 days of the covered accident. This benefit is limited to three payments per insured per covered accident. Follow-up at an urgent care center is not covered under this benefit.

**Prosthetics**

If an insured is injured in a covered accident and sustains the loss of a limb, hand, foot or sight in an eye, we will pay the prosthetic benefit shown on the specifications page, subject to the following:

(1) this benefit is limited to payment for two prosthetic devices per insured per covered accident; and
(2) the prosthetic device(s) must be prescribed by a physician and ordered within 180 days after the covered accident.

Prosthetic device refers to an artificial device that replaces a missing limb, hand, foot or an eye. For purposes of this benefit, the term prosthetic device does not include corrective lenses or other cosmetic prostheses.

In addition, this benefit does not provide coverage for damaged prosthetics; more than one prosthetic device for the same limb, hand, foot or eye; the replacement of a prosthetic device; or a joint replacement.

**Transportation**

If an insured receives follow-up treatment ordered by a physician for an injury sustained in a covered accident and is required to travel more than 100 miles (one way) from the insured’s primary residence to a hospital or other treatment facility, we will pay the transportation benefit shown on the specifications page subject to the following:

(1) a benefit is payable under this certificate for the same injury; and
(2) the follow-up treatment is ordered by a physician and is not available within 100 miles (one way) of the insured’s primary residence; and
(3) the Ambulance benefit is not payable for the same trip.

Mileage is measured from the insured’s primary residence to the hospital or treatment facility where the follow-up treatment is provided.

This benefit is limited to two payments per insured per covered accident.

**Support Care**

**Adult Companion Lodging**

If an insured is injured in a covered accident, we will pay the adult companion lodging benefit shown on the specifications page for each day the insured is receiving treatment in a hospital or rehabilitative facility for the injury, subject to the following conditions:

(1) a companion who accompanies the insured stays in lodging for which a charge is made; and
(2) either the hospital stay benefit or rehabilitative therapy (inpatient) benefit is payable for the same day the adult companion lodging benefit is payable; and
(3) the companion is 18 or older.

Lodging refers to an establishment licensed under the laws applicable to where it is located, such as a motel, hotel, or other facility that provides sleeping accommodations to the general public in exchange for a fee and is located at least 100 miles from the insured’s primary residence.

This benefit is limited to 30 days per covered accident. Proof must be provided that the companion incurred an expense for staying at a lodging.
Exclusions and Limitations

Are there any other exclusions that apply?

Yes. In no event will we pay benefits where the insured’s accident, injury or loss is caused directly or indirectly by, results in whole or in part from or during, or there is contribution from, any of the following:

1. Intentionally self-inflicted injury while sane; or
2. Suicide or attempted suicide, while sane; or
3. Your participation in, or your attempt to commit, a crime, assault, felony, or any illegal activity, regardless of any legal proceedings thereto; or
4. The use of alcohol; or
5. The use of prescription drugs (unless taken upon the advice of a licensed physician in the verifiable prescribed manner and dosage), non-prescription drugs, illegal drugs, medications, poisons, gases, fumes or other substances taken, absorbed, inhaled, ingested or injected; or
6. Motor vehicle collision or accident where you are the operator of the motor vehicle and your blood alcohol level meets or exceeds the level at which intoxication is defined in the state where the collision or accident occurred, regardless of any legal proceedings thereto; or
7. War or any act of war, whether declared or undeclared; or
8. Bodily or mental infirmity, illness or disease; or
9. Infection, other than pyogenic infection occurring simultaneously with, and as a direct and independent result of, the injury, and other than bacterial infection due to accidental ingestion of a contaminated substance; or
10. Repetitive stress syndromes including but not limited to rotator cuff syndrome, bursitis, tendonitis, carpal tunnel syndrome, ulnar nerve syndrome, stress fractures, neuropathy, epicondylitis or neuritis; or
11. Medical or surgical treatment or diagnostic procedures including any resulting complications, or when the outcome is not as planned or expected, including claims of medical malpractice; or
12. Travel in or descent from any aircraft, except as a fare-paying passenger on a regularly scheduled commercial flight on a licensed passenger aircraft carrier; or
13. Participation in the following activities: scuba diving, bungee jumping, base jumping, hang gliding, sail gliding, parasailing, parakiting, or mountain climbing; or
14. Riding or driving in any motor-driven vehicle in a race, stunt show or speed test; or
15. Practicing for or participating in any semi-professional or professional competitive athletics.

Are there any additional limitations that apply?

Yes. Benefits are not payable for any care, treatment or diagnostic measures which were received outside of the United States or United States territory.

Claims

What notice of claim must be provided?

Written notice of claim must be given to us within 20 days of the date of a loss resulting from a covered accident, or as soon thereafter as reasonably possible.

Notice given by or on the insured’s behalf to us at our home office or to any authorized agent of ours, with information to identify the insured, shall be deemed notice to us.

Will claim forms be provided?

Upon receipt of notice of claim, we will provide a claim form. If the claim form is not provided within 15 days after the insured has given notice of claim, we will deem the insured to have complied with the requirements for filing proof of a loss resulting from a covered accident if the insured submits, within the time period for filing proof of the loss, written proof of the occurrence, character and extent of the loss for which claim is made which is satisfactory to us.

When is proof of a loss resulting from a covered accident required?

Written proof of a loss resulting from a covered accident satisfactory to us must be provided to us within 90 days of the date of the loss. Failure to provide proof of the loss within this time will not invalidate or reduce a claim if it was not reasonably possible to provide proof within this 90 day period. However, proof must be provided within 1 year of the date of the loss, except in the absence of legal capacity.

When will the benefit be paid?

We will pay a benefit for a loss resulting from a covered accident after receipt at our home office of written proof of the loss which meets all policy requirements and is satisfactory to us. You are responsible for all costs associated with claim form(s) completion, records, and the submission of your claim.

To whom will benefits be paid?

All benefits including dependent’s benefits will be paid to you, if you are living. If you die before the claim is paid, benefits will be paid to your estate.

What are our physical examination rights?

After an insured has filed a claim and provided at his or her expense all requested claim forms and records,
we have the right to have the insured examined by a physician of our choice and at our expense. This right may be exercised as often as reasonably necessary while an insured has a claim pending with us.

**Termination**

**When does your coverage terminate?**

Coverage ends on the earliest of the following:

1. the date you no longer meet the eligibility requirements; or
2. 31 days (the grace period) after the due date of any premium which is not paid; or
3. the last day for which premium contributions have been paid following your request to cancel your coverage; or
4. the date the group policy ends.

**When does an insured dependent's coverage terminate?**

An insured dependent's coverage ends on the earliest of the following:

1. the date the dependent no longer meets the eligibility requirements; or
2. 31 days (the grace period) after the due date of any premium contribution which is not paid; or
3. the last day for which premium contributions have been paid following your written request that insurance on your eligible dependents be terminated; or
4. the date you are no longer covered under the group policy.

You must notify us or your employer when you no longer have dependents eligible for coverage under this certificate so that premiums may be discontinued. All premiums paid for dependents who are no longer eligible for coverage under this certificate will be refunded without any payment of claim.

**Additional Information**

**Can your insurance coverage be contested?**

Yes. If an insured experiences a loss resulting from a covered accident within two years of the original effective date of coverage or increase in coverage, we will verify the accuracy of the information provided during the application process. If we discover a material misrepresentation, the affected coverage will be rescinded and an otherwise valid claim will be denied. This two year period will be extended by fraud or as otherwise allowed by applicable laws.

**Is the policyholder required to maintain records?**

Yes. The policyholder is required to maintain adequate records of any information necessary for us to administer the policy, and shall provide access to such records when required for us to administer the policy. If a clerical error is made in keeping records on the insurance under the group policy, it will not affect otherwise valid insurance.

A clerical error does not continue insurance which is otherwise stopped, make insurance effective when it should not have been or change the benefit amount provided by the provisions of the policy and no claim shall be paid on amounts affected by a clerical error. If an error causes a change in premium payment, a fair adjustment will be made.

**Will the provisions of this certificate conform with applicable state law?**

Yes. If any provision in this certificate, or in the provisions of the group policy, is in conflict with the applicable laws of the state governing the certificates or the group policy, the provision will be deemed to be amended to conform to such laws.

**What if an insured's age has been misstated?**

If an insured's age has been misstated, all amounts payable will be adjusted to that amount which the premium would have purchased at the correct age. This will be determined by applying the ratio of the paid premium over the required premium to the initial benefit amount.

**Can this insurance be assigned?**

No. Insurance coverage under the group policy cannot be assigned.

**What is the policy interpretation right and authority?**

The following applies only when the administration of the policy is governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. 1001 et seq.:

Securian Life has the exclusive right and authority, in its sole discretion, to interpret the group policy and decide all matters arising thereunder. Securian Life's exercise of that authority shall be conclusive and binding on all persons unless it can be shown that the determination was arbitrary and capricious.
Group Accident Insurance Portability Certificate Supplement

Securian Life Insurance Company
400 Robert Street North • St. Paul, Minnesota 55101-2098

General Information

This certificate supplement is subject to every term, condition, exclusion, limitation and provision of the certificate unless otherwise expressly provided for herein.

What does this supplement provide?

This supplement provides for continuation of insurance if an insured no longer meets the eligibility requirements of the certificate, except as provided for herein.

To continue insurance the insured must make a written request and make the first premium payment within 31 days after insurance provided by the group policy would otherwise terminate. Coverage provided by this supplement will then be deemed effective retroactive to the beginning of the 31-day period. This date is considered to be the insured’s portability date and the insured is then considered to have portability status.

Who is eligible to continue insurance under this supplement?

An insured employee is eligible to continue group accident insurance under the terms of this supplement if he or she no longer meets the eligibility requirements of the certificate due to any of the following:

1. the employee terminates employment, including retirement; or
2. the employee is no longer in a class eligible for insurance or is on a leave or layoff; or
3. a class or group of employees insured under the policy are no longer considered eligible and there is no successor plan for that class or group. Successor plan means an insurance policy or policies provided by us or another insurer that replaces insurance provided under this policy.

Regardless of whether an insured is otherwise eligible under this supplement to continue, an insured will not be eligible to request coverage under this supplement if he or she:

1. has attained the age of 70; or
2. is an employee and was not actively at work due to sickness or injury on the date immediately preceding his or her portability date; or
3. loses eligibility due to a class or group of employees no longer being eligible under the policy and there is a successor plan for that class or group of employees; or
4. loses eligibility due to termination of the group policy.

What insurance can be continued under this supplement?

Group accident insurance may be continued under this supplement. If an employee elects to continue his or her own coverage according to the provisions of this supplement, he or she may also elect to continue insurance for any other individual insured under his or her certificate.

What benefit amounts can be continued under this supplement?

The benefit amounts that can be continued under this supplement shall be the amounts shown on the specifications page applicable to the insured based on the benefit plan selected by the insured employee.

Can an insured request a change in the benefit plan continued under this supplement?

Yes. The insured employee may change the benefit plan to one that provides lower benefit amounts, but may not change the benefit plan to one that provides higher benefit amounts.

How will premiums be paid?

Premiums will be paid directly to us on a monthly, quarterly, semi-annual, or annual basis and will be subject to an administrative charge per billing period.

Can the premium rate change?

Yes. The premium rates for ported coverage may be different than the premium rates for active employees, and are not subject to the premium rate provision of the policy.

What happens if an insured again becomes eligible under the certificate?

If an insured is continuing coverage under the terms of this supplement, and again meets the eligibility requirements of the certificate the insured shall no longer be considered to have portability status. Insurance may be continued only under the terms of the certificate, not including this supplement, unless and until the insured no longer meets the eligibility requirements of the certificate and again returns to portability status as provided for herein.

What happens to insurance provided under this supplement when the group policy terminates?

Any insurance continued under the terms of this supplement will remain in force until terminated by the provisions of the section entitled “When will insurance continued under this supplement terminate?”
No individual may elect coverage under this supplement on or after the date of termination of the group policy.

**When will insurance continued under this supplement terminate?**

An insured's insurance being continued under this supplement will terminate on the earliest of the following:

1. the insured’s 70th birthday;
2. the date the insured again meets the eligibility requirements of the certificate, not including the terms of this supplement;
3. in the case of a dependent child or a spouse, the date your coverage is no longer being continued under this supplement or the date the spouse or child ceases to be eligible as defined under the terms of your certificate; or
4. the date the group policy is terminated; or
5. 31 days after the due date of any premium contribution which is not made.

[Signatures]

Secretary

President
This Certificate Endorsement is a part of the certificate of insurance describing the benefits available to you under Group Policy No. 76013, issued by Securian Life Insurance Company to Concordia Plan Services. This endorsement is subject to every term, condition, exclusion and provision of the certificate unless otherwise expressly provided for herein.

The following applies to you if you were a resident of the state of Idaho at the time your coverage under this certificate became effective:

1. The definition of **spouse** under the Definitions section of the certificate is amended in its entirety and replaced with the following:

   **spouse**

   Your legally married spouse. Spouse does not include any person who is eligible as an employee.

2. The definition of **child or children** under the Definitions section of the certificate is amended in its entirety and replaced with the following:

   **child or children**

   Your or your spouse’s natural newborn child from and after the moment of birth, and adopted, stepchild or foster child who is less than 26 years old. An adopted child includes a child legally placed for adoption with you. Eligibility begins at live birth (stillborn or unborn children are not eligible). The age limit does not apply to a child who is unmarried and both (a) incapable of self-sustaining employment by reason of intellectual disability or physical disability and who became incapable prior to attainment of limiting age; and (b) chiefly dependent upon you for support and maintenance.

   “Newborn child” means your newborn child, including adopted newborn children that are placed with you within 60 days of the adopted child’s date of birth. Coverage for an adopted newborn placed with you more than 60 days after the birth of the adopted child is effective from and after the moment of placement. However, coverage will not continue if the placement is disrupted prior to legal adoption or if the child is removed from placement. The due date for payment of any additional premium, if required, shall not be less than thirty-one (31) days following receipt by you of a billing for the required premium.

   “Placed, Placement” means physical placement in your or your spouse’s care. If physical placement is prevented due to the medical needs of the child, “placed” means the date you or your spouse signs an agreement for adoption of the child and assumes financial responsibility for the child.

   Congenital anomalies of newborn or newly adopted children are covered under this certificate. “Congenital anomaly” means a condition existing at or from birth that is a significant deviation from the common form or function of the body, whether caused by a hereditary or developmental defect or disease which impairs the function of the body and includes but it not limited to the conditions of cleft lip, cleft palate, webbed fingers or toes, sixth toes or fingers, or defects of metabolism and other conditions that are medically diagnosed to be congenital anomalies.

3. The benefit entitled **Child Organized Sports Injury** under the Injury Benefits section of the certificate is amended in its entirety and replaced with the following:

   **Child Organized Sports Injury**

   The child organized sports injury benefit is subject to the following conditions.

   (1) the insured dependent child suffers an injury in a covered accident while participating in an organized sport; and

   (2) a benefit is payable for the insured dependent child under another provision of the group policy for the same covered accident; and

   (3) the insured dependent child has not attained 26 years of age and is insured on the date the covered accident occurs;
A child organized sport refers to a sport activity that is governed by an organization and requires formal registration to participate. Adult supervision of practice and competition is required. Proof of registration must be submitted with claims.

The child organized sports injury benefit amount is shown on the specifications page.

This benefit is limited to one payment per insured dependent child per calendar year.

4. The numbered exclusions under the provision entitled *Are there any other exclusions that apply?* under the Exclusions and Limitations section of the certificate are amended in their entirety and replaced with the following:

   (1) intentionally self-inflicted injury while sane; or
   (2) suicide or attempted suicide while sane; or
   (3) your participation in a felony; or
   (4) alcoholism; or
   (5) drug addiction; or
   (6) war or any act of war, whether declared or undeclared; or
   (7) bodily or mental infirmity, illness or disease; or
   (8) infection, other than infection occurring simultaneously with, and as a direct and independent result of, the injury; or
   (9) travel in or descent from any aircraft, except as a fare-paying passenger on a regularly scheduled commercial flight on a licensed passenger aircraft carrier; or
   (10) practicing for or participating in any professional competitive athletics.

5. The provision entitled *When will the benefit be paid?* under the Claims section of the certificate is amended in its entirety and replaced with the following:

   When will the benefit be paid?

   We will pay a benefit for a loss resulting from a covered accident immediately after receipt at our home office of written proof of the loss which meets all policy requirements and is satisfactory to us. You are responsible for all costs associated with claim form(s) completion, records, and the submission of your claim.

[Signature]
Secretary

[Signature]
President
Group Accident Certificate of Insurance

Securian Life Insurance Company • A Stock Company
400 Robert Street North • St. Paul, Minnesota 55101-2098

Applies to Resident of Indiana

POLICYHOLDER: Concordia Plan Services
POLICY NUMBER: 76013

THIS CERTIFICATE IS NOT MAJOR MEDICAL INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL INSURANCE. IT DOES NOT QUALIFY AS MINIMUM ESSENTIAL HEALTH COVERAGE UNDER THE FEDERAL AFFORDABLE CARE ACT. THIS CERTIFICATE DOES NOT SATISFY THE FEDERAL REQUIREMENT THAT YOU HAVE HEALTH INSURANCE COVERAGE, WHICH BECAME EFFECTIVE JANUARY 1, 2014.

THIS IS A LIMITED BENEFIT CERTIFICATE: This certificate provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses. Read your certificate carefully.

THIS CERTIFICATE IS NOT A MEDICARE SUPPLEMENT CONTRACT. If you are eligible for Medicare, review the Guide to Health Insurance for people with Medicare available from us.

Read Your Certificate Carefully

If you meet the eligibility and enrollment requirements herein, you are insured under the group policy shown on the specifications page. This certificate summarizes the principal provisions of the group policy that affect you. The provisions summarized in this certificate are subject in every respect to the group policy. You may examine the group policy at the principal office of the policyholder during regular working hours.

Legal Actions

No legal action may be brought to recover on this certificate within the first sixty days after written proof of loss has been given as required by this certificate. No such action may be brought after three years from the time written proof of loss is required to be given.

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GROUP ACCIDENT CERTIFICATE OF INSURANCE

15-32401.13

Securian Life 1
EdF91296 03-2018
GENERAL INFORMATION

POLICYHOLDER: Concordia Plan Services

POLICY NUMBER: 76013

ASSOCIATED COMPANIES: All subsidiaries and affiliates reported to Securian Life by the policyholder for inclusion in the policy.

POLICY SITUS: The policy was issued and delivered in Missouri.

POLICY EFFECTIVE DATE: January 1, 2019.

This certificate and/or certificate specifications page replaces any and all certificates and/or certificate specifications pages previously issued to you under the group policy. Please replace any certificate and/or certificate specifications page previously issued to you with this new certificate and/or specifications page.

GROUP:

The group is composed of all active employees of the policyholder and its associated companies working in the United States in the following classes:

Class 1: Active employees working at least 20 hours per week.

All new employees of the employer will be added to such group and classes for which they become eligible.

NO DOUBLE COVERAGE:

A person cannot be covered under more than one class. A person cannot be covered as both an active employee and a retiree. Any person who is eligible as an employee or retiree under the policy, or insured under the portability provisions, is not eligible as a dependent. Only one person can insure an eligible dependent child.

ENROLLMENT PERIOD: 90 days from the first day of eligibility for contributory insurance.

WAITING PERIOD: None

MINIMUM HOURS PER WEEK REQUIREMENT: 20 hours per week

PLAN OF INSURANCE

EMPLOYEE BENEFIT SCHEDULE

EMPLOYEE GROUP ACCIDENT INSURANCE:

Supplemental Group Accident Insurance

<table>
<thead>
<tr>
<th>Eligible Class</th>
<th>Employee Supplemental Group Accident Insurance Benefit Plans</th>
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</thead>
<tbody>
<tr>
<td>Class 1</td>
<td>Low Plan or High Plan as elected by the employee.</td>
</tr>
</tbody>
</table>
GENERAL PROVISIONS FOR EMPLOYEE INSURANCE

RETIREMENT REDUCTIONS: All insurance terminates at retirement, except as otherwise provided for under any applicable certificate supplement.

CONTRIBUTORY/NONCONTRIBUTORY: Supplemental insurance is contributory insurance.

PORTABILITY BENEFIT: Low Plan or High Plan as elected by the employee.

DEPENDENT BENEFIT SCHEDULE

An employee must be insured in order to elect dependent group accident insurance.

SPOUSE GROUP ACCIDENT INSURANCE

Supplemental Group Accident Insurance

<table>
<thead>
<tr>
<th>Eligible Class</th>
<th>Spouse Supplemental Group Accident Insurance Benefit Plans</th>
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<tbody>
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<td>Class 1</td>
<td>Spouse benefit plan will match the employee’s Supplemental Group Accident Benefit Plan.</td>
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CHILD GROUP ACCIDENT INSURANCE

Supplemental Group Accident Insurance

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<th>Eligible Class</th>
<th>Child Supplemental Group Accident Insurance Benefit Plans</th>
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</thead>
<tbody>
<tr>
<td>Class 1</td>
<td>Child benefit plan will match the employee’s Supplemental Group Accident Benefit Plan.</td>
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</tbody>
</table>

GENERAL PROVISIONS FOR DEPENDENT INSURANCE

CONTRIBUTORY/NONCONTRIBUTORY: Supplemental insurance is contributory insurance.

SPOUSE AND CHILD PORTABILITY BENEFIT: Spouse benefit plan will match the employee’s Group Accident Benefit Plan. Child benefit plan will match the employee’s Group Accident Benefit Plan.

COVERED BENEFITS

Refer to the Injury Benefits, Emergency Care, Hospital Care, Surgery Benefits, Follow-up Care and Support Care sections of the Certificate for additional benefit details.

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<thead>
<tr>
<th>INJURY BENEFITS</th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
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<tr>
<td>Burn Benefit</td>
<td></td>
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<td>Less than 10% of the body</td>
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<td>$250</td>
<td>$750</td>
</tr>
<tr>
<td>20% or more of the body</td>
<td>$500</td>
<td>$1,500</td>
</tr>
<tr>
<td>3rd degree burns</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 10% of the body</td>
<td>$1,000</td>
<td>$3,000</td>
</tr>
<tr>
<td>Between 10% and 20% of the body</td>
<td>$2,500</td>
<td>$7,500</td>
</tr>
<tr>
<td>20% or more of the body</td>
<td>$5,000</td>
<td>$15,000</td>
</tr>
<tr>
<td>Child Organized Sports Injury</td>
<td>$50</td>
<td>$100</td>
</tr>
<tr>
<td>INJURY BENEFITS</td>
<td>LOW PLAN</td>
<td>HIGH PLAN</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>----------</td>
<td>-----------</td>
</tr>
<tr>
<td>Concussion</td>
<td>$100</td>
<td>$200</td>
</tr>
<tr>
<td>Dislocation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Principal Amount (Surgical)</td>
<td>$2,000</td>
<td>$5,000</td>
</tr>
<tr>
<td>Hip/Thigh</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Foot</td>
<td>40%</td>
<td>40%</td>
</tr>
<tr>
<td>Ankle</td>
<td>40%</td>
<td>40%</td>
</tr>
<tr>
<td>Knee</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Hand or wrist (excluding fingers)</td>
<td>Hand: 20%</td>
<td>Hand: 20%</td>
</tr>
<tr>
<td></td>
<td>Wrist: 30%</td>
<td>Wrist: 30%</td>
</tr>
<tr>
<td>Lower jaw</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Shoulder</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Collarbone</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Ribs</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Finger</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Toe</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Elbow</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Non-surgical</td>
<td>50% of surgical benefit</td>
<td>50% of surgical benefit</td>
</tr>
<tr>
<td>Partial dislocation</td>
<td>25% of non-surgical benefit</td>
<td>25% of non-surgical benefit</td>
</tr>
<tr>
<td>Eye Injury - with Surgery</td>
<td>$120</td>
<td>$300</td>
</tr>
<tr>
<td>Eye Injury – Removal of Foreign Object without Surgery</td>
<td>$30</td>
<td>$75</td>
</tr>
<tr>
<td>Fracture</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Principal Amount (Surgical)</td>
<td>$2,000</td>
<td>$5,000</td>
</tr>
<tr>
<td>Hip/Thigh</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Vertebral body</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Vertebral processes</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Pelvis</td>
<td>75%</td>
<td>75%</td>
</tr>
<tr>
<td>Sternum</td>
<td>75%</td>
<td>75%</td>
</tr>
<tr>
<td>Coccyx</td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td>Skull – non depressed</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Skull – depressed</td>
<td>150%</td>
<td>150%</td>
</tr>
<tr>
<td>Lower leg</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Foot</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Ankle</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Kneecap</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Upper arm</td>
<td>35%</td>
<td>35%</td>
</tr>
<tr>
<td>Facial excluding lower jaw</td>
<td>35%</td>
<td>35%</td>
</tr>
<tr>
<td>Forearm</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Hand or wrist (except fingers)</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Lower jaw</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Shoulder blade</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Collarbone</td>
<td>15%</td>
<td>15%</td>
</tr>
<tr>
<td>Ribs</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Finger</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Toe</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Nose</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Non-surgical</td>
<td>50% of surgical benefit</td>
<td>50% of surgical benefit</td>
</tr>
<tr>
<td>Chip fracture</td>
<td>25% of non-surgical Benefit</td>
<td>25% of non-surgical benefit</td>
</tr>
</tbody>
</table>
## INJURY BENEFITS

<table>
<thead>
<tr>
<th>Condition</th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lacerations</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>With stitches or staples</td>
<td>$100</td>
<td>$500</td>
</tr>
<tr>
<td>Without stitches or staples</td>
<td>$25%</td>
<td>$25%</td>
</tr>
<tr>
<td><strong>Paralysis</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Principal Amount</strong></td>
<td>$20,000</td>
<td>$60,000</td>
</tr>
<tr>
<td>Quadriplegia</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Paraplegia</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Hemiplegia</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Uniplegia</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td><strong>Traumatic Brain Injury</strong></td>
<td>$200</td>
<td>$400</td>
</tr>
</tbody>
</table>

## EMERGENCY CARE

<table>
<thead>
<tr>
<th>Service</th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ambulance</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ground or water</td>
<td>$100</td>
<td>$200</td>
</tr>
<tr>
<td>Air</td>
<td>$500</td>
<td>$1,000</td>
</tr>
<tr>
<td><strong>Blood, Plasma or Platelets Transfusion</strong></td>
<td>$300</td>
<td>$600</td>
</tr>
<tr>
<td><strong>Emergency Dental</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crown</td>
<td>$150</td>
<td>$300</td>
</tr>
<tr>
<td>Extraction</td>
<td>$50</td>
<td>$100</td>
</tr>
<tr>
<td><strong>Emergency Room Treatment</strong></td>
<td>$100</td>
<td>$300</td>
</tr>
<tr>
<td><strong>Initial Physician's Office Visit</strong></td>
<td>$50</td>
<td>$100</td>
</tr>
<tr>
<td><strong>Hospital Stay</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initial benefit, non-ICU</td>
<td>$400</td>
<td>$1,200</td>
</tr>
<tr>
<td>Initial benefit, ICU</td>
<td>$800</td>
<td>$2,400</td>
</tr>
<tr>
<td>Daily benefit, non-ICU</td>
<td>$100</td>
<td>$300</td>
</tr>
<tr>
<td>Daily benefit, ICU</td>
<td>$200</td>
<td>$600</td>
</tr>
</tbody>
</table>

## SURGERY

<table>
<thead>
<tr>
<th>Surgery</th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal or Pelvic Surgery</td>
<td>$1,000</td>
<td>$2,000</td>
</tr>
<tr>
<td>Cranial Surgery</td>
<td>$1,000</td>
<td>$2,000</td>
</tr>
<tr>
<td><strong>Knee Cartilage Surgery</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Open</td>
<td>$500</td>
<td>$1,000</td>
</tr>
<tr>
<td>Arthroscopic</td>
<td>$250</td>
<td>$500</td>
</tr>
<tr>
<td>Ruptured Disc Surgery</td>
<td>$500</td>
<td>$1,000</td>
</tr>
<tr>
<td><strong>Tendon, Ligament or Rotator Cuff Surgery</strong></td>
<td>$500</td>
<td>$1,000</td>
</tr>
</tbody>
</table>
### INJURY BENEFITS

<table>
<thead>
<tr>
<th></th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arthroscopic</td>
<td>$250</td>
<td>$500</td>
</tr>
<tr>
<td>Thoracic Surgery</td>
<td>$1,000</td>
<td>$2,000</td>
</tr>
</tbody>
</table>

### FOLLOW-UP CARE

<table>
<thead>
<tr>
<th></th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adaptive Home and Vehicle Benefit</td>
<td>$500</td>
<td>$1,000</td>
</tr>
<tr>
<td>Appliances</td>
<td>$50</td>
<td>$250</td>
</tr>
<tr>
<td>Follow-Up Physician’s Office Visit</td>
<td>$50</td>
<td>$100</td>
</tr>
</tbody>
</table>

### Prosthetics

<table>
<thead>
<tr>
<th></th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>One prosthetic</td>
<td>$500</td>
<td>$1,000</td>
</tr>
<tr>
<td>Two or more prosthetics</td>
<td>2x one prosthetic</td>
<td>2x one prosthetic</td>
</tr>
<tr>
<td>Transportation</td>
<td>$200 per visit</td>
<td>$500 per visit</td>
</tr>
</tbody>
</table>

### SUPPORT CARE

<table>
<thead>
<tr>
<th></th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Companion Lodging</td>
<td>$75 per day</td>
<td>$150 per day</td>
</tr>
</tbody>
</table>

### ADDITIONAL INFORMATION

#### ANNUAL OPEN ENROLLMENTS:

During the policyholder’s annual open enrollment an employee may elect or change employee and dependent accident insurance benefit plans.

Coverage will be effective on the January 1 following the annual enrollment, subject to the actively at work requirement for employees and the hospitalization/non-confinement provision for dependents (this does not apply to a newborn child).

**Special Enrollment Periods:** Upon mutual agreement between the Policyholder and Securian, one or more special enrollment periods may be offered to eligible employees. These special enrollment periods (if offered) will be in addition to the annual enrollment opportunities described above. In the event that a special enrollment period is offered, the details of the special enrollment, including enrollment dates, allowed changes, and evidence of insurability requirements, will be communicated to you in advance of the special enrollment period and documented in the group policy on file with the policyholder and Securian.

#### QUALIFIED STATUS CHANGES:

An employee who experiences a Qualified Status Changes as defined below may elect or change employee and dependent accident insurance benefit plans provided enrollment is made within 60 days of the status change.

- An active employee may elect accident insurance for the first time or increase coverage from the low plan to the high plan.
- An active employee may elect dependent coverage.

Coverage will be effective on the date of the election. All increases are subject to the actively at work requirement for employees and the hospitalization/non-confinement provision for dependents (this does not apply to a newborn child).

A qualified status change for the purpose of waiving the evidence of insurability requirement means marriage, birth or adoption.
SUPPLEMENTS TO THE CERTIFICATE

Portability
Definitions

Any use in this certificate of a term defined in this section is to be given the meaning defined in this section unless otherwise defined in another provision of this certificate.

accident

An act or event which is:

1. unintended, unexpected and unforeseen; and
2. directly results in bodily injury to the insured.

application

Your application or enrollment for insurance under the group policy.

associated company

Any company which is a subsidiary or affiliate of the policyholder which is designated by the policyholder and agreed to by us to participate under the group policy.

child or children

Your or your spouse’s natural, adopted, stepchild, child subject to your legal guardianship or foster child who is less than 26 years old. Eligibility begins from the moment of birth.

Coverage for an adopted child is effective upon the earlier of the date the child is legally placed for adoption with you or the date that child is part of an order granting adoptive custody to you or your spouse for the purposes of adoption. Coverage for an adopted child shall be effective for 31 days unless the placement is disrupted prior to legal adoption and the child is removed from placement. You must apply for dependent coverage for an adopted child within 31 days of the adoption and pay the additional required premium in order to have coverage continue beyond the 31-day period.

contributory insurance

Insurance for which you are required to make premium contributions.

covered accident

An accident which:

1. is not excluded under the Exclusions and Limitations section or any other terms of this certificate; and
2. occurs while the insured’s coverage is in force; and
3. occurs in the United States or a United States territory.

dependent

Your children or spouse.

If both parents of a child qualify as eligible employees under the group policy, the child shall be considered a dependent of only one parent for purposes of this certificate. If any child qualifies as an eligible employee under the group policy, he or she is not eligible to be insured as a dependent child.

emergency room

A department of a hospital or a satellite emergency center that is designated for persons requiring immediate medical care. This area must be staffed and equipped to handle trauma, be supervised and provide treatment by physicians, and provide care seven days per week, 24 hours per day.

A satellite emergency center is a licensed facility providing outpatient care under the direction of a licensed physician on a 24-hour basis. Available services must include:

1. diagnostic care, including laboratory services and diagnostic x-rays; and
2. treatment or medical care, including availability of the means for stabilization of emergency medical conditions.

A satellite emergency center does not include a hospital or an office maintained by a licensed physician for the practice of medicine or dentistry.

employee

An individual who is employed by the policyholder or by an associated company. A sole proprietor will be considered the employee of the proprietorship. A partner in a partnership will be considered an employee so long as the partner’s principal work is the conduct of the partnership’s business. The term employee does not include temporary employees nor corporate directors who are not otherwise employees.

employer

The policyholder or any designated associated companies.

family member

A parent, spouse, child, sibling, grandparent, aunt, uncle, first cousin, niece or nephew. This includes adopted, in-law and step relatives.

hospital

A short-term, acute care general facility that:

1. is legally licensed and operated as a hospital;
2. provides overnight care of injured and sick people;
3. requires that every patient be supervised by a physician;
4. provides 24 hour nursing service by or under the supervision of a registered nurse;
5. has on-site or pre-arranged use of x-ray equipment, laboratory, and surgical facilities; and
(6) maintains permanent medical history records.

A hospital is not a rehabilitation center, nursing home, rest home, extended-care facility, convalescent home, a place for alcoholics or drug addicts or a mental institution, even if such facilities are affiliated with or adjoined to a hospital.

**injury or injuries**

A bodily injury which is sustained as a direct result of a covered accident.

**insured**

An employee, spouse or child covered for insurance under this certificate.

**noncontributory insurance**

Insurance for which you are not required to make premium contributions.

**non-work day**

A day on which you are not regularly scheduled to work, including scheduled time off for vacations, personal holidays, weekends and holidays, and approved leaves of absence for non-medical reasons.

Non-work day does not include time off for medical leave of absence, temporary layoff, employer suspension of operations in total or in part, strike, and any time off due to sickness or injury including sick days, short-term disability, or long term disability.

**physician**

A medical doctor or other person recognized by law or regulation in the United States or United States territory where services are rendered as a physician. The person must be licensed as required by the United States jurisdiction where care is given and must be operating in the scope of his or her license.

A physician cannot be a person who:

1. ordinarily resides in your household; or
2. is a family member.

**policyholder**

The owner of the group policy as shown on the specifications page.

**specifications page**

The summary of the plan specifics available under the group policy.

**spouse**

Your legally married spouse as recognized under the laws of the jurisdiction of celebration.

Spouse does not include any person who is eligible as an employee.

**surgery**

Medical treatment in which a physician cuts into someone’s body in order to repair or remove damaged parts as a result of a covered accident. The surgery must be performed solely because of injuries sustained in a covered accident.

**urgent care center**

A health care facility that is separate from a hospital or a separate unit within a hospital and whose primary purpose is the offering and provision of immediate, short term medical care, without appointment, for urgent care.

**waiting period**

The period, if any, of continuous employment with the employer that the employee must satisfy prior to becoming eligible for coverage under this certificate. You are not eligible to become insured until the first day following the waiting period. Any such waiting period is shown on the specifications page.

**we, our, us**

Securian Life Insurance Company.

**you, your, certificate holder**

An insured employee.

**General Information**

**What is your agreement with us?**

If you meet the eligibility and enrollment requirements, you are insured under the group policy shown on the specifications page. Your application is deemed a part of this certificate. This certificate summarizes the principal provisions of the group policy that affect your insurance coverage. The provisions summarized in this certificate are subject in every respect to the group policy.

Any statements made in your application will be considered representations and not warranties. Also, any statement made will not be used to void your insurance nor defend against a claim unless a copy of the instrument containing the statement is or has been furnished to you, or in the event of your death or incapacity, to your beneficiary or personal representative.

**Can this certificate be amended?**

Yes. We retain the right to amend this certificate at any time without your consent. Any amendment will be without prejudice to any claim incurred for benefits prior to the date of the amendment.
Who is eligible for insurance?

You are eligible for group accident insurance if you:

1. are a member of the eligible group and of an eligible class as defined on the specifications page; and
2. work for the employer for at least the number of hours per week shown as the minimum hours per week requirement on the specifications page; and
3. have satisfied the waiting period as shown on the specifications page; and
4. meet the actively at work requirement described in the “What is the actively at work requirement?” provision of this section.

Are your dependents eligible for insurance?

Yes. If you are insured for group accident coverage, your dependents are eligible for insurance.

Are employees of associated companies eligible for insurance under the group policy?

Yes. Employees of associated companies may be eligible for insurance under the group policy. The policyholder represents any associated company in all transactions pertaining to the group policy. The policyholder’s acts or omissions and every notice given by us to the policyholder shall be binding on every associated company. When an associated company ceases its participation under the policy, the policy shall be considered to be terminated for all employees of the associated company. All provisions related to policy termination will apply to such employees.

What is the actively at work requirement?

To be eligible to become insured or to receive an increase in the benefit amount, you must be actively at work, fully performing your customary duties for your regularly scheduled number of hours at the employer’s normal place of business, or at other places the employer’s business requires you to travel.

If you are not working due to illness or injury, you do not meet the actively at work requirement. If you are receiving sick pay, short-term disability benefits or long-term disability benefits, you do not meet the actively at work requirement.

If you are not actively at work on the date coverage would otherwise begin, or on the date an increase in your benefit amount would otherwise be effective, you will not be eligible for the coverage or increase until you return to active work. However, if the absence is on a non-work day, coverage will not be delayed provided you were actively at work on the work day immediately preceding the non-work day.

Except as otherwise provided for in this certificate, you are eligible to continue to be insured only while you remain actively at work.

Can your coverage be continued during sickness, injury, leave of absence or temporary layoff?

Yes. Insurance may be continued on an insured employee who is not actively at work due to sickness, injury, leave of absence or temporary layoff, subject to the employer’s practices and procedures, including the employer’s limits on the length of continuation allowed for the type of absence. Continuation is contingent upon continued premium payment.

Coverage during a leave of absence and upon return from a leave of absence shall meet all state and federal requirements.

Enrollment

When can you elect or make changes to your insurance?

You must enroll in order to be insured for contributory coverage under the group policy. You can enroll for coverage within 90 days of when you first become eligible. After that period, you can only enroll for coverage or make changes during your annual open enrollment or within 60 days of a qualified status change event, as defined by the state and federal rules and regulations.

When does your insurance become effective?

Your insurance becomes effective on the date all of the following conditions have been met:

1. you meet all eligibility requirements, including the actively at work requirement; and
2. for contributory coverage, application is made in accordance with the application methods agreed upon by the policyholder and us

When does insurance for a dependent become effective?

Insurance on a dependent becomes effective on the date when all of the following conditions have been met:

1. your insurance becomes effective;
2. the dependent meets all eligibility requirements; and
3. for contributory insurance, you apply for dependent coverage on forms which are approved by us.
When will changes in your coverage amount be effective?

Requested changes in the amount of your contributory insurance are effective on the first day of the month following receipt of your request for a change.

However, elections made during an enrollment period will not become effective prior to the effective date for that enrollment.

### Premiums

When and how often are your premium contributions due?

Unless the policyholder and we have agreed to some other premium payment procedure, any premium contributions you are required to make for contributory insurance are to be paid by you to the policyholder on a periodic basis. Premium rates are subject to change in accordance with the group policy.

How is the premium determined?

The premium will be the applicable premium rate in force on the date premiums are due. The premium may also be computed by any other method on which the policyholder and we agree.

Premium rates are subject to change according to the provisions of the group policy.

Can a premium be paid after the date it is due?

Yes. The group policy has a 31-day grace period. If a premium is not paid on or before the date it is due, that premium may be paid during the 31-day period following the due date. The insurance under the group policy will remain in effect during the 31-day grace period.

### Injury Benefits

Burn Benefit

If an insured sustains a second or third degree burn in a covered accident, we will pay the appropriate amount shown on the specifications page based on the type of burn and the percentage of the body surface burned.

The burn must be treated by a physician within 72 hours after the covered accident. If the burn meets more than one of the burn classifications shown on the specifications page, the amount we pay will be based on the burn classification that pays the highest benefit.

We will pay the burn benefit no more than one time per insured per covered accident. No benefits are payable for sunburns or first degree burns.

Child Organized Sports Injury

The child organized sports injury benefit is subject to the following conditions.

(1) the insured dependent child suffers an injury in a covered accident while participating in an organized sport; and

(2) a benefit is payable for the insured dependent child under another provision of the group policy for the same covered accident; and

(3) the insured dependent child has not attained 19 years of age and is insured on the date the covered accident occurs;

A child organized sport refers to a sport activity that is governed by an organization and requires formal registration to participate. Adult supervision of practice and competition is required. Proof of registration must be submitted with claims.

The child organized sports injury benefit amount is shown on the specifications page.

This benefit is limited to one payment per insured dependent child per calendar year.

Concussion

If an insured is injured in a covered accident and the injury causes a concussion, we will pay the amount shown on the specifications page. The insured must be treated by a physician within 72 hours of a covered accident and the concussion must be diagnosed by a physician within 15 days of the covered accident.

Concussion refers to a disruption of brain function resulting from a traumatic blow to the head.

This benefit is limited to one payment per insured per covered accident per calendar year.

The concussion benefit is not payable if a traumatic brain injury benefit is payable under this certificate for the same accident.

Dislocation

If a joint is dislocated in a covered accident, and it is diagnosed and treated by a physician within 90 days after the covered accident, we will pay the amount shown on the specifications page. The amount varies based on the joint that is dislocated, whether the dislocation is a full or a partial dislocation, and whether surgery is required to treat the dislocation.

A full dislocation refers to a completely separated joint due to a covered accident. A partial dislocation means the joint is misaligned but not completely dislocated, as diagnosed by a physician.

If more than one dislocation benefit is payable resulting from the same covered accident, we will pay the lesser of:

(1) the total of the benefit amounts shown for each applicable dislocation on the specifications page; or
(2) 2 times the highest dislocation benefit that would otherwise be payable for any one of the dislocations involved.

**Eye Injury – with Surgery**

If an insured is injured in a covered accident and the injury results in an eye injury that requires surgery, we will pay the amount shown on the specifications page. The insured must be seen by a physician within 60 days of the covered accident and surgery must be performed within 180 days of the covered accident. This benefit is limited to one payment per eye per insured per covered accident.

**Eye Injury – Removal of Foreign Object without Surgery**

If an insured is injured in a covered accident and the injury results in an eye injury that requires removal of a foreign object, but does not require surgery, we will pay the amount shown on the specifications page. The insured must be seen by a physician within 60 days of the covered accident and removal of the foreign object must be performed within 180 days of the covered accident. This benefit is limited to one payment per eye per insured per covered accident.

**Fracture**

If a bone is fractured in a covered accident, and it is diagnosed and treated by a physician within 90 days after the covered accident, we will pay the amount shown on the specifications page. The amount varies based on the bone that is fractured, whether or not the fracture is a chip fracture, and whether surgery is required to treat the fracture.

Fracture refers to a break in a bone that can be seen by x-ray. A chip fracture is a fracture in which a small fragment of the bone is broken off.

If more than one fracture benefit is payable resulting from the same covered accident, we will pay the lesser of:

1. the total of the benefit amounts shown for each applicable fracture on the specifications page; or
2. 3 times the highest fracture benefit that would otherwise be payable for any one of the bones involved.

We will pay no more than one fracture benefit per bone, per covered accident per insured. In no event will multiple fracture benefits be paid for the same fracture benefit shown on the specifications page unless it is a bi-lateral fracture. Bi-lateral fracture means the fracture of the same bone on both the left and right sides of the body.

**Lacerations**

If an insured is injured in a covered accident and the injury results in a laceration, we will pay the appropriate amount shown on the specifications page based on the type of treatment provided.

The laceration must be treated by a physician within 72 hours after the covered accident.

This benefit is limited to one payment per insured per covered accident. In no event will we pay more than one laceration benefit per calendar year.

**Paralysis**

If an insured is injured in a covered accident and the injury causes paralysis which lasts more than 180 days we will pay the appropriate amount shown on the specifications page. Paralysis refers to the total, permanent, and irrevocable loss of movement. The paralysis must be diagnosed by a physician within 180 days after the accident.

The amount payable will be based on the the type of paralysis, as follows:

- Quadriplegia refers to paralysis of both upper limbs (from the shoulder down including total paralysis of both hands) and both lower limbs (from the waist down including total paralysis of both feet).
- Paraplegia refers to paralysis of both lower limbs (from the waist down including total paralysis of both feet).
- Hemiplegia refers to paralysis of both the upper limb (from the shoulder down including total paralysis of the hand) and lower limb (from the waist down including total paralysis of the foot) on one side of the body
- Uniplegia refers to paralysis of one limb (from the shoulder down including total paralysis of the hand if claiming an upper limb and from the waist down including total paralysis of the foot if claiming a lower limb).

We will pay no more than one paralysis benefit per covered accident per insured. In the event that an insured qualifies under multiple types of paralysis, the highest benefit amount will be paid.

**Traumatic Brain Injury**

If an insured is injured in a covered accident and the injury results in a traumatic brain injury, we will pay the amount shown on the specifications page.

Traumatic brain injury means only the following: intracranial hemorrhage, cerebral contusion or cerebral laceration.

The insured must be treated by a physician within 72 hours after the covered accident. The traumatic brain injury must be diagnosed within 30 days after the accident by computer tomography (CT) scan or magnetic resonance imaging (MRI).

This benefit is payable only once per insured per covered accident. Scalp hematomas and scalp lacerations are not covered under this benefit.
Emergency Care

Ambulance

If an insured is injured in a covered accident and requires transportation to a hospital (or between hospitals) we will pay the appropriate ambulance benefit shown on the specifications page. Ground or water transportation must be provided by a licensed professional ambulance service within 90 days of the covered accident. Air transportation must be provided by a licensed professional ambulance service within 72 hours. This benefit is limited to one payment per insured per covered accident. If an insured requires more than one ambulance transport, the highest benefit amount will be paid.

Ambulance means any publicly or privately owned surface, water or air vehicle, including a helicopter that is specifically designed and constructed or modified and equipped to be used, maintained or operated primarily for the transportation of individuals who are sick, injured or wounded.

Ambulance does not include a surface, water or air vehicle that is owned and operated to accommodate an incapacitated or disabled person who does not require medical monitoring, care or treatment during transport.

Blood, Plasma or Platelets Transfusion

If an insured is injured in a covered accident and requires a blood, plasma or platelets transfusion, we will pay the blood/plasma/platelets transfusion benefit shown on the specifications page. The transfusion must occur within 90 days of the covered accident. This benefit is limited to one payment per insured per covered accident.

Emergency Dental

If an insured has an injury to sound natural teeth as a result of a covered accident, we will pay the appropriate emergency dental benefit shown on the specifications page. A benefit is payable for a broken tooth repaired with crown(s) or a broken tooth requiring extraction. Treatment must occur within 60 days of the covered accident. The maximum number of crown benefits payable per insured per covered accident is two. The maximum number of extraction benefits payable per insured per covered accident is two.

Proof of the soundness of the injured tooth must be submitted with claims. Injuries resulting from biting or chewing are not covered under this benefit.

Sound natural teeth are defined as teeth that are free of active or chronic clinical decay, have at least 50% bone support and are functional in the arch.

Emergency Room Treatment

If an insured is injured in a covered accident and requires treatment in an emergency room, we will pay the emergency room treatment benefit shown on the specifications page. Treatment must occur within 72 hours of the covered accident.

This benefit is limited to one payment per insured per covered accident.

Initial Physician's Office Visit

If an insured is injured in a covered accident, we will pay the initial physician’s office visit benefit shown on the specifications page.

Benefits are payable for the initial treatment received in a physician’s office or an urgent care center for injuries resulting from a covered accident. Treatment must occur within 72 hours of the covered accident. The maximum number of benefits per insured per calendar year is two. The benefit is not payable if the insured receives care in an emergency room within the same 72 hour period. Only one benefit is payable per covered accident.

Hospital Care

Hospital Stay

If an insured is injured in a covered accident and requires treatment in a hospital for the injury within 180 days of a covered accident, we will pay the hospital stay benefit shown on the specifications page subject to the following.

Initial Benefit

We will pay the initial benefit shown on the specifications page for the first day of a hospital stay provided the insured is receiving treatment for a covered accident in the hospital for a minimum of 18 continuous hours.

The benefit payment will be based on the type of room and level of care the insured receives. The Intensive Care Unit (ICU) benefit is payable if the insured is receiving treatment in an ICU room of a hospital. The non-ICU benefit is payable if the insured is receiving treatment in a non-ICU room.

This benefit is limited to one payment per insured per covered accident. In the event the insured receives treatment in both a non-ICU and an ICU room, the higher benefit will be payable as an initial benefit.

Daily Benefit

If an initial benefit is payable, the insured will also receive a daily benefit for each day he or she is treated in the hospital, including the first day.
The amount payable for the daily benefit is shown on the specifications page.

The daily benefit payment will be based on the type of room and level of care the insured receives. The ICU benefit is payable if the insured is receiving treatment in an ICU room of a hospital. The non-ICU benefit is payable if the insured is receiving treatment in a non-ICU room.

The ICU daily benefit will be limited to a maximum of 15 days per insured per covered accident. The combination of the both ICU and non-ICU benefits will be limited to a cumulative maximum of 120 days per insured per covered accident.

If an insured is released from the hospital and subsequently requires treatment in a hospital for injuries sustained in the same covered accident, the subsequent treatment will be considered a continuation of the same hospital stay for purposes of determining the cumulative maximum daily benefit so long as the treatment occurs within two years of the date of the covered accident.

Intensive Care Unit (ICU) refers to a specifically designated part of a hospital that provides the highest level of medical care and is restricted to patients who are critically ill or injured and who require intensive comprehensive observation and care. Hospital Intensive Care Units must be:

(1) separate and apart from the surgical recovery room; and
(2) separate and apart from rooms, beds, and wards customarily used for patient confinement; and
(3) permanently equipped with special life-saving equipment to care for the critically ill or injured; and
(4) under constant and continuous observation by nursing staffs assigned to the Intensive Care Unit.

**Surgery Benefits**

**Abdominal or Pelvic Surgery**

If an insured is injured in a covered accident and requires abdominal or pelvic surgery to treat the injuries, we will pay the abdominal or pelvic surgery benefit shown on the specifications page. The surgery must be performed within 72 hours of the covered accident. This benefit is limited to one payment per insured per covered accident. Surgery required to treat a fracture or dislocation is payable under the fracture or dislocation benefit and is not covered under the abdominal or pelvic surgery benefit.

**Cranial Surgery**

If an insured is injured in a covered accident and requires cranial surgery to treat the injuries, we will pay the cranial surgery benefit shown on the specifications page.

The surgery must be performed within 72 hours of the covered accident. This benefit is limited to one payment per insured per covered accident.

Surgery required to treat a skull fracture is payable under the fracture benefit and is not covered under the cranial surgery benefit.

**Knee Cartilage Surgery**

If an insured is injured in a covered accident and requires knee cartilage surgery to treat the injury, we will pay the knee cartilage surgery benefit shown on the specifications page. The insured must be treated by a physician within 60 days of the covered accident and surgery must be performed within 180 days of the covered accident. This benefit is limited to one payment per insured per covered accident.

If both open and arthroscopic surgeries are required for the same injury, only the open benefit will be paid.

**Ruptured Disc Surgery**

If an insured is injured in a covered accident and requires surgery for one or more ruptured discs to treat the injury, we will pay the ruptured disc surgery benefit shown on the specifications page. The insured must be treated by a physician within 60 days of the covered accident and surgery must be performed within 180 days of the covered accident. This benefit is limited to one payment per insured per covered accident.

If both open and arthroscopic surgeries are required, only the open benefit will be paid.

**Tendon, Ligament or Rotator Cuff Surgery**

If an insured is injured in a covered accident and requires tendon, ligament or rotator cuff surgery to treat the injuries, we will pay the tendon, ligament or rotator cuff surgery benefit shown on the specifications page. The insured must be treated by a physician within 60 days of the covered accident and surgery must be performed within 180 days of the covered accident. This benefit is limited to one payment per insured per covered accident.

If both open and arthroscopic surgeries are required, only the open benefit will be paid.

**Thoracic Surgery**

If an insured is injured in a covered accident and requires thoracic surgery to treat the injuries, we will pay the thoracic surgery benefit shown on the specifications page. The surgery must be performed within 72 hours of the covered accident. This benefit is limited to one payment per insured per covered accident.

Surgery required to treat a fracture or dislocation is payable under the fracture or dislocation benefit and is not covered under the thoracic surgery benefit.
Follow-Up Care

Adaptive Home and Vehicle Benefit

If an insured is injured in a covered accident and requires adaptive modifications to his or her primary residence or private vehicle to be made drivable or rideable, we will pay the adaptive home and vehicle benefit shown on the specifications page subject to the following conditions:

1. A benefit is payable under the paralysis benefit of the Injury Benefits section of this certificate; and
2. The modification must take place within two years of the covered accident; and
3. Such home alterations are made by a person or persons with experience in such alterations and recommended by a recognized organization associated with the injury; and
4. Such vehicle modifications are carried out by a person or persons with experience in such matters and approved by the Motor Vehicle Department.

This benefit is limited to one payment per insured per covered accident.

Appliances

If an insured is injured in a covered accident and a medical appliance is prescribed by a physician for mobility, we will pay the appliance benefit shown on the specifications page. The order for the appliance must be placed within 180 days of the covered accident. This benefit is limited to payment for two covered appliances per insured per covered accident.

Covered appliances means only the following: crutches, canes, walkers, wheelchairs/scooters, leg braces and back braces. This benefit does not cover replacement appliances.

Follow-Up Physician’s Office Visit

If an insured is injured in a covered accident and follow-up care for the injury is ordered by the treating physician, we will pay the follow-up physician’s office visit benefit shown on the specifications page. The follow-up visit(s) must occur within 180 days of the covered accident. This benefit is limited to three payments per insured per covered accident. Follow-up at an urgent care center is not covered under this benefit.

Prosthetics

If an insured is injured in a covered accident and sustains the loss of a limb, hand, foot or sight in an eye, we will pay the prosthetic benefit shown on the specifications page, subject to the following:

1. This benefit is limited to payment for two prosthetic devices per insured per covered accident; and
2. The prosthetic device(s) must be prescribed by a physician and ordered within 180 days after the covered accident.

Prosthetic device refers to an artificial device that replaces a missing limb, hand, foot or an eye. For purposes of this benefit, the term prosthetic device does not include corrective lenses or other cosmetic prostheses.

In addition, this benefit does not provide coverage for damaged prosthetics; more than one prosthetic device for the same limb, hand, foot or eye; the replacement of a prosthetic device; or a joint replacement.

Transportation

If an insured receives follow-up treatment ordered by a physician for an injury sustained in a covered accident and is required to travel more than 100 miles (one way) from the insured’s primary residence to a hospital or other treatment facility, we will pay the transportation benefit shown on the specifications page subject to the following:

1. A benefit is payable under this certificate for the same injury; and
2. The follow-up treatment is ordered by a physician and is not available within 100 miles (one way) of the insured’s primary residence; and
3. The Ambulance benefit is not payable for the same trip.

Mileage is measured from the insured’s primary residence to the hospital or treatment facility where the follow-up treatment is provided.

This benefit is limited to two payments per insured per covered accident.

Support Care

Adult Companion Lodging

If an insured is injured in a covered accident, we will pay the adult companion lodging benefit shown on the specifications page for each day the insured is receiving treatment in a hospital or rehabilitative facility for the injury, and for the 24 hours following the last day the insured is receiving treatment in a hospital or rehabilitative facility for the injury subject to the following conditions:

1. A companion who accompanies the insured stays in lodging for which a charge is made; and
2. Either the hospital stay benefit or rehabilitative therapy (inpatient) benefit is payable for the same day the adult companion lodging benefit is payable; and
3. The companion is 18 or older.

Lodging refers to an establishment licensed under the laws applicable to where it is located, such as a motel,
hotel, or other facility that provides sleeping accommodations to the general public in exchange for a fee and is located at least 100 miles from the insured’s primary residence.

This benefit is limited to 30 days per covered accident. Proof must be provided that the companion incurred an expense for staying at a lodging.

Exclusions and Limitations

Are there any other exclusions that apply?

Yes. In no event will we pay benefits where the insured’s accident, injury or loss is caused directly or indirectly by, results in whole or in part from or during, or there is contribution from, any of the following:

1. intentionally self-inflicted injury while sane; or
2. suicide or attempted suicide while sane; or
3. your commission of, or your attempt to commit, a felony, or your being engaged in an illegal occupation; or
4. your being intoxicated; or
5. the use of prescription drugs, non-prescription drugs, illegal drugs or medications, unless administered on the advice of a physician; or
6. poisons, gases, fumes or other substances taken, absorbed, inhaled, ingested or injected; or
7. motor vehicle collision or accident where you are the operator of the motor vehicle and your blood alcohol level meets or exceeds the level at which intoxication is defined in the state where the collision or accident occurred, regardless of any legal proceedings thereto; or
8. war or any act of war, whether declared or undeclared; or
9. bodily or mental infirmity, illness or disease; or
10. infection, other than infection occurring simultaneously with, and as a direct and independent result of, the injury; or
11. repetitive stress syndromes including but not limited to rotator cuff syndrome, bursitis, tendonitis, carpal tunnel syndrome, ulnar nerve syndrome, stress fractures, neuropathy, epicondylitis or neuritis; or
12. medical or surgical treatment or diagnostic procedures including any resulting complications, or when the outcome is not as planned or expected, including claims of medical malpractice; or
13. travel in or descent from any aircraft, except as a fare-paying passenger on a regularly scheduled commercial flight on a licensed passenger aircraft carrier; or
14. participation in the following activities: scuba diving, bungee jumping, base jumping, hang gliding, sail gliding, parasailing, parakiting, or mountain climbing; or
15. riding or driving in any motor-driven vehicle in a race, stunt show or speed test; or
16. practicing for or participating in any semi-professional or professional competitive athletics.

Are there any additional limitations that apply?

Yes. Benefits are not payable for any care, treatment or diagnostic measures which were received outside of the United States or United States territory.

Claims

What notice of claim must be provided?

Written notice of claim must be given to us within 20 days of the date of a loss resulting from a covered accident, or as soon thereafter as reasonably possible. Notice given by or on the insured’s behalf or to us at our home office or to any authorized agent of ours, with information to identify the insured, shall be deemed notice to us.

Will claim forms be provided?

Upon receipt of notice of claim, we will provide a claim form. If the claim form is not provided within 15 days after the insured has given notice of claim, we will deem the insured to have complied with the requirements for filing proof of a loss resulting from a covered accident if the insured submits, within the time period for filing proof of the loss, written proof of the occurrence, character and extent of the loss for which claim is made which is satisfactory to us.

When is proof of a loss resulting from a covered accident required?

Written proof of a loss resulting from a covered accident satisfactory to us must be provided to us within 90 days of the date of the loss. Failure to provide proof of the loss within this time will not invalidate or reduce a claim if it was not reasonably possible to provide proof within this 90 day period. However, proof must be provided within 1 year of the date of the loss, except in the absence of legal capacity.

When will the benefit be paid?

We will pay a benefit for a loss resulting from a covered accident immediately upon receipt at our home office of written proof of the loss which meets all policy requirements and is satisfactory to us. You are responsible for all costs associated with claim form(s) completion, records, and the submission of your claim.

To whom will benefits be paid?

All benefits including dependent’s benefits will be paid to you, if you are living. If you die before the claim is paid, benefits will be paid to your estate.
What are our physical examination rights?

After an insured has filed a claim and provided at his or her expense all requested claim forms and records, we have the right to have the insured examined by a physician of our choice and at our expense. This right may be exercised as often as reasonably necessary while an insured has a claim pending with us.

Termination

When does your coverage terminate?

Coverage ends on the earliest of the following:

1. the date you no longer meet the eligibility requirements; or
2. 31 days (the grace period) after the due date of any premium which is not paid; or
3. the last day for which premium contributions have been paid following your request to cancel your coverage; or
4. the date the group policy ends.

When does an insured dependent's coverage terminate?

An insured dependent's coverage ends on the earliest of the following:

1. the date the dependent no longer meets the eligibility requirements; or
2. 31 days (the grace period) after the due date of any premium contribution which is not paid; or
3. the last day for which premium contributions have been paid following your written request that insurance on your eligible dependents be terminated; or
4. the date you are no longer covered under the group policy.

You must notify us or your employer when you no longer have dependents eligible for coverage under this certificate so that premiums may be discontinued. All premiums paid for dependents who are no longer eligible for coverage under this certificate will be refunded without any payment of claim.

Additional Information

Can your insurance coverage be contested?

Yes. If an insured experiences a loss resulting from a covered accident within two years of the original effective date of coverage or increase in coverage, we will verify the accuracy of the information provided during the application process. If we discover a material misrepresentation, the affected coverage will be rescinded and an otherwise valid claim will be denied.

Is the policyholder required to maintain records?

Yes. The policyholder is required to maintain adequate records of any information necessary for us to administer the policy, and shall provide access to such records when required for us to administer the policy. If a clerical error is made in keeping records on the insurance under the group policy, it will not affect otherwise valid insurance.

A clerical error does not continue insurance which is otherwise stopped, make insurance effective when it should not have been or change the benefit amount provided by the provisions of the policy and no claim shall be paid on amounts affected by a clerical error. If an error causes a change in premium payment, a fair adjustment will be made.

Will the provisions of this certificate conform with applicable state law?

Yes. If any provision in this certificate, or in the provisions of the group policy, is in conflict with the applicable laws of the state governing the certificates or the group policy, the provision will be deemed to be amended to conform to such laws.

What if an insured's age has been misstated?

If an insured's age has been misstated, all amounts payable will be adjusted to that amount which the premium would have purchased at the correct age. This will be determined by applying the ratio of the paid premium over the required premium to the initial benefit amount.

Can this insurance be assigned?

No. Insurance coverage under the group policy cannot be assigned.

What is the policy interpretation right and authority?

The following applies only when the administration of the policy is governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. 1001 et seq.:

Securian Life has the exclusive right and authority, in its sole discretion, to interpret the group policy and decide all matters arising thereunder. Securian Life's exercise of that authority shall be conclusive and binding on all persons unless it can be shown that the determination was arbitrary and capricious.
What insurance can be continued under this supplement?

Group accident insurance may be continued under this supplement. If an employee elects to continue his or her own coverage according to the provisions of this supplement, he or she may also elect to continue insurance for any other individual insured under his or her certificate.

What benefit amounts can be continued under this supplement?

The benefit amounts that can be continued under this supplement shall be the amounts shown on the specifications page applicable to the insured based on the benefit plan selected by the insured employee.

Can an insured request a change in the benefit plan continued under this supplement?

Yes. The insured employee may change the benefit plan to one that provides lower benefit amounts, but may not change the benefit plan to one that provides higher benefit amounts.

How will premiums be paid?

Premiums will be paid directly to us on a monthly, quarterly, semi-annual, or annual basis and will be subject to an administrative charge per billing period.

Can the premium rate change?

Yes. The premium rates for ported coverage may be different than the premium rates for active employees, and are not subject to the premium rate provision of the policy.

What happens if an insured again becomes eligible under the certificate?

If an insured is continuing coverage under the terms of this supplement, and again meets the eligibility requirements of the certificate the insured shall no longer be considered to have portability status. Insurance may be continued only under the terms of the certificate, not including this supplement, unless and until the insured no longer meets the eligibility requirements of the certificate and again returns to portability status as provided for herein.

What happens to insurance provided under this supplement when the group policy terminates?

Any insurance continued under the terms of this supplement will remain in force until terminated by the provisions of the section entitled “When will insurance continued under this supplement terminate?”
No individual may elect coverage under this supplement on or after the date of termination of the group policy.

When will insurance continued under this supplement terminate?

An insured's insurance being continued under this supplement will terminate on the earliest of the following:

(1) the insured's 70th birthday;
(2) the date the insured again meets the eligibility requirements of the certificate, not including the terms of this supplement;
(3) in the case of a dependent child or a spouse, the date your coverage is no longer being continued under this supplement or the date the spouse or child ceases to be eligible as defined under the terms of your certificate; or
(4) the date the group policy is terminated; or
(5) 31 days after the due date of any premium contribution which is not made.

Secretary                      President
Questions regarding your policy or coverage should be directed to:

Securian Life Insurance Company
400 Robert Street North
St. Paul, MN 55101-2098

Telephone: 651-665-3500

If you (a) need the assistance of a governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with your insurer you may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, IN 46204-2787

Consumer Hot Line 800-622-4461
In the Indianapolis Area 317-232-2395

Complaints can be filed electronically at www.in.gov/doi.
NOTICE OF PROTECTION PROVIDED BY THE INDIANA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a brief summary of the Indiana Life and Health Insurance Guaranty Association ("ILHIGA") and the protection it provides for policyholders. ILHIGA was established to provide protection to policyholders in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations. If this should happen, ILHIGA will typically arrange to continue coverage and pay claims, in accordance with Indiana law, with funding from assessments paid by other insurance companies.

Basic Protections Currently Provided by ILHIGA

Generally, an individual is covered by ILHIGA if the insurer was a member of ILHIGA and the individual lives in Indiana at the time the insurer is ordered into liquidation with a finding of insolvency. The coverage limits below apply only to companies placed in rehabilitation or liquidation on or after January 1, 2013.

- **Life Insurance**
  - $300,000 in death benefits
  - $100,000 in cash surrender or withdrawal values

- **Health Insurance**
  - $500,000 in basic hospital, medical and surgical or major medical insurance benefits
  - $300,000 in disability and long term care insurance
  - $100,000 in other types of health insurance

- **Annuities**
  - $250,000 in present value of annuity benefits (including cash surrender or withdrawal values)
  - $5,000,000 for covered unallocated annuities

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000. Special rules may apply with regard to basic hospital, medical and surgical or major medical insurance benefits.

The protections listed above apply only to the extent that benefits are payable under covered policy(s). In no event will the ILHIGA provide benefits greater than those given in the life, annuity, or health insurance policy or contract. The statutory limits on ILHIGA coverage have changed over the years and coverage in prior years may not be the same as that set forth in this notice.

**Note:** Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract.

To learn more about the protections provided by ILHIGA, please visit the ILHIGA website at [www.inlifega.org](http://www.inlifega.org) or contact:

**Indiana Life and Health Insurance Guaranty Association**
3502 Woodview Trace, Suite 100
Indianapolis, IN 46268
317-636-8204

**Indiana Department of Insurance**
311 West Washington Street, Suite 103
Indianapolis, IN 46204
317-232-2385
The policy or contract that this notice accompanies might not be fully covered by ILHIGA and even if coverage is currently provided, coverage is (a) subject to substantial limitations and exclusions (some of which are described above), (b) generally conditioned on continued residence in Indiana, and (c) subject to possible change as a result of future amendments to Indiana law and court decisions.

Complaints to allege a violation of any provision of the Indiana Life and Health Insurance Guaranty Association Act must be filed with the Indiana Department of Insurance, 311 West Washington Street, Suite 103, Indianapolis, IN 46204; (telephone) 317-232-2385.

Insurance companies and agents are not allowed by Indiana law to use the existence of ILHIGA or its coverage to encourage you to purchase any form of insurance. (IC 27-8-8-18(a)). When selecting an insurance company, you should not rely on ILHIGA coverage. If there is any inconsistency between this notice and Indiana law, Indiana law will control.

Questions regarding the financial condition of a company or your life, health insurance policy or annuity should be directed to your insurance company or agent.
GROUP ACCIDENT CERTIFICATE OF INSURANCE

POLICYHOLDER: Concordia Plan Services
POLICY NUMBER: 76013

THIS CERTIFICATE IS NOT MAJOR MEDICAL INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL INSURANCE. IT DOES NOT QUALIFY AS MINIMUM ESSENTIAL HEALTH COVERAGE UNDER THE FEDERAL AFFORDABLE CARE ACT. THIS CERTIFICATE DOES NOT SATISFY THE FEDERAL REQUIREMENT THAT YOU HAVE HEALTH INSURANCE COVERAGE, WHICH BECAME EFFECTIVE JANUARY 1, 2014.

THIS IS A LIMITED BENEFIT CERTIFICATE: This certificate provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses. Read your certificate carefully.

THIS CERTIFICATE IS NOT A MEDICARE SUPPLEMENT CONTRACT. If you are eligible for Medicare, review the Guide to Health Insurance for people with Medicare available from us.

Read Your Certificate Carefully

If you meet the eligibility and enrollment requirements herein, you are insured under the group policy shown on the specifications page. This certificate summarizes the principal provisions of the group policy that affect you. The provisions summarized in this certificate are subject in every respect to the group policy. You may examine the group policy at the principal office of the policyholder during regular working hours.

Legal Actions

No legal action may be brought to recover on this certificate within the first sixty days after written proof of loss has been given as required by this certificate. No such action may be brought after three years from the time written proof of loss is required to be given.

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GROUP ACCIDENT CERTIFICATE OF INSURANCE
GENERAL INFORMATION

POLICYHOLDER: Concordia Plan Services

POLICY NUMBER: 76013

ASSOCIATED COMPANIES: All subsidiaries and affiliates reported to Securian Life by the policyholder for inclusion in the policy.

POLICY SITUS: The policy was issued and delivered in Missouri.

POLICY EFFECTIVE DATE: January 1, 2019.

This certificate and/or certificate specifications page replaces any and all certificates and/or certificate specifications pages previously issued to you under the group policy. Please replace any certificate and/or certificate specifications page previously issued to you with this new certificate and/or specifications page.

GROUP: The group is composed of all active employees of the policyholder and its associated companies working in the United States in the following classes:

Class 1: Active employees working at least 20 hours per week.

All new employees of the employer will be added to such group and classes for which they become eligible.

NO DOUBLE COVERAGE: A person cannot be covered under more than one class. A person cannot be covered as both an active employee and a retiree. Any person who is eligible as an employee or retiree under the policy, or insured under the portability provisions, is not eligible as a dependent. Only one person can insure an eligible dependent child.

ENROLLMENT PERIOD: 90 days from the first day of eligibility for contributory insurance.

WAITING PERIOD: None

MINIMUM HOURS PER WEEK REQUIREMENT: 20 hours per week

PLAN OF INSURANCE

EMPLOYEE BENEFIT SCHEDULE

EMPLOYEE GROUP ACCIDENT INSURANCE:

Supplemental Group Accident Insurance

<table>
<thead>
<tr>
<th>Eligible Class</th>
<th>Employee Supplemental Group Accident Insurance Benefit Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class 1</td>
<td>Low Plan or High Plan as elected by the employee.</td>
</tr>
</tbody>
</table>
GENERAL PROVISIONS FOR EMPLOYEE INSURANCE

RETIREMENT REDUCTIONS: All insurance terminates at retirement, except as otherwise provided for under any applicable certificate supplement.

CONTRIBUTORY/NONCONTRIBUTORY: Supplemental insurance is contributory insurance.

PORTABILITY BENEFIT: Low Plan or High Plan as elected by the employee.

DEPENDENT BENEFIT SCHEDULE

An employee must be insured in order to elect dependent group accident insurance.

SPOUSE GROUP ACCIDENT INSURANCE

Supplemental Group Accident Insurance

<table>
<thead>
<tr>
<th>Eligible Class</th>
<th>Spouse Supplemental Group Accident Insurance Benefit Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class 1</td>
<td>Spouse benefit plan will match the employee’s Supplemental Group Accident Benefit Plan.</td>
</tr>
</tbody>
</table>

CHILD GROUP ACCIDENT INSURANCE

Supplemental Group Accident Insurance

<table>
<thead>
<tr>
<th>Eligible Class</th>
<th>Child Supplemental Group Accident Insurance Benefit Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class 1</td>
<td>Child benefit plan will match the employee’s supplemental Group Accident Benefit Plan.</td>
</tr>
</tbody>
</table>

GENERAL PROVISIONS FOR DEPENDENT INSURANCE

CONTRIBUTORY/NONCONTRIBUTORY: Supplemental insurance is contributory insurance.

SPOUSE AND CHILD PORTABILITY BENEFIT: Spouse benefit plan will match the employee’s Group Accident Benefit Plan. Child benefit plan will match the employee’s Group Accident Benefit Plan.

COVERED BENEFITS

Refer to the Injury Benefits, Emergency Care, Hospital Care, Surgery Benefits, Follow-up Care and Support Care sections of the Certificate for additional benefit details.

<table>
<thead>
<tr>
<th>INJURY BENEFITS</th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burn Benefit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2nd degree burns</td>
<td>$100</td>
<td>$300</td>
</tr>
<tr>
<td>Less than 10% of the body</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Between 10% and 20% of the body</td>
<td>$250</td>
<td>$750</td>
</tr>
<tr>
<td>20% or more of the body</td>
<td>$500</td>
<td>$1,500</td>
</tr>
<tr>
<td>3rd degree burns</td>
<td>$1,000</td>
<td>$3,000</td>
</tr>
<tr>
<td>Less than 10% of the body</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Between 10% and 20% of the body</td>
<td>$2,500</td>
<td>$7,500</td>
</tr>
<tr>
<td>20% or more of the body</td>
<td>$5,000</td>
<td>$15,000</td>
</tr>
<tr>
<td>Child Organized Sports Injury</td>
<td>$50</td>
<td>$100</td>
</tr>
<tr>
<td>INJURY BENEFITS</td>
<td>LOW PLAN</td>
<td>HIGH PLAN</td>
</tr>
<tr>
<td>----------------</td>
<td>----------</td>
<td>-----------</td>
</tr>
<tr>
<td>Concussion</td>
<td>$100</td>
<td>$200</td>
</tr>
<tr>
<td>Dislocation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Principal Amount (Surgical )</td>
<td>$2,000</td>
<td>$5,000</td>
</tr>
<tr>
<td></td>
<td>% of Principal Amount</td>
<td>% of Principal Amount</td>
</tr>
<tr>
<td>Hip/Thigh</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Foot</td>
<td>40%</td>
<td>40%</td>
</tr>
<tr>
<td>Ankle</td>
<td>40%</td>
<td>40%</td>
</tr>
<tr>
<td>Knee</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Hand or wrist (excluding fingers)</td>
<td>Hand: 20%</td>
<td>Hand: 20%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Wrist: 30%</td>
</tr>
<tr>
<td>Lower jaw</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Shoulder</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Collarbone</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Ribs</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Finger</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Toe</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Elbow</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Non-surgical</td>
<td>50% of surgical benefit</td>
<td>50% of surgical benefit</td>
</tr>
<tr>
<td>Partial dislocation</td>
<td>25% of non-surgical benefit</td>
<td>25% of non-surgical benefit</td>
</tr>
<tr>
<td>Eye Injury - with Surgery</td>
<td>$120</td>
<td>$300</td>
</tr>
<tr>
<td>Eye Injury – Removal of Foreign Object without Surgery</td>
<td>$30</td>
<td>$75</td>
</tr>
<tr>
<td>Fracture</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Principal Amount (Surgical)</td>
<td>$2,000</td>
<td>$5,000</td>
</tr>
<tr>
<td></td>
<td>% of Principal Amount</td>
<td>% of Principal Amount</td>
</tr>
<tr>
<td>Hip/Thigh</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Vertebral body</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Vertebral processes</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Pelvis</td>
<td>75%</td>
<td>75%</td>
</tr>
<tr>
<td>Sternum</td>
<td>75%</td>
<td>75%</td>
</tr>
<tr>
<td>Coccyx</td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td>Skull – non depressed</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Skull – depressed</td>
<td>150%</td>
<td>150%</td>
</tr>
<tr>
<td>Lower leg</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Foot</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Ankle</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Kneecap</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Upper arm</td>
<td>35%</td>
<td>35%</td>
</tr>
<tr>
<td>Facial excluding lower jaw</td>
<td>35%</td>
<td>35%</td>
</tr>
<tr>
<td>Forearm</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Hand or wrist (except fingers)</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Lower jaw</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Shoulder blade</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Collarbone</td>
<td>15%</td>
<td>15%</td>
</tr>
<tr>
<td>Ribs</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Finger</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Toe</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Nose</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Non-surgical</td>
<td>50% of surgical benefit</td>
<td>50% of surgical benefit</td>
</tr>
<tr>
<td>Chip fracture</td>
<td>25% of non-surgical Benefit</td>
<td>25% of non-surgical benefit</td>
</tr>
</tbody>
</table>
### INJURY BENEFITS

<table>
<thead>
<tr>
<th></th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lacerations</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>With stitches or staples</td>
<td>$100</td>
<td>$500</td>
</tr>
<tr>
<td>Without stitches or staples</td>
<td>25% of benefit provided with stitches or staples</td>
<td>25% of benefit provided with stitches or staples</td>
</tr>
<tr>
<td><strong>Paralysis</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Principal Amount</td>
<td>$20,000</td>
<td>$60,000</td>
</tr>
<tr>
<td>Quadriplegia</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Paraplegia</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Hemiplegia</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Uniplegia</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td><strong>Traumatic Brain Injury</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$200</td>
<td>$400</td>
</tr>
</tbody>
</table>

### EMERGENCY CARE

<table>
<thead>
<tr>
<th></th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ambulance</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ground or water</td>
<td>$100</td>
<td>$200</td>
</tr>
<tr>
<td>Air</td>
<td>$500</td>
<td>$1,000</td>
</tr>
<tr>
<td><strong>Blood, Plasma or Platelets Transfusion</strong></td>
<td>$300</td>
<td>$600</td>
</tr>
<tr>
<td><strong>Emergency Dental</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crown</td>
<td>$150</td>
<td>$300</td>
</tr>
<tr>
<td>Extraction</td>
<td>$50</td>
<td>$100</td>
</tr>
<tr>
<td><strong>Emergency Room Treatment</strong></td>
<td>$100</td>
<td>$300</td>
</tr>
<tr>
<td><strong>Initial Physician's Office Visit</strong></td>
<td>$50</td>
<td>$100</td>
</tr>
<tr>
<td><strong>Hospital Stay</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initial benefit, non-ICU</td>
<td>$400</td>
<td>$1,200</td>
</tr>
<tr>
<td>Initial benefit, ICU</td>
<td>$800</td>
<td>$2,400</td>
</tr>
<tr>
<td>Daily benefit, non-ICU</td>
<td>$100</td>
<td>$300</td>
</tr>
<tr>
<td>Daily benefit, ICU</td>
<td>$200</td>
<td>$600</td>
</tr>
</tbody>
</table>

### SURGERY

<table>
<thead>
<tr>
<th></th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Abdominal or Pelvic Surgery</strong></td>
<td>$1,000</td>
<td>$2,000</td>
</tr>
<tr>
<td><strong>Cranial Surgery</strong></td>
<td>$1,000</td>
<td>$2,000</td>
</tr>
<tr>
<td><strong>Knee Cartilage Surgery</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Open</td>
<td>$500</td>
<td>$1,000</td>
</tr>
<tr>
<td>Arthroscopic</td>
<td>$250</td>
<td>$500</td>
</tr>
<tr>
<td><strong>Ruptured Disc Surgery</strong></td>
<td>$500</td>
<td>$1,000</td>
</tr>
<tr>
<td><strong>Tendon, Ligament or Rotator Cuff Surgery</strong></td>
<td>$500</td>
<td>$1,000</td>
</tr>
<tr>
<td>INJURY BENEFITS</td>
<td>LOW PLAN</td>
<td>HIGH PLAN</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>----------</td>
<td>-----------</td>
</tr>
<tr>
<td>Arthroscopic</td>
<td>$250</td>
<td>$500</td>
</tr>
<tr>
<td>Thoracic Surgery</td>
<td>$1,000</td>
<td>$2,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FOLLOW-UP CARE</th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adaptive Home and Vehicle Benefit</td>
<td>$500</td>
<td>$1,000</td>
</tr>
<tr>
<td>Appliances</td>
<td>$50</td>
<td>$250</td>
</tr>
<tr>
<td>Follow-Up Physician’s Office Visit</td>
<td>$50</td>
<td>$100</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Prosthetics</th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>One prosthetic</td>
<td>$500</td>
<td>$1,000</td>
</tr>
<tr>
<td>Two or more prosthetics</td>
<td>2x one prosthetic</td>
<td>2x one prosthetic</td>
</tr>
<tr>
<td>Transportation</td>
<td>$200 per visit</td>
<td>$500 per visit</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SUPPORT CARE</th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Companion Lodging</td>
<td>$75 per day</td>
<td>$150 per day</td>
</tr>
</tbody>
</table>

**ADDITIONAL INFORMATION**

**ANNUAL OPEN ENROLLMENTS:**

During the policyholder’s annual open enrollment an employee may elect or change employee and dependent accident insurance benefit plans.

Coverage will be effective on the January 1 following the annual enrollment, subject to the actively at work requirement for employees and the hospitalization/non-confinement provision for dependents (this does not apply to a newborn child).

**Special Enrollment Periods:** Upon mutual agreement between the Policyholder and Securian, one or more special enrollment periods may be offered to eligible employees. These special enrollment periods (if offered) will be in addition to the annual enrollment opportunities described above. In the event that a special enrollment period is offered, the details of the special enrollment, including enrollment dates, allowed changes, and evidence of insurability requirements, will be communicated to you in advance of the special enrollment period and documented in the group policy on file with the policyholder and Securian.

**QUALIFIED STATUS CHANGES:**

An employee who experiences a Qualified Status Changes as defined below may elect or change employee and dependent accident insurance benefit plans provided enrollment is made within 60 days of the status change.

- An active employee may elect accident insurance for the first time or increase coverage from the low plan to the high plan.
- An active employee may elect dependent coverage.

Coverage will be effective on the date of the election. All increases are subject to the actively at work requirement for employees and the hospitalization/non-confinement provision for dependents (this does not apply to a newborn child)

A qualified status change for the purpose of waiving the evidence of insurability requirement means marriage, birth or adoption.
SUPPLEMENTS TO THE CERTIFICATE

Portability
Definitions
Any use in this certificate of a term defined in this section is to be given the meaning defined in this section unless otherwise defined in another provision of this certificate.

accident
An act or event which is:

(1) unintended, unexpected and unforeseen; and
(2) directly results in bodily injury to the insured.

application
Your application or enrollment for insurance under the group policy.

associated company
Any company which is a subsidiary or affiliate of the policyholder which is designated by the policyholder and agreed to by us to participate under the group policy.

child or children
Your or your spouse’s natural, adopted, stepchild or foster child, who is less than 26 years old, unmarried grandchildren who are in the legal custody of and residing with you, and any unmarried child who is placed in your home following execution of an act of voluntary surrender in the favor of you or your legal representative. An adopted child includes a child legally placed for adoption with you. Eligibility begins at live birth (stillborn or unborn children are not eligible).

The limiting age shall not apply while the child is and continues to be both (1) incapable of self-sustaining employment, and (2) chiefly dependent upon you for support and maintenance.

contributory insurance
Insurance for which you are required to make premium contributions.

covered accident
An accident which:

(1) is not excluded under the Exclusions and Limitations section or any other terms of this certificate; and
(2) occurs while the insured’s coverage is in force; and
(3) occurs in the United States or a United States territory.

dependent
Your children and spouse
If both parents of a child qualify as eligible employees under the group policy, the child shall be considered a dependent of only one parent for purposes of this certificate. If any child qualifies as an eligible employee under the group policy, he or she is not eligible to be insured as a dependent child.

emergency room
A department of a hospital or a satellite emergency center that is designated for persons requiring immediate medical care. This area must be staffed and equipped to handle trauma, be supervised and provide treatment by physicians, and provide care seven days per week, 24 hours per day.

A satellite emergency center is a licensed facility providing outpatient care under the direction of a licensed physician on a 24-hour basis. Available services must include:

(1) diagnostic care, including laboratory services and diagnostic x-rays; and
(2) treatment or medical care, including availability of the means for stabilization of emergency medical conditions.

A satellite emergency center does not include a hospital or an office maintained by a licensed physician for the practice of medicine or dentistry.

employee
An individual who is employed by the policyholder or by an associated company. A sole proprietor will be considered the employee of the proprietorship. A partner in a partnership will be considered an employee so long as the partner’s principal work is the conduct of the partnership’s business. The term employee does not include temporary employees nor corporate directors who are not otherwise employees.

employer
The policyholder or any designated associated companies.

family member
A parent, spouse, child, sibling, grandparent, aunt, uncle, first cousin, niece or nephew. This includes adopted, in-law and step relatives.

hospital
A short-term, acute care general facility that:

(1) is legally licensed and operated as a hospital;
(2) provides overnight care of injured and sick people;
(3) requires that every patient be supervised by a physician;
(4) provides 24 hour nursing service by or under the supervision of a registered nurse;
(5) has on-site or pre-arranged use of x-ray equipment, laboratory, and surgical facilities; and
(6) maintains permanent medical history records.
A hospital is not a rehabilitation center, nursing home, rest home, extended-care facility, convalescent home, a place for alcoholics or drug addicts or a mental institution, even if such facilities are affiliated with or adjoined to a hospital.

**injury or injuries**
A bodily injury which is sustained as a direct result of a covered accident.

**insured**
An employee, spouse or child covered for insurance under this certificate.

**noncontributory insurance**
Insurance for which you are not required to make premium contributions.

**non-work day**
A day on which you are not regularly scheduled to work, including scheduled time off for vacations, personal holidays, weekends and holidays, and approved leaves of absence for non-medical reasons.

Non-work day does not include time off for medical leave of absence, temporary layoff, employer suspension of operations in total or in part, strike, and any time off due to sickness or injury including sick days, short-term disability, or long term disability.

**physician**
A medical doctor or other person recognized by law or regulation in the United States or United States territory where services are rendered as a physician. The person must be licensed as required by the United States jurisdiction where care is given and must be operating in the scope of his or her license.

A physician cannot be a person who:

(1) ordinarily resides in your household; or
(2) is a family member

**policyholder**
The owner of the group policy as shown on the specifications page.

**specifications page**
The summary of the plan specifics available under the group policy.

**spouse**
Your legally married spouse.

Spouse does not include any person who is eligible as an employee.

**surgery**
Medical treatment in which a physician cuts into someone’s body in order to repair or remove damaged parts as a result of a covered accident. The surgery must be performed solely because of injuries sustained in a covered accident.

**urgent care center**
A health care facility that is separate from a hospital or a separate unit within a hospital and whose primary purpose is the offering and provision of immediate, short term medical care, without appointment, for urgent care.

**waiting period**
The period, if any, of continuous employment with the employer that the employee must satisfy prior to becoming eligible for coverage under this certificate. You are not eligible to become insured until the first day following the waiting period. Any such waiting period is shown on the specifications page.

**we, our, us**
Securian Life Insurance Company.

**you, your, certificate holder**
An insured employee.

**General Information**

**What is your agreement with us?**
If you meet the eligibility and enrollment requirements, you are insured under the group policy shown on the specifications page. Your application is deemed a part of this certificate. This certificate summarizes the principal provisions of the group policy that affect your insurance coverage. The provisions summarized in this certificate are subject in every respect to the group policy.

Any statements made in your application will, in the absence of fraud, be considered representations and not warranties. Also, any statement made will not be used to void your insurance nor defend against a claim unless the statement is contained in the application.

**Can this certificate be amended?**
Yes. We retain the right to amend this certificate at any time without your consent. Any amendment will be without prejudice to any claim incurred for benefits prior to the date of the amendment.

**Who is eligible for insurance?**
You are eligible for group accident insurance if you:

(1) are a member of the eligible group and of an eligible class as defined on the specifications page; and
(2) work for the employer for at least the number of hours per week shown as the minimum hours per week requirement on the specifications page; and
(3) have satisfied the waiting period as shown on the specifications page; and
(4) meet the actively at work requirement described in the “What is the actively at work requirement?” provision of this section.

Are your dependents eligible for insurance?
Yes. If you are insured for group accident coverage, your dependents are eligible for insurance.

Are employees of associated companies eligible for insurance under the group policy?
Yes. Employees of associated companies may be eligible for insurance under the group policy. The policyholder represents any associated company in all transactions pertaining to the group policy. The policyholder's acts or omissions and every notice given by us to the policyholder shall be binding on every associated company. When an associated company ceases its participation under the policy, the policy shall be considered to be terminated for all employees of the associated company. All provisions related to policy termination will apply to such employees.

What is the actively at work requirement?
To be eligible to become insured or to receive an increase in the benefit amount, you must be actively at work, fully performing your customary duties for your regularly scheduled number of hours at the employer's normal place of business, or at other places the employer's business requires you to travel.

If you are not working due to illness or injury, you do not meet the actively at work requirement. If you are receiving sick pay, short-term disability benefits or long-term disability benefits, you do not meet the actively at work requirement. If you are not actively at work on the date coverage would otherwise begin, or on the date an increase in your benefit amount would otherwise be effective, you will not be eligible for the coverage or increase until you return to active work. However, if the absence is on a non-work day, coverage will not be delayed provided you were actively at work on the work day immediately preceding the non-work day.

Except as otherwise provided for in this certificate, you are eligible to continue to be insured only while you remain actively at work.

Any insurance or increase in insurance which is elected or put in force while you are not actively at work will not be eligible for claim payment. You or your beneficiary will receive a refund of premium for any contributory insurance for which you were not eligible.

What is the dependent non-confinement requirement?
If a dependent is hospitalized or confined because of illness or disease on the date his or her insurance would otherwise become effective, his or her effective date shall be delayed until he or she is released from such hospitalization or confinement. This does not apply to a newborn child. In no event will insurance on a dependent be effective before your insurance is effective.

Can your coverage be continued during sickness, injury, leave of absence or temporary layoff?
Yes. Insurance may be continued on an insured employee who is not actively at work due to sickness, injury, leave of absence or temporary layoff, subject to the employer's practices and procedures, including the employer's limits on the length of continuation allowed for the type of absence. Continuation is contingent upon continued premium payment.

Coverage during a leave of absence and upon return from a leave of absence shall meet all state and federal requirements.

Enrollment

When can you elect or make changes to your insurance?
You must enroll in order to be insured for contributory coverage under the group policy. You can enroll for coverage within 90 days of when you first become eligible. After that period, you can only enroll for coverage or make changes during your annual open enrollment or within 60 days of a qualified status change event, as defined by the state and federal rules and regulations.

When does your insurance become effective?
Your insurance becomes effective on the date all of the following conditions have been met:

(1) you meet all eligibility requirements, including the actively at work requirement; and
(2) for contributory coverage, application is made in accordance with the application methods agreed upon by the policyholder and us

When does insurance for a dependent become effective?
Insurance on a dependent becomes effective on the date when all of the following conditions have been met:

(1) your insurance becomes effective;
(2) the dependent meets all eligibility requirements; and
(3) for contributory insurance, you apply for dependent coverage on forms which are approved by us.
When will changes in your coverage amount be effective?

Requested changes in the amount of your contributory insurance are effective on the first day of the month following receipt of your request for a change. However, elections made during an enrollment period will not become effective prior to the effective date for that enrollment.

Premiums

When and how often are your premium contributions due?

Unless the policyholder and we have agreed to some other premium payment procedure, any premium contributions you are required to make for contributory insurance are to be paid by you to the policyholder on a periodic basis. Premium rates are subject to change in accordance with the group policy.

How is the premium determined?

The premium will be the applicable premium rate in force on the date premiums are due. The premium may also be computed by any other method on which the policyholder and we agree.

Premium rates are subject to change according to the provisions of the group policy.

Can a premium be paid after the date it is due?

Yes. The group policy has a 31-day grace period. If a premium is not paid on or before the date it is due, that premium may be paid during the 31-day period following the due date. The insurance under the group policy will remain in effect during the 31-day grace period.

Injury Benefits

Burn Benefit

If an insured sustains a second or third degree burn in a covered accident, we will pay the appropriate amount shown on the specifications page based on the type of burn and the percentage of the body surface burned.

The burn must be treated by a physician within 72 hours after the covered accident. If the burn meets more than one of the burn classifications shown on the specifications page, the amount we pay will be based on the burn classification that pays the highest benefit.

We will pay the burn benefit no more than one time per insured per covered accident. No benefits are payable for sunburns or first degree burns.

Child Organized Sports Injury

The child organized sports injury benefit is subject to the following conditions.

(1) the insured dependent child suffers an injury in a covered accident while participating in an organized sport; and
(2) a benefit is payable for the insured dependent child under another provision of the group policy for the same covered accident; and
(3) the insured dependent child has not attained 19 years of age and is insured on the date the covered accident occurs;

A child organized sport refers to a sport activity that is governed by an organization and requires formal registration to participate. Adult supervision of practice and competition is required. Proof of registration must be submitted with claims.

The child organized sports injury benefit amount is shown on the specifications page.

This benefit is limited to one payment per insured dependent child per calendar year.

Concussion

If an insured is injured in a covered accident and the injury causes a concussion, we will pay the amount shown on the specifications page. The insured must be treated by a physician within 72 hours of a covered accident and the concussion must be diagnosed by a physician within 15 days of the covered accident.

Concussion refers to a disruption of brain function resulting from a traumatic blow to the head.

This benefit is limited to one payment per insured per covered accident per calendar year.

The concussion benefit is not payable if a traumatic brain injury benefit is payable under this certificate for the same accident.

Dislocation

If a joint is dislocated in a covered accident, and it is diagnosed and treated by a physician within 90 days after the covered accident, we will pay the amount shown on the specifications page. The amount varies based on the joint that is dislocated, whether the dislocation is a full or a partial dislocation, and whether surgery is required to treat the dislocation.

A full dislocation refers to a completely separated joint due to a covered accident. A partial dislocation means the joint is misaligned but not completely dislocated, as diagnosed by a physician.

If more than one dislocation benefit is payable resulting from the same covered accident, we will pay the lesser of:

(1) the total of the benefit amounts shown for each applicable dislocation on the specifications page; or
2 times the highest dislocation benefit that would otherwise be payable for any one of the dislocations involved.

**Eye Injury – with Surgery**

If an insured is injured in a covered accident and the injury results in an eye injury that requires surgery, we will pay the amount shown on the specifications page. The insured must be seen by a physician within 60 days of the covered accident and surgery must be performed within 180 days of the covered accident. This benefit is limited to one payment per eye per insured per covered accident.

**Eye Injury – Removal of Foreign Object without Surgery**

If an insured is injured in a covered accident and the injury results in an eye injury that requires removal of a foreign object, but does not require surgery, we will pay the amount shown on the specifications page. The insured must be seen by a physician within 60 days of the covered accident and removal of the foreign object must be performed within 180 days of the covered accident. This benefit is limited to one payment per eye per insured per covered accident.

**Fracture**

If a bone is fractured in a covered accident, and it is diagnosed and treated by a physician within 90 days after the covered accident, we will pay the amount shown on the specifications page. The amount varies based on the bone that is fractured, whether or not the fracture is a chip fracture, and whether surgery is required to treat the fracture.

Fracture refers to a break in a bone that can be seen by x-ray. A chip fracture is a fracture in which a small fragment of the bone is broken off.

If more than one fracture benefit is payable resulting from the same covered accident, we will pay the lesser of:

1. the total of the benefit amounts shown for each applicable fracture on the specifications page; or
2. 3 times the highest fracture benefit that would otherwise be payable for any one of the bones involved.

We will pay no more than one fracture benefit per bone per covered accident per insured. In no event will multiple fracture benefits be paid for the same fracture benefit shown on the specifications page unless it is a bi-lateral fracture. Bi-lateral fracture means the fracture of the same bone on both the left and right sides of the body.

**Lacerations**

If an insured is injured in a covered accident and the injury results in a laceration, we will pay the appropriate amount shown on the specifications page based on the type of treatment provided.

The laceration must be treated by a physician within 72 hours after the covered accident. This benefit is limited to one payment per insured per covered accident. In no event will we pay more than one laceration benefit per calendar year.

**Paralysis**

If an insured is injured in a covered accident and the injury causes paralysis which lasts more than 180 days we will pay the appropriate amount shown on the specifications page. Paralysis refers to the total, permanent, and irrevocable loss of movement. The paralysis must be diagnosed by a physician within 180 days after the accident.

The amount payable will be based on the type of paralysis, as follows:

- Quadriplegia refers to paralysis of both upper limbs (from the shoulder down including total paralysis of both hands) and both lower limbs (from the waist down including total paralysis of both feet).
- Paraplegia refers to paralysis of both lower limbs (from the waist down including total paralysis of both feet).
- Hemiplegia refers to paralysis of both upper limbs (from the shoulder down including total paralysis of the hand) and lower limb (from the waist down including total paralysis of the foot) on one side of the body.
- Uniplegia refers to paralysis of one limb (from the shoulder down including total paralysis of the hand if claiming an upper limb and from the waist down including total paralysis of the foot if claiming a lower limb).

We will pay no more than one paralysis benefit per covered accident per insured. In the event that an insured qualifies under multiple types of paralysis, the highest benefit amount will be paid.

**Traumatic Brain Injury**

If an insured is injured in a covered accident and the injury results in a traumatic brain injury, we will pay the amount shown on the specifications page.

Traumatic brain injury means only the following: intracranial hemorrhage, cerebral contusion or cerebral laceration.

The insured must be treated by a physician within 72 hours after the covered accident. The traumatic brain injury must be diagnosed within 30 days after the accident by computer tomography (CT) scan or magnetic resonance imaging (MRI). This benefit is payable only once per insured per covered accident. Scalp hematomas and scalp lacerations are not covered under this benefit.
Emergency Care

Ambulance

If an insured is injured in a covered accident and requires transportation to a hospital (or between hospitals) we will pay the appropriate ambulance benefit shown on the specifications page. Ground or water transportation must be provided by a licensed professional ambulance service within 90 days of the covered accident. Air transportation must be provided by a licensed professional ambulance service within 72 hours. This benefit is limited to one payment per insured per covered accident. If an insured requires more than one ambulance transport, the highest benefit amount will be paid.

Ambulance means any publicly or privately owned surface, water or air vehicle, including a helicopter that is specifically designed and constructed or modified and equipped to be used, maintained or operated primarily for the transportation of individuals who are sick, injured or wounded.

Ambulance does not include a surface, water or air vehicle that is owned and operated to accommodate an incapacitated or disabled person who does not require medical monitoring, care or treatment during transport.

Blood, Plasma or Platelets Transfusion

If an insured is injured in a covered accident and requires a blood, plasma or platelets transfusion, we will pay the blood/plasma/platelets transfusion benefit shown on the specifications page. The transfusion must occur within 90 days of the covered accident. This benefit is limited to one payment per insured per covered accident.

Emergency Dental

If an insured has an injury to sound natural teeth as a result of a covered accident, we will pay the appropriate emergency dental benefit shown on the specifications page. A benefit is payable for a broken tooth repaired with crown(s) or a broken tooth requiring extraction. Treatment must occur within 60 days of the covered accident. The maximum number of crown benefits payable per insured per covered accident is two. The maximum number of extraction benefits payable per insured per covered accident is two. Proof of the soundness of the injured tooth must be submitted with claims. Injuries resulting from biting or chewing are not covered under this benefit.

Sound natural teeth are defined as teeth that are free of active or chronic clinical decay, have at least 50% bone support and are functional in the arch.

Emergency Room Treatment

If an insured is injured in a covered accident and requires treatment in an emergency room, we will pay the emergency room treatment benefit shown on the specifications page. Treatment must occur within 72 hours of the covered accident.

This benefit is limited to one payment per insured per covered accident.

Initial Physician’s Office Visit

If an insured is injured in a covered accident, we will pay the initial physician’s office visit benefit shown on the specifications page.

Benefits are payable for the initial treatment received in a physician’s office or an urgent care center for injuries resulting from a covered accident. Treatment must occur within 72 hours of the covered accident. The maximum number of benefits per insured per calendar year is two. The benefit is not payable if the insured receives care in an emergency room within the same 72 hour period. Only one benefit is payable per covered accident.

Hospital Care

Hospital Stay

If an insured is injured in a covered accident and requires treatment in a hospital for the injury within 180 days of a covered accident, we will pay the hospital stay benefit shown on the specifications page subject to the following.

Initial Benefit

We will pay the initial benefit shown on the specifications page for the first day of a hospital stay provided the insured is receiving treatment for a covered accident in the hospital for a minimum of 18 continuous hours.

The benefit payment will be based on the type of room and level of care the insured receives. The Intensive Care Unit (ICU) benefit is payable if the insured is receiving treatment in an ICU room of a hospital. The non-ICU benefit is payable if the insured is receiving treatment in a non-ICU room.

This benefit is limited to one payment per insured per covered accident. In the event the insured receives treatment in both a non-ICU and an ICU room, the higher benefit will be payable as an initial benefit.

Daily Benefit

If an initial benefit is payable, the insured will also receive a daily benefit for each day he or she is treated in the hospital, including the first day. The amount payable for the daily benefit is shown on the specifications page.
The daily benefit payment will be based on the type of room and level of care the insured receives. The ICU benefit is payable if the insured is receiving treatment in an ICU room of a hospital. The non-ICU benefit is payable if the insured is receiving treatment in a non-ICU room.

The ICU daily benefit will be limited to a maximum of 15 days per insured per covered accident. The combination of the both ICU and non-ICU benefits will be limited to a cumulative maximum of 120 days per insured per covered accident.

If an insured is released from the hospital and subsequently requires treatment in a hospital for injuries sustained in the same covered accident, the subsequent treatment will be considered a continuation of the same hospital stay for purposes of determining the cumulative maximum daily benefit so long as the treatment occurs within two years of the date of the covered accident.

Intensive Care Unit (ICU) refers to a specifically designated part of a hospital that provides the highest level of medical care and is restricted to patients who are critically ill or injured and who require intensive comprehensive observation and care. Hospital Intensive Care Units must be:

1. separate and apart from the surgical recovery room; and
2. separate and apart from rooms, beds, and wards customarily used for patient confinement; and
3. permanently equipped with special life-saving equipment to care for the critically ill or injured; and
4. under constant and continuous observation by nursing staffs assigned to the Intensive Care Unit.

**Surgery Benefits**

**Abdominal or Pelvic Surgery**

If an insured is injured in a covered accident and requires abdominal or pelvic surgery to treat the injuries, we will pay the abdominal or pelvic surgery benefit shown on the specifications page. The surgery must be performed within 72 hours of the covered accident. This benefit is limited to one payment per insured per covered accident.

Surgery required to treat a fracture or dislocation is payable under the fracture or dislocation benefit and is not covered under the cranial surgery benefit.

**Cranial Surgery**

If an insured is injured in a covered accident and requires cranial surgery to treat the injuries, we will pay the cranial surgery benefit shown on the specifications page.

The surgery must be performed within 72 hours of the covered accident. This benefit is limited to one payment per insured per covered accident.

Surgery required to treat a skull fracture is payable under the fracture benefit and is not covered under the cranial surgery benefit.

**Knee Cartilage Surgery**

If an insured is injured in a covered accident and requires knee cartilage surgery to treat the injury, we will pay the knee cartilage surgery benefit shown on the specifications page. The insured must be treated by a physician within 60 days of the covered accident and surgery must be performed within 180 days of the covered accident. This benefit is limited to one payment per insured per covered accident.

If both open and arthroscopic surgeries are required for the same injury, only the open benefit will be paid.

**Ruptured Disc Surgery**

If an insured is injured in a covered accident and requires surgery for one or more ruptured discs to treat the injury, we will pay the ruptured disc surgery benefit shown on the specifications page. The insured must be treated by a physician within 60 days of the covered accident and surgery must be performed within 180 days of the covered accident. This benefit is limited to one payment per insured per covered accident.

**Tendon, Ligament or Rotator Cuff Surgery**

If an insured is injured in a covered accident and requires tendon, ligament or rotator cuff surgery to treat the injuries, we will pay the tendon, ligament or rotator cuff surgery benefit shown on the specifications page. The insured must be treated by a physician within 60 days of the covered accident and surgery must be performed within 180 days of the covered accident. This benefit is limited to one payment per insured per covered accident.

If both open and arthroscopic surgeries are required, only the open benefit will be paid.

**Thoracic Surgery**

If an insured is injured in a covered accident and requires thoracic surgery to treat the injuries, we will pay the thoracic surgery benefit shown on the specifications page. The surgery must be performed within 72 hours of the covered accident. This benefit is limited to one payment per insured per covered accident.

Surgery required to treat a fracture or dislocation is payable under the fracture or dislocation benefit and is not covered under the thoracic surgery benefit.
Follow-Up Care

Adaptive Home and Vehicle Benefit

If an insured is injured in a covered accident and requires adaptive modifications to his or her primary residence or private vehicle to be made drivable or rideable, we will pay the adaptive home and vehicle benefit shown on the specifications page subject to the following conditions:

1. a benefit is payable under the paralysis benefit of the Injury Benefits section of this certificate, or under the dismemberment benefit of the Accidental Death and Dismemberment Certificate Supplement; and
2. the modification must take place within two years of the covered accident; and
3. such home alterations are made by a person or persons with experience in such alterations and recommended by a recognized organization associated with the injury; and
4. such vehicle modifications are carried out by a person or persons with experience in such matters and approved by the Motor Vehicle Department.

This benefit is limited to one payment per insured per covered accident.

Appliances

If an insured is injured in a covered accident and a medical appliance is prescribed by a physician for mobility, we will pay the appliance benefit shown on the specifications page. The order for the appliance must be placed within 180 days of the covered accident. This benefit is limited to payment for two covered appliances per insured per covered accident.

Covered appliances means only the following: crutches, canes, walkers, wheelchairs/scooters, leg braces and back braces. This benefit does not cover replacement appliances.

Follow-Up Physician’s Office Visit

If an insured is injured in a covered accident and follow-up care for the injury is ordered by the treating physician, we will pay the follow-up physician’s office visit benefit shown on the specifications page. The follow-up visit(s) must occur within 180 days of the covered accident. This benefit is limited to three payments per insured per covered accident. Follow-up at an urgent care center is not covered under this benefit.

Prosthetics

If an insured is injured in a covered accident and sustains the loss of a limb, hand, foot or sight in an eye, we will pay the prosthetic benefit shown on the specifications page, subject to the following:

1. this benefit is limited to payment for two prosthetic devices per insured per covered accident; and
2. the prosthetic device(s) must be prescribed by a physician and ordered within 180 days after the covered accident.

Prosthetic device refers to an artificial device that replaces a missing limb, hand, foot or an eye. For purposes of this benefit, the term prosthetic device does not include corrective lenses or other cosmetic prostheses.

In addition, this benefit does not provide coverage for damaged prosthetics; more than one prosthetic device for the same limb, hand, foot or eye; the replacement of a prosthetic device; or a joint replacement.

Transportation

If an insured receives follow-up treatment ordered by a physician for an injury sustained in a covered accident and is required to travel more than 100 miles (one way) from the insured’s primary residence to a hospital or other treatment facility, we will pay the transportation benefit shown on the specifications page subject to the following:

1. a benefit is payable under this certificate for the same injury; and
2. the follow-up treatment is ordered by a physician and is not available within 100 miles (one way) of the insured’s primary residence; and
3. the Ambulance benefit is not payable for the same trip.

Mileage is measured from the insured’s primary residence to the hospital or treatment facility where the follow-up treatment is provided.

This benefit is limited to two payments per insured per covered accident.

Support Care

Adult Companion Lodging

If an insured is injured in a covered accident, we will pay the adult companion lodging benefit shown on the specifications page for each day the insured is receiving treatment in a hospital or rehabilitative facility for the injury, and for the 24 hours following the last day the insured is receiving treatment in a hospital or rehabilitative facility for the injury subject to the following conditions:

1. a companion who accompanies the insured stays in lodging for which a charge is made; and
2. either the hospital stay benefit or rehabilitative therapy (inpatient) benefit is payable for the same day the adult companion lodging benefit is payable; and
3. the companion is 18 or older.
Lodging refers to an establishment licensed under the laws applicable to where it is located, such as a motel, hotel, or other facility that provides sleeping accommodations to the general public in exchange for a fee and is located at least 100 miles from the insured’s primary residence.

This benefit is limited to 30 days per covered accident. Proof must be provided that the companion incurred an expense for staying at a lodging.

Exclusions and Limitations

Are there any other exclusions that apply?

Yes. In no event will we pay benefits where the insured’s accident, injury or loss is caused directly or indirectly by, results in whole or in part from or during, or there is contribution from, any of the following:

1. intentionally self-inflicted injury while sane; or
2. suicide or attempted suicide while sane; or
3. your commission of, or your attempt to commit, a felony, or your being engaged in an illegal occupation; or
4. your being intoxicated; or
5. your being under the influence of narcotics, unless administered on the advice of a licensed physician; or
6. the use of poisons, gases, fumes or illegal drugs taken, absorbed, inhaled, ingested or injected; or
7. motor vehicle collision or accident where you are the operator of the motor vehicle and your blood alcohol level meets or exceeds the level at which intoxication is defined in the state where the collision or accident occurred, regardless of any legal proceedings thereto; or
8. war or any act of war, whether declared or undeclared; or
9. bodily or mental infirmity, illness or disease; or
10. infection, other than infection occurring simultaneously with, and as a direct and independent result of, the injury; or
11. repetitive stress syndromes including but not limited to rotator cuff syndrome, bursitis, tendonitis, carpal tunnel syndrome, ulnar nerve syndrome, stress fractures, neuropathy, epicondylitis or neuritis; or
12. medical or surgical treatment or diagnostic procedures including any resulting complications, or when the outcome is not as planned or expected, including claims of medical malpractice; or
13. travel in or descent from any aircraft, except as a fare-paying passenger on a regularly scheduled commercial flight on a licensed passenger aircraft carrier; or
14. participation in the following activities: scuba diving, bungee jumping, base jumping, hang gliding, sail gliding, parasailing, parakiting, or mountain climbing; or
15. riding or driving in any motor-driven vehicle in a race, stunt show or speed test; or
16. practicing for or participating in any semi-professional or professional competitive athletics.

Are there any additional limitations that apply?

Yes. Benefits are not payable for any care, treatment or diagnostic measures which were received outside of the United States or United States territory.

Claims

What notice of claim must be provided?

Written notice of claim must be given to us within 20 days of the date of a loss resulting from a covered accident, or as soon thereafter as reasonably possible. Notice given by or on the insured’s behalf to us at our home office or to any authorized agent of ours, with information to identify the insured, shall be deemed notice to us. However, failure to give such notice within the time provided will not invalidate the claim if it is shown that notice was given as soon as reasonably possible.

Will claim forms be provided?

Upon receipt of notice of claim, we will provide a claim form. If the claim form is not provided within 15 days after the insured has given notice of claim, we will deem the insured to have complied with the requirements for filing proof of a loss resulting from a covered accident if the insured submits, within the time period for filing proof of the loss, written proof of the occurrence, character and extent of the loss for which claim is made which is satisfactory to us.

When is proof of a loss resulting from a covered accident required?

Written proof of a loss resulting from a covered accident satisfactory to us must be provided to us within 90 days of the date of the loss. Failure to provide proof of the loss within this time will not invalidate or reduce a claim if it was not reasonably possible to provide proof within this 90 day period. However, proof must be provided within 1 year of the date of the loss, except in the absence of legal capacity.

When will the benefit be paid?

We will pay a benefit for a loss resulting from a covered accident within 30 days after receipt at our home office of written proof of the loss which meets all policy requirements and is satisfactory to us. You are responsible for all costs associated with claim form(s) completion, records, and the submission of your claim.

To whom will benefits be paid?

All benefits including dependent’s benefits will be paid to you, if you are living. If you die before the claim is paid, benefits will be paid to your estate.
What are our physical examination rights?

After an insured has filed a claim and provided at his or her expense all requested claim forms and records, we have the right to have the insured examined by a physician of our choice and at our expense. This right may be exercised as often as reasonably necessary while an insured has a claim pending with us.

Termination

When does your coverage terminate?

Coverage ends on the earliest of the following:

1. the date you no longer meet the eligibility requirements; or
2. 31 days (the grace period) after the due date of any premium which is not paid; or
3. the last day for which premium contributions have been paid following your request to cancel your coverage; or
4. the date the group policy ends.

When does an insured dependent’s coverage terminate?

An insured dependent’s coverage ends on the earliest of the following:

1. the date the dependent no longer meets the eligibility requirements; or
2. 31 days (the grace period) after the due date of any premium contribution which is not paid; or
3. the last day for which premium contributions have been paid following your written request that insurance on your eligible dependents be terminated; or
4. the date you are no longer covered under the group policy.

You must notify us or your employer when you no longer have dependents eligible for coverage under this certificate so that premiums may be discontinued.

All premiums paid for dependents who are no longer eligible for coverage under this certificate will be refunded without any payment of claim.

Additional Information

Can your insurance coverage be contested?

Yes. If an insured experiences a loss resulting from a covered accident within three years of the original effective date of coverage or increase in coverage, we will verify the accuracy of the information provided during the application process.

If we discover a material misrepresentation, the affected coverage will be rescinded and an otherwise valid claim will be denied. This three year period will be extended by fraud or as otherwise allowed by applicable laws.

Is the policyholder required to maintain records?

Yes. The policyholder is required to maintain adequate records of any information necessary for us to administer the policy, and shall provide access to such records when required for us to administer the policy. If a clerical error is made in keeping records on the insurance under the group policy, it will not affect otherwise valid insurance.

A clerical error does not continue insurance which is otherwise stopped, make insurance effective when it should not have been or change the benefit amount provided by the provisions of the policy and no claim shall be paid on amounts affected by a clerical error. If an error causes a change in premium payment, a fair adjustment will be made.

Will the provisions of this certificate conform with applicable state law?

Yes. If any provision in this certificate, or in the provisions of the group policy, is in conflict with the applicable laws of the state governing the certificates or the group policy, the provision will be deemed to be amended to conform to such laws.

What if an insured’s age has been misstated?

If an insured’s age has been misstated, all amounts payable will be adjusted to that amount which the premium would have purchased at the correct age. This will be determined by applying the ratio of the paid premium over the required premium to the initial benefit amount.

Can this insurance be assigned?

No. Insurance coverage under the group policy cannot be assigned.

What is the policy interpretation right and authority?

The following applies only when the administration of the policy is governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. 1001 et seq.:

Securian Life has the exclusive right and authority, in its sole discretion, to interpret the group policy and decide all matters arising thereunder. Securian Life’s exercise of that authority shall be conclusive and binding on all persons unless it can be shown that the determination was arbitrary and capricious.
Group Accident Insurance Portability
Certificate Supplement
Securian Life Insurance Company
400 Robert Street North • St. Paul, Minnesota 55101-2098

General Information

This certificate supplement is subject to every term, condition, exclusion, limitation and provision of the certificate unless otherwise expressly provided for herein.

What does this supplement provide?

This supplement provides for continuation of insurance if an insured no longer meets the eligibility requirements of the certificate, except as provided for herein.

To continue insurance the insured must make a written request and make the first premium payment within 31 days after insurance provided by the group policy would otherwise terminate. Coverage provided by this supplement will then be deemed effective retroactive to the beginning of the 31-day period. This date is considered to be the insured’s portability date and the insured is then considered to have portability status.

Who is eligible to continue insurance under this supplement?

An insured employee is eligible to continue group accident insurance under the terms of this supplement if he or she no longer meets the eligibility requirements of the certificate due to any of the following:

1. the employee terminates employment, including retirement; or
2. the employee is no longer in a class eligible for insurance or is on a leave or layoff; or
3. a class or group of employees insured under the policy are no longer considered eligible and there is no successor plan for that class or group. Successor plan means an insurance policy or policies provided by us or another insurer that replaces insurance provided under this policy.

Regardless of whether an insured is otherwise eligible under this supplement to continue, an insured will not be eligible to request coverage under this supplement if he or she:

1. has attained the age of 70; or
2. is an employee and was not actively at work due to sickness or injury on the date immediately preceding his or her portability date; or
3. loses eligibility due to a class or group of employees no longer being eligible under the policy and there is a successor plan for that class or group of employees; or
4. loses eligibility due to termination of the group policy.

What insurance can be continued under this supplement?

Group accident insurance may be continued under this supplement. If an employee elects to continue his or her own coverage according to the provisions of this supplement, he or she may also elect to continue insurance for any other individual insured under his or her certificate.

What benefit amounts can be continued under this supplement?

The benefit amounts that can be continued under this supplement shall be the amounts shown on the specifications page applicable to the insured based on the benefit plan selected by the insured employee.

Can an insured request a change in the benefit plan continued under this supplement?

Yes. The insured employee may change the benefit plan to one that provides lower benefit amounts, but may not change the benefit plan to one that provides higher benefit amounts.

How will premiums be paid?

Premiums will be paid directly to us on a monthly, quarterly, semi-annual, or annual basis and will be subject to an administrative charge per billing period.

Can the premium rate change?

Yes. The premium rates for ported coverage may be different than the premium rates for active employees. In no event will the premium rate for ported coverage change during the first 12 months after the policy effective date. Premium rates may not be increased more frequently than once every six months.

What happens if an insured again becomes eligible under the certificate?

If an insured is continuing coverage under the terms of this supplement, and again meets the eligibility requirements of the certificate the insured shall no longer be considered to have portability status. Insurance may be continued only under the terms of the certificate, not including this supplement, unless and until the insured no longer meets the eligibility requirements of the certificate and again returns to portability status as provided for herein.

What happens to insurance provided under this supplement when the group policy terminates?

Any insurance continued under the terms of this supplement will remain in force until terminated by the
provisions of the section entitled “When will insurance continued under this supplement terminate?”

No individual may elect coverage under this supplement on or after the date of termination of the group policy.

**When will insurance continued under this supplement terminate?**

An insured’s insurance being continued under this supplement will terminate on the earliest of the following:

1. the insured’s 70th birthday;
2. the date the insured again meets the eligibility requirements of the certificate, not including the terms of this supplement;
3. in the case of a dependent child or a spouse, the date your coverage is no longer being continued under this supplement or the date the spouse or child ceases to be eligible as defined under the terms of your certificate.
4. the date the group policy is terminated; or
5. 31 days after the due date of any premium contribution which is not made.

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

DISCLAIMER

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

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

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

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

Louisiana Life and Health
Insurance Guaranty Association
PO Box 3337
Baton Rouge, Louisiana 70821

Louisiana Department of Insurance
PO Box 94214
Baton Rouge, Louisiana 70804-9214

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

Generally, individuals will be protected by the Louisiana Life and Health Insurance Guaranty Association if they live in this state and hold a direct, non-group life, health, or annuity policy or contract, a certificate under a direct group policy or contract for a supplemental contract to any of these, or an unallocated annuity contract issued by an insurer authorized to conduct business in Louisiana. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state unless they are afforded coverage by the guaranty association of another state, or other circumstances described under the law are applicable.

EXCLUSIONS FROM COVERAGE

A person who holds a direct non-group life, health, or annuity policy or contract, a certificate under a direct group policy or contract for a supplemental contract to any of these, or an unallocated annuity contract, is not protected by LLHIGA, if:

1. 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);
2. the insurer was not authorized to do business in this state;
3. their policy was issued by a profit or non-profit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, an insurance exchange, an organization that issues charitable gift annuities as is defined in R.S. 22:952(A)(3), or any entity similar to any of these.

LLHIGA also does not provide coverage for:

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

LIMITS ON AMOUNT OF COVERAGE

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

a. LLHIGA cannot pay more than what the insurance company would owe under a policy or contract if it were not an impaired or an insolvent insurer.

b. For any one insured life, regardless of the number of policies or contracts there are with the same company, LLHIGA will pay a maximum of $300,000 in life insurance death benefits, but not more than $100,000 in net cash surrender and net cash withdrawal values of life insurance.

c. For any one insured life, regardless of the number of policies or contracts there are with the same company, LLHIGA will pay a maximum of $500,000 in health insurance benefits, and a maximum of $250,000 in present value of annuities, including net cash surrender and net cash withdrawal values.

In no event, regardless of the number of policies and contracts there were with the same company, and no matter how many different types of coverages, LLHIGA shall not be liable to expend more than $500,000 in the aggregate with respect to any one individual.
THIS COVERAGE IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

(1) Read Your Certificate Carefully - This Outline of Coverage provides a very brief description of the important features of your certificate. This is not the insurance contract and only the actual certificate provisions shall control. The certificate sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR CERTIFICATE CAREFULLY!

(2) This certificate is NOT A MEDICARE SUPPLEMENT CONTRACT. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from us.

(3) ACCIDENT COVERAGE provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses. Read your certificate carefully.

(4) BENEFITS – The benefit amount payable will depend on whether the insured is enrolled in the Low Plan or High Plan, the number of benefits you qualify for, the care you receive and the terms and conditions of the policy.

<table>
<thead>
<tr>
<th>INJURY BENEFITS</th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burn Benefit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2\textsuperscript{nd} degree burns</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 10% of the body</td>
<td>$100</td>
<td>$300</td>
</tr>
<tr>
<td>Between 10% and 20% of the body</td>
<td>$250</td>
<td>$750</td>
</tr>
<tr>
<td>20% or more of the body</td>
<td>$500</td>
<td>$1,500</td>
</tr>
<tr>
<td>3\textsuperscript{rd} degree burns</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 10% of the body</td>
<td>$1,000</td>
<td>$3,000</td>
</tr>
<tr>
<td>Between 10% and 20% of the body</td>
<td>$2,500</td>
<td>$7,500</td>
</tr>
<tr>
<td>20% or more of the body</td>
<td>$5,000</td>
<td>$15,000</td>
</tr>
<tr>
<td>Child Organized Sports Injury</td>
<td>$50</td>
<td>$100</td>
</tr>
<tr>
<td>Concussion</td>
<td>$100</td>
<td>$200</td>
</tr>
<tr>
<td>Dislocation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Principal Amount (Surgical)</td>
<td>$2,000</td>
<td>$5,000</td>
</tr>
<tr>
<td>% of Principal Amount</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hip/Thigh</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Foot</td>
<td>40%</td>
<td>40%</td>
</tr>
<tr>
<td>Ankle</td>
<td>40%</td>
<td>40%</td>
</tr>
<tr>
<td>Knee</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Hand or wrist (excluding fingers)</td>
<td>Hand: 20%</td>
<td>Hand: 20%</td>
</tr>
<tr>
<td>Wrist: 30%</td>
<td></td>
<td>Wrist: 30%</td>
</tr>
<tr>
<td>Lower jaw</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Shoulder</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Collarbone</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Ribs</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Finger</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Toe</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Elbow</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Non-surgical</td>
<td>50% of surgical benefit</td>
<td>50% of surgical benefit</td>
</tr>
<tr>
<td>INJURY BENEFITS</td>
<td>LOW PLAN</td>
<td>HIGH PLAN</td>
</tr>
<tr>
<td>-----------------</td>
<td>----------</td>
<td>-----------</td>
</tr>
<tr>
<td>Partial dislocation</td>
<td>25% of non-surgical benefit</td>
<td>25% of non-surgical benefit</td>
</tr>
<tr>
<td>Eye Injury - with Surgery</td>
<td>$120</td>
<td>$300</td>
</tr>
<tr>
<td>Eye Injury – Removal of Foreign Object without Surgery</td>
<td>$30</td>
<td>$75</td>
</tr>
<tr>
<td>Fracture</td>
<td>$2,000</td>
<td>$5,000</td>
</tr>
<tr>
<td>Principal Amount (Surgical)</td>
<td>% of Principal Amount</td>
<td>% of Principal Amount</td>
</tr>
<tr>
<td>Hip/Thigh</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Vertebral body</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Vertebral processes</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Pelvis</td>
<td>75%</td>
<td>75%</td>
</tr>
<tr>
<td>Sternum</td>
<td>75%</td>
<td>75%</td>
</tr>
<tr>
<td>Coccyx</td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td>Skull – non depressed</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Skull – depressed</td>
<td>150%</td>
<td>150%</td>
</tr>
<tr>
<td>Lower leg</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Foot</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Ankle</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Kneecap</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Upper arm</td>
<td>35%</td>
<td>35%</td>
</tr>
<tr>
<td>Facial excluding lower jaw</td>
<td>35%</td>
<td>35%</td>
</tr>
<tr>
<td>Forearm</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Hand or wrist (except fingers)</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Lower jaw</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Shoulder blade</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Collarbone</td>
<td>15%</td>
<td>15%</td>
</tr>
<tr>
<td>Ribs</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Finger</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Toe</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Nose</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Non-surgical</td>
<td>50% of surgical benefit</td>
<td>50% of surgical benefit</td>
</tr>
<tr>
<td>Chip fracture</td>
<td>25% of non-surgical Benefit</td>
<td>25% of non-surgical Benefit</td>
</tr>
<tr>
<td>Lacerations</td>
<td>$100</td>
<td>$500</td>
</tr>
<tr>
<td>With stitches or staples</td>
<td>25% of benefit provided with stitches or staples</td>
<td>25% of benefit provided with stitches or staples</td>
</tr>
<tr>
<td>Paralysis</td>
<td>$20,000</td>
<td>$60,000</td>
</tr>
<tr>
<td>Principal Amount</td>
<td>% of Principal Amount</td>
<td>% of Principal Amount</td>
</tr>
<tr>
<td>Quadriplegia</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Paraplegia</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Hemiplegia</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Uniplegia</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Traumatic Brain Injury</td>
<td>$200</td>
<td>$400</td>
</tr>
</tbody>
</table>
### INJURY BENEFITS

<table>
<thead>
<tr>
<th></th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>EMERGENCY CARE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ground or water</td>
<td>$100</td>
<td>$200</td>
</tr>
<tr>
<td>Air</td>
<td>$500</td>
<td>$1,000</td>
</tr>
<tr>
<td>Blood, Plasma or Platelets Transfusion</td>
<td>$300</td>
<td>$600</td>
</tr>
<tr>
<td>Emergency Dental</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crown</td>
<td>$150</td>
<td>$300</td>
</tr>
<tr>
<td>Extraction</td>
<td>$50</td>
<td>$100</td>
</tr>
<tr>
<td>Emergency Room Treatment</td>
<td>$100</td>
<td>$300</td>
</tr>
<tr>
<td>Initial Physician’s Office Visit</td>
<td>$50</td>
<td>$100</td>
</tr>
</tbody>
</table>

### HOSPITAL CARE

<table>
<thead>
<tr>
<th></th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospital Stay</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initial benefit, non-ICU</td>
<td>$400</td>
<td>$1,200</td>
</tr>
<tr>
<td>Initial benefit, ICU</td>
<td>$800</td>
<td>$2,400</td>
</tr>
<tr>
<td>Daily benefit, non-ICU</td>
<td>$100</td>
<td>$300</td>
</tr>
<tr>
<td>Daily benefit, ICU</td>
<td>$200</td>
<td>$600</td>
</tr>
</tbody>
</table>

### SURGERY

<table>
<thead>
<tr>
<th></th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Abdominal or Pelvic Surgery</strong></td>
<td>$1,000</td>
<td>$2,000</td>
</tr>
<tr>
<td><strong>Cranial Surgery</strong></td>
<td>$1,000</td>
<td>$2,000</td>
</tr>
<tr>
<td><strong>Knee Cartilage Surgery</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Open</td>
<td>$500</td>
<td>$1,000</td>
</tr>
<tr>
<td>Arthroscopic</td>
<td>$250</td>
<td>$500</td>
</tr>
<tr>
<td><strong>Ruptured Disc Surgery</strong></td>
<td>$500</td>
<td>$1,000</td>
</tr>
<tr>
<td><strong>Tendon, Ligament or Rotator Cuff Surgery</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Open</td>
<td>$500</td>
<td>$1,000</td>
</tr>
<tr>
<td>Arthroscopic</td>
<td>$250</td>
<td>$500</td>
</tr>
<tr>
<td><strong>Thoracic Surgery</strong></td>
<td>$1,000</td>
<td>$2,000</td>
</tr>
</tbody>
</table>
### FOLLOW-UP CARE

<table>
<thead>
<tr>
<th></th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adaptive Home and Vehicle Benefit</td>
<td>$500</td>
<td>$1,000</td>
</tr>
<tr>
<td>Appliances</td>
<td>$50</td>
<td>$250</td>
</tr>
<tr>
<td>Follow-Up Physician’s Office Visit</td>
<td>$50</td>
<td>$100</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appliances</td>
<td>$50</td>
<td>$250</td>
</tr>
</tbody>
</table>

### Prosthetics

<table>
<thead>
<tr>
<th></th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>One prosthetic</td>
<td>$500</td>
<td>$1,000</td>
</tr>
<tr>
<td>Two or more prosthetics</td>
<td>2x one prosthetic</td>
<td>2x one prosthetic</td>
</tr>
</tbody>
</table>

### Transportation

<table>
<thead>
<tr>
<th></th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>$200 per visit</td>
<td>$500 per visit</td>
<td></td>
</tr>
</tbody>
</table>

### SUPPORT CARE

<table>
<thead>
<tr>
<th></th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Companion Lodging</td>
<td>$75 per day</td>
<td>$150 per day</td>
</tr>
</tbody>
</table>

---

(5) EXCLUSIONS AND LIMITATIONS - In no event will we pay benefits where the insured’s accident, injury or loss is caused directly or indirectly by, results in whole or in part from or during, or there is contribution from, any of the following:

1. intentionally self-inflicted injury while sane; or
2. suicide or attempted suicide while sane; or
3. your participation in, or your attempt to commit, a crime, assault, felony, or any illegal activity, regardless of any legal proceedings thereto; or
4. the voluntary use of alcohol; or
5. the voluntary use of prescription drugs, non-prescription drugs, illegal drugs, medications, poisons, gases, fumes or other substances taken, absorbed, inhaled, ingested or injected; or
6. motor vehicle collision or accident where you are the operator of the motor vehicle and your blood alcohol level meets or exceeds the level at which intoxication is defined in the state where the collision or accident occurred, regardless of any legal proceedings thereto; or
7. war or any act of war, whether declared or undeclared; or
8. bodily or mental infirmity, illness or disease; or
9. infection, other than infection occurring simultaneously with, and as a direct and independent result of, the injury; or
10. repetitive stress syndromes including but not limited to rotator cuff syndrome, bursitis, tendonitis, carpal tunnel syndrome, ulnar nerve syndrome, stress fractures, neuropathy, epicondylitis or neuritis; or
11. medical or surgical treatment or diagnostic procedures including any resulting complications, or when the outcome is not as planned or expected, including claims of medical malpractice; or
12. travel in or descent from any aircraft, except as a fare-paying passenger on a regularly scheduled commercial flight on a licensed passenger aircraft carrier; or
13. participation in the following activities: scuba diving, bungee jumping, base jumping, hang gliding, sail gliding, parasailing, parakiting, or mountain climbing; or
14. riding or driving in any motor-driven vehicle in a race, stunt show or speed test; or
15. practicing for or participating in any semi-professional or professional competitive athletics.

(6) RENEWABILITY - The group policy will continue in force until it is canceled by either the group policyholder or Securian Life. Subject to the termination section of the certificate, the certificate may be renewed by making the required premium payments.

(7) PREMIUMS – Unless the policyholder and we have agreed to some other premium payment procedure, any premium contributions you are required to make for contributory insurance are to be paid by you to the policyholder on a regular periodic basis. We apply premiums consecutively to keep the insurance in force. We reserve the right to change premium rates on any premium due date, but not more than once in each 12-month period.
We will provide at least 60 days advance notice of any change in premium rates. Premium rates are established based on expected losses and expenses. Premium charges are based on experience under the group policy. There is no trend data for premium increases or decreases available.

Your monthly premium contribution is shown on the profile page.

(8) TERMINATION - Please refer to the Termination section of your certificate for information about when coverage will end. In the event that you lose eligibility under the group policy, you may continue your coverage according to the terms of the Continuation of Insurance Certificate Supplement.

(Signed)
Secretary

(Signed)
President
Group Accident Certificate of Insurance
Securian Life Insurance Company • A Stock Company
400 Robert Street North • St. Paul, Minnesota 55101-2098

Applies to Residents of Montana

POLICYHOLDER: Concordia Plan Services
POLICY NUMBER: 76013

THIS CERTIFICATE IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

THIS IS A LIMITED BENEFIT CERTIFICATE: This certificate provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses. Read your certificate carefully.

THIS CERTIFICATE IS NOT A MEDICARE SUPPLEMENT CONTRACT. If you are eligible for Medicare, review the Guide to Health Insurance for people with Medicare available from us.

Read Your Certificate Carefully
If you meet the eligibility and enrollment requirements herein, you are insured under the group policy shown on the specifications page. This certificate summarizes the principal provisions of the group policy that affect you. The provisions summarized in this certificate are subject in every respect to the group policy. You may examine the group policy at the principal office of the policyholder during regular working hours.

Legal Actions
No legal action may be brought to recover on this certificate within the first sixty days after written proof of loss has been given as required by this certificate. No such action may be brought after the expiration of any applicable statutes of limitations.

Secretary

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GROUP ACCIDENT CERTIFICATE OF INSURANCE
GENERAL INFORMATION

POLICYHOLDER: Concordia Plan Services

POLICY NUMBER: 76013

ASSOCIATED COMPANIES: All subsidiaries and affiliates reported to Securian Life by the policyholder for inclusion in the policy.

POLICY SITUS: The policy was issued and delivered in Missouri.

POLICY EFFECTIVE DATE: January 1, 2019.

This certificate and/or certificate specifications page replaces any and all certificates and/or certificate specifications pages previously issued to you under the group policy. Please replace any certificate and/or certificate specifications page previously issued to you with this new certificate and/or specifications page.

GROUP:

The group is composed of all active employees of the policyholder and its associated companies working in the United States in the following classes:

Class 1: Active employees working at least 20 hours per week.

All new employees of the employer will be added to such group and classes for which they become eligible.

NO DOUBLE COVERAGE:

A person cannot be covered under more than one class. A person cannot be covered as both an active employee and a retiree. Any person who is eligible as an employee or retiree under the policy, or insured under the portability provisions, is not eligible as a dependent. Only one person can insure an eligible dependent child.

ENROLLMENT PERIOD: 90 days from the first day of eligibility for contributory insurance.

WAITING PERIOD: None

MINIMUM HOURS PER WEEK REQUIREMENT: 20 hours per week

PLAN OF INSURANCE

EMPLOYEE BENEFIT SCHEDULE

EMPLOYEE GROUP ACCIDENT INSURANCE:

Supplemental Group Accident Insurance

<table>
<thead>
<tr>
<th>Eligible Class</th>
<th>Employee Supplemental Group Accident Insurance Benefit Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class 1</td>
<td>Low Plan or High Plan as elected by the employee.</td>
</tr>
</tbody>
</table>
GENERAL PROVISIONS FOR EMPLOYEE INSURANCE

RETIREMENT REDUCTIONS: All insurance terminates at retirement, except as otherwise provided for under any applicable certificate supplement.

CONTRIBUTORY/NONCONTRIBUTORY: Supplemental insurance is contributory insurance.

PORTABILITY BENEFIT: Low Plan or High Plan as elected by the employee.

DEPENDENT BENEFIT SCHEDULE

An employee must be insured in order to elect dependent group accident insurance.

SPOUSE GROUP ACCIDENT INSURANCE

Supplemental Group Accident Insurance

<table>
<thead>
<tr>
<th>Eligible Class</th>
<th>Spouse Supplemental Group Accident Insurance Benefit Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class 1</td>
<td>Spouse benefit plan will match the employee’s Supplemental Group Accident Benefit Plan.</td>
</tr>
</tbody>
</table>

CHILD GROUP ACCIDENT INSURANCE

Supplemental Group Accident Insurance

<table>
<thead>
<tr>
<th>Eligible Class</th>
<th>Child Supplemental Group Accident Insurance Benefit Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class 1</td>
<td>Child benefit plan will match the employee’s Supplemental Group Accident Benefit Plan.</td>
</tr>
</tbody>
</table>

GENERAL PROVISIONS FOR DEPENDENT INSURANCE

CONTRIBUTORY/NONCONTRIBUTORY: Supplemental insurance is contributory insurance.

SPOUSE AND CHILD PORTABILITY BENEFIT: Spouse benefit plan will match the employee’s Group Accident Benefit Plan. Child benefit plan will match the employee’s Group Accident Benefit Plan.

COVERED BENEFITS

Refer to the Injury Benefits, Emergency Care, Hospital Care, Surgery Benefits, Follow-up Care and Support Care sections of the Certificate for additional benefit details.

<table>
<thead>
<tr>
<th>INJURY BENEFITS</th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burn Benefit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2nd degree burns</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 10% of the body</td>
<td>$100</td>
<td>$300</td>
</tr>
<tr>
<td>Between 10% and 20% of the body</td>
<td>$250</td>
<td>$750</td>
</tr>
<tr>
<td>20% or more of the body</td>
<td>$500</td>
<td>$1,500</td>
</tr>
<tr>
<td>3rd degree burns</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 10% of the body</td>
<td>$1,000</td>
<td>$3,000</td>
</tr>
<tr>
<td>Between 10% and 20% of the body</td>
<td>$2,500</td>
<td>$7,500</td>
</tr>
<tr>
<td>20% or more of the body</td>
<td>$5,000</td>
<td>$15,000</td>
</tr>
<tr>
<td>Child Organized Sports Injury</td>
<td>$50</td>
<td>$100</td>
</tr>
<tr>
<td>INJURY BENEFITS</td>
<td>LOW PLAN</td>
<td>HIGH PLAN</td>
</tr>
<tr>
<td>------------------------------------------------------</td>
<td>----------</td>
<td>-----------</td>
</tr>
<tr>
<td>Concussion</td>
<td>$100</td>
<td>$200</td>
</tr>
<tr>
<td>Dislocation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Principal Amount (Surgical)</td>
<td>$2,000</td>
<td>$5,000</td>
</tr>
<tr>
<td>% of Principal Amount</td>
<td>% of Principal Amount</td>
<td></td>
</tr>
<tr>
<td>Hip/Thigh</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Foot</td>
<td>40%</td>
<td>40%</td>
</tr>
<tr>
<td>Ankle</td>
<td>40%</td>
<td>40%</td>
</tr>
<tr>
<td>Knee</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Hand or wrist (excluding fingers)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hand: 20%</td>
<td></td>
<td>Hand: 20%</td>
</tr>
<tr>
<td>Wrist: 30%</td>
<td></td>
<td>Wrist: 30%</td>
</tr>
<tr>
<td>Lower jaw</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Shoulder</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Collarbone</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Ribs</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Finger</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Toe</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Elbow</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Non-surgical</td>
<td>50% of surgical benefit</td>
<td>50% of surgical benefit</td>
</tr>
<tr>
<td>Partial dislocation</td>
<td>25% of non-surgical benefit</td>
<td>25% of non-surgical benefit</td>
</tr>
<tr>
<td>Eye Injury - with Surgery</td>
<td>$120</td>
<td>$300</td>
</tr>
<tr>
<td>Eye Injury – Removal of Foreign Object without Surgery</td>
<td>$30</td>
<td>$75</td>
</tr>
<tr>
<td>Fracture</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Principal Amount (Surgical)</td>
<td>$2,000</td>
<td>$5,000</td>
</tr>
<tr>
<td>% of Principal Amount</td>
<td>% of Principal Amount</td>
<td></td>
</tr>
<tr>
<td>Hip/Thigh</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Vertebral body</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Vertebral processes</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Pelvis</td>
<td>75%</td>
<td>75%</td>
</tr>
<tr>
<td>Sternum</td>
<td>75%</td>
<td>75%</td>
</tr>
<tr>
<td>Coccyx</td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td>Skull – non depressed</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Skull – depressed</td>
<td>150%</td>
<td>150%</td>
</tr>
<tr>
<td>Lower leg</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Foot</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Ankle</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Kneecap</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Upper arm</td>
<td>35%</td>
<td>35%</td>
</tr>
<tr>
<td>Facial excluding lower jaw</td>
<td>35%</td>
<td>35%</td>
</tr>
<tr>
<td>Forearm</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Hand or wrist (except fingers)</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Lower jaw</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Shoulder blade</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Collarbone</td>
<td>15%</td>
<td>15%</td>
</tr>
<tr>
<td>Ribs</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Finger</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Toe</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Nose</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Non-surgical</td>
<td>50% of surgical benefit</td>
<td>50% of surgical benefit</td>
</tr>
<tr>
<td>Chip fracture</td>
<td>25% of non-surgical benefit</td>
<td>25% of non-surgical benefit</td>
</tr>
</tbody>
</table>
## INJURY BENEFITS

### Lacerations
- **With stitches or staples**
  - **LOW PLAN**: $100
  - **HIGH PLAN**: $500
- **Without stitches or staples**
  - 25% of benefit provided with stitches or staples

### Paralysis
- **Principal Amount**
  - **LOW PLAN**: $20,000
  - **HIGH PLAN**: $60,000
  - **% of Principal Amount**
    - Quadriplegia: 100%
    - Paraplegia: 50%
    - Hemiplegia: 50%
    - Uniplegia: 25%

### Traumatic Brain Injury
- **LOW PLAN**: $200
- **HIGH PLAN**: $400

### EMERGENCY CARE

#### Ambulance
- **Ground or water**
  - **LOW PLAN**: $100
  - **HIGH PLAN**: $200
- **Air**
  - **LOW PLAN**: $500
  - **HIGH PLAN**: $1,000

#### Blood, Plasma or Platelets Transfusion
- **LOW PLAN**: $300
- **HIGH PLAN**: $600

#### Emergency Dental
- **Crown**
  - **LOW PLAN**: $150
  - **HIGH PLAN**: $300
- **Extraction**
  - **LOW PLAN**: $50
  - **HIGH PLAN**: $100

#### Emergency Room Treatment
- **LOW PLAN**: $100
- **HIGH PLAN**: $300

#### Initial Physician’s Office Visit
- **LOW PLAN**: $50
- **HIGH PLAN**: $100

#### Hospital Stay
- **Initial benefit, non-ICU**
  - **LOW PLAN**: $400
  - **HIGH PLAN**: $1,200
- **Initial benefit, ICU**
  - **LOW PLAN**: $800
  - **HIGH PLAN**: $2,400
- **Daily benefit, non-ICU**
  - **LOW PLAN**: $100
  - **HIGH PLAN**: $300
- **Daily benefit, ICU**
  - **LOW PLAN**: $200
  - **HIGH PLAN**: $600

### SURGERY

#### Abdominal or Pelvic Surgery
- **LOW PLAN**: $1,000
- **HIGH PLAN**: $2,000

#### Cranial Surgery
- **LOW PLAN**: $1,000
- **HIGH PLAN**: $2,000

#### Knee Cartilage Surgery
- **Open**
  - **LOW PLAN**: $500
  - **HIGH PLAN**: $1,000
- **Arthroscopic**
  - **LOW PLAN**: $250
  - **HIGH PLAN**: $500

#### Ruptured Disc Surgery
- **LOW PLAN**: $500
- **HIGH PLAN**: $1,000

#### Tendon, Ligament or Rotator Cuff Surgery
- **Open**
  - **LOW PLAN**: $500
  - **HIGH PLAN**: $1,000
### INJURY BENEFITS

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Low Plan</th>
<th>High Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arthroscopic</td>
<td>$250</td>
<td>$500</td>
</tr>
<tr>
<td>Thoracic Surgery</td>
<td>$1,000</td>
<td>$2,000</td>
</tr>
</tbody>
</table>

### FOLLOW-UP CARE

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Low Plan</th>
<th>High Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adaptive Home and Vehicle Benefit</td>
<td>$500</td>
<td>$1,000</td>
</tr>
<tr>
<td>Appliances</td>
<td>$50</td>
<td>$250</td>
</tr>
<tr>
<td>Follow-Up Physician’s Office Visit</td>
<td>$50</td>
<td>$100</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Prosthetics</th>
<th>Low Plan</th>
<th>High Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>One prosthetic</td>
<td>$500</td>
<td>$1,000</td>
</tr>
<tr>
<td>Two or more prosthetics</td>
<td>2x one prosthetic</td>
<td>2x one prosthetic</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Transportation</th>
<th>Low Plan</th>
<th>High Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$200 per visit</td>
<td>$500 per visit</td>
</tr>
</tbody>
</table>

### SUPPORT CARE

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Low Plan</th>
<th>High Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Companion Lodging</td>
<td>$75 per day</td>
<td>$150 per day</td>
</tr>
</tbody>
</table>

### ADDITIONAL INFORMATION

**ANNUAL OPEN ENROLLMENTS:**

During the policyholder’s annual open enrollment an employee may elect or change employee and dependent accident insurance benefit plans.

Coverage will be effective on the January 1 following the annual enrollment, subject to the actively at work requirement for employees and the hospitalization/non-confinement provision for dependents (this does not apply to a newborn child).

**Special Enrollment Periods:** Upon mutual agreement between the Policyholder and Securian, one or more special enrollment periods may be offered to eligible employees. These special enrollment periods (if offered) will be in addition to the annual enrollment opportunities described above. In the event that a special enrollment period is offered, the details of the special enrollment, including enrollment dates, allowed changes, and evidence of insurability requirements, will be communicated to you in advance of the special enrollment period and documented in the group policy on file with the policyholder and Securian.

**QUALIFIED STATUS CHANGES:**

An employee who experiences a Qualified Status Changes as defined below may elect or change employee and dependent accident insurance benefit plans provided enrollment is made within 60 days of the status change.

- An active employee may elect accident insurance for the first time or increase coverage from the low plan to the high plan.
- An active employee may elect dependent coverage.

Coverage will be effective on the date of the election. All increases are subject to the actively at work requirement for employees and the hospitalization/non-confinement provision for dependents (this does not apply to a newborn child).

A qualified status change for the purpose of waiving the evidence of insurability requirement means marriage, birth or adoption.
SUPPLEMENTS TO THE CERTIFICATE

Portability
Definitions

Any use in this certificate of a term defined in this section is to be given the meaning defined in this section unless otherwise defined in another provision of this certificate.

accident
An act or event which is:

(1) unintended, unexpected and unforeseen; and
(2) directly results in bodily injury to the insured.

application
Your application or enrollment for insurance under the group policy.

associated company
Any company which is a subsidiary or affiliate of the policyholder which is designated by the policyholder and agreed to by us to participate under the group policy.

child or children
Your or your spouse’s natural, adopted, stepchild or foster child who is less than 26 years old. An adopted child includes a child legally placed for adoption with you. Eligibility begins from the moment of birth.

Coverage for a child who reaches the limiting age does not terminate while the child continues to be both (1) incapable of self-sustaining employment by reason of a physical disability or an intellectual disability; and (2) chiefly dependent on you for support and maintenance.

contributory insurance
Insurance for which you are required to make premium contributions.

covered accident
An accident which:

(1) is not excluded under the Exclusions and Limitations section or any other terms of this certificate; and
(2) occurs while the insured’s coverage is in force; and
(3) occurs in the United States or a United States territory.

dependent
Your children or spouse.

If both parents of a child qualify as eligible employees under the group policy, the child shall be considered a dependent of only one parent for purposes of this certificate. If any child qualifies as an eligible employee under the group policy, he or she is not eligible to be insured as a dependent child.

emergency room
A department of a hospital or a satellite emergency center that is designated for persons requiring immediate medical care. This area must be staffed and equipped to handle trauma, be supervised and provide treatment by physicians, and provide care seven days per week, 24 hours per day.

A satellite emergency center is a licensed facility providing outpatient care under the direction of a licensed physician on a 24-hour basis. Available services must include:

(1) diagnostic care, including laboratory services and diagnostic x-rays; and
(2) treatment or medical care, including availability of the means for stabilization of emergency medical conditions.

A satellite emergency center does not include a hospital or an office maintained by a licensed physician for the practice of medicine or dentistry.

employee
An individual who is employed by the policyholder or by an associated company. A sole proprietor will be considered the employee of the proprietorship. A partner in a partnership will be considered an employee so long as the partner’s principal work is the conduct of the partnership’s business. The term employee does not include temporary employees nor corporate directors who are not otherwise employees.

employer
The policyholder or any designated associated companies.

family member
A parent, spouse, child, sibling, grandparent, aunt, uncle, first cousin, niece or nephew. This includes adopted, in-law and step relatives.

hospital
A short-term, acute care general facility that:

(1) is legally licensed and operated as a hospital;
(2) provides overnight care of injured and sick people;
(3) requires that every patient be supervised by a physician;
(4) provides 24 hour nursing service by or under the supervision of a registered nurse;
(5) has on-site or pre-arranged use of x-ray equipment, laboratory, and surgical facilities; and
(6) maintains permanent medical history records.

A hospital is not a rehabilitation center, nursing home, rest home, extended-care facility, convalescent home, a place for alcoholics or drug addicts or a mental institution, even if such facilities are affiliated with or joined to a hospital.
injury or injuries

A bodily injury which is sustained as a direct result of a covered accident.

insured

An employee, spouse or child covered for insurance under this certificate.

noncontributory insurance

Insurance for which you are not required to make premium contributions.

non-work day

A day on which you are not regularly scheduled to work, including scheduled time off for vacations, personal holidays, weekends and holidays, and approved leaves of absence for non-medical reasons.

Non-work day does not include time off for medical leave of absence, temporary layoff, employer suspension of operations in total or in part, strike, and any time off due to sickness or injury including sick days, short-term disability, or long term disability.

physician

A medical doctor, physician’s assistant, dentist, osteopath, chiropractor, optometrist, podiatrist, psychologist, licensed social worker, licensed professional counselor, acupuncturist, naturopathic physician, physical therapist, speech-language pathologist, audiologist, licensed addiction counselor or advanced practice registered nurse recognized by law or regulation in the United States or United States territory where services are rendered as a physician. The person must be licensed as required by the United States jurisdiction where care is given and must be operating in the scope of his or her license.

A physician cannot be a person who:

1. ordinarily resides in your household; or
2. is a family member

policyholder

The owner of the group policy as shown on the specifications page.

 specifications page

The summary of the plan specifics available under the group policy.

spouse

Your legally married spouse as recognized under the laws of the jurisdiction of celebration.

Spouse does not include any person who is eligible as an employee.

surgery

Medical treatment in which a physician cuts into someone’s body in order to repair or remove damaged parts as a result of a covered accident. The surgery must be performed solely because of injuries sustained in a covered accident.

urgent care center

A health care facility that is separate from a hospital or a separate unit within a hospital and whose primary purpose is the offering and provision of immediate, short term medical care, without appointment, for urgent care.

waiting period

The period, if any, of continuous employment with the employer that the employee must satisfy prior to becoming eligible for coverage under this certificate. You are not eligible to become insured until the first day following the waiting period. Any such waiting period is shown on the specifications page.

we, our, us

Securian Life Insurance Company.

you, your, certificate holder

An insured employee.

General Information

What is your agreement with us?

If you meet the eligibility and enrollment requirements, you are insured under the group policy shown on the specifications page. Your application is deemed a part of this certificate. This certificate summarizes the principal provisions of the group policy that affect your insurance coverage. The provisions summarized in this certificate are subject in every respect to the group policy.

Any statements made in your application will, in the absence of fraud, be considered representations and not warranties. No written statement made by any insured will be used in any contest unless a copy of the instrument containing the statement is or had been furnished to the insured or the insured’s beneficiary.

Can this certificate be amended?

Yes. We retain the right to amend this certificate at any time without your consent. Any amendment will be without prejudice to any claim incurred for benefits prior to the date of the amendment.

Who is eligible for insurance?

You are eligible for group accident insurance if you:
(1) are a member of the eligible group and of an eligible class as defined on the specifications page; and
(2) work for the employer for at least the number of hours per week shown as the minimum hours per week requirement on the specifications page; and
(3) have satisfied the waiting period as shown on the specifications page; and
(4) meet the actively at work requirement described in the "What is the actively at work requirement?" provision of this section.

**Are your dependents eligible for insurance?**

Yes. If you are insured for group accident coverage, your dependents are eligible for insurance.

**Are employees of associated companies eligible for insurance under the group policy?**

Yes. Employees of associated companies may be eligible for insurance under the group policy. The policyholder represents any associated company in all transactions pertaining to the group policy. The policyholder’s acts or omissions and every notice given by us to the policyholder shall be binding on every associated company. When an associated company ceases its participation under the policy, the policy shall be considered to be terminated for all employees of the associated company. All provisions related to policy termination will apply to such employees.

**What is the actively at work requirement?**

To be eligible to become insured or to receive an increase in the benefit amount, you must be actively at work, fully performing your customary duties for your regularly scheduled number of hours at the employer’s normal place of business, or at other places the employer’s business requires you to travel.

If you are not working due to illness or injury, you do not meet the actively at work requirement. If you are receiving sick pay, short-term disability benefits or long-term disability benefits, you do not meet the actively at work requirement.

If you are not actively at work on the date coverage would otherwise begin, or on the date an increase in your benefit amount would otherwise be effective, you will not be eligible for the coverage or increase until you return to active work. However, if the absence is on a non-work day, coverage will not be delayed provided you were actively at work on the work day immediately preceding the non-work day.

Except as otherwise provided for in this certificate, you are eligible to continue to be insured only while you remain actively at work.

Any insurance or increase in insurance which is elected or put in force while you are not actively at work will not be eligible for claim payment.

You or your beneficiary will receive a refund of premium for any contributory insurance for which you were not eligible.

**What is the dependent non-confinement requirement?**

If a dependent is hospitalized or confined because of illness or disease on the date his or her insurance would otherwise become effective, his or her effective date shall be delayed until he or she is released from such hospitalization or confinement. This does not apply to a newborn child. In no event will insurance on a dependent be effective before your insurance is effective.

**Can your coverage be continued during sickness, injury, leave of absence or temporary layoff?**

Yes. Insurance may be continued on an insured employee who is not actively at work due to sickness, injury, leave of absence or temporary layoff, subject to the employer’s practices and procedures, including the employer’s limits on the length of continuation allowed for the type of absence. Continuation is contingent upon continued premium payment.

Coverage during a leave of absence and upon return from a leave of absence shall meet all state and federal requirements.

**Enrollment**

**When can you elect or make changes to your insurance?**

You must enroll in order to be insured for contributory coverage under the group policy. You can enroll for coverage within 90 days of when you first become eligible. After that period, you can only enroll for coverage or make changes during your annual open enrollment or within 60 days of a qualified status change event, as defined by the state and federal rules and regulations.

**When does your insurance become effective?**

Your insurance becomes effective on the date all of the following conditions have been met:

(1) you meet all eligibility requirements, including the actively at work requirement; and
(2) for contributory coverage, application is made in accordance with the application methods agreed upon by the policyholder and us

**When does insurance for a dependent become effective?**

Insurance on a dependent becomes effective on the date when all of the following conditions have been met:

(1) your insurance becomes effective; and
(2) the dependent meets all eligibility requirements; and
What if a child is born or adopted after you have enrolled your dependents?

Coverage for each newborn child of any insured begins at the moment of birth. Coverage for each newly adopted child begins on the date the child is placed with you for the purpose of adoption.

Coverage will continue for a period of 31 days from the date of birth or placement for the purpose of adoption. You must notify us and pay the additional premium within the 31-day period or coverage will terminate at the end of the 31st day.

When will changes in your coverage amount be effective?

Requested changes in the amount of your contributory insurance are effective on the first day of the month following receipt of your request for a change. However, elections made during an enrollment period will not become effective prior to the effective date for that enrollment.

Premiums

When and how often are your premium contributions due?

Unless the policyholder and we have agreed to some other premium payment procedure, any premium contributions you are required to make for contributory insurance are to be paid by you to the policyholder on a periodic basis. Premium rates are subject to change in accordance with the group policy.

How is the premium determined?

The premium will be the applicable premium rate in force on the date premiums are due. The premium may also be computed by any other method on which the policyholder and we agree.

Premium rates are subject to change according to the provisions of the group policy.

Can a premium be paid after the date it is due?

Yes. The group policy has a 31-day grace period. If a premium is not paid on or before the date it is due, that premium may be paid during the 31-day period following the due date. The insurance under the group policy will remain in effect during the 31-day grace period.

Injury Benefits

Burn Benefit

If an insured sustains a second or third degree burn in a covered accident, we will pay the appropriate amount shown on the specifications page based on the type of burn and the percentage of the body surface burned.

The burn must be treated by a physician within 72 hours after the covered accident. If the burn meets more than one of the burn classifications shown on the specifications page, the amount we pay will be based on the burn classification that pays the highest benefit.

We will pay the burn benefit no more than one time per insured per covered accident. No benefits are payable for sunburns or first degree burns.

Child Organized Sports Injury

The child organized sports injury benefit is subject to the following conditions.

1. the insured dependent child suffers an injury in a covered accident while participating in an organized sport; and
2. a benefit is payable for the insured dependent child under another provision of the group policy for the same covered accident; and
3. the insured dependent child has not attained 19 years of age and is insured on the date the covered accident occurs;

A child organized sport refers to a sport activity that is governed by an organization and requires formal registration to participate. Adult supervision of practice and competition is required. Proof of registration must be submitted with claims.

The child organized sports injury benefit amount is shown on the specifications page.

This benefit is limited to one payment per insured dependent child per calendar year.

Concussion

If an insured is injured in a covered accident and the injury causes a concussion, we will pay the amount shown on the specifications page. The insured must be treated by a physician within 72 hours of a covered accident and the concussion must be diagnosed by a physician within 15 days of the covered accident.

Concussion refers to a disruption of brain function resulting from a traumatic blow to the head.

This benefit is limited to one payment per insured per covered accident per calendar year.

The concussion benefit is not payable if a traumatic brain injury benefit is payable under this certificate for the same accident.
Dislocation

If a joint is dislocated in a covered accident, and it is diagnosed and treated by a physician within 90 days after the covered accident, we will pay the amount shown on the specifications page. The amount varies based on the joint that is dislocated, whether the dislocation is a full or a partial dislocation, and whether surgery is required to treat the dislocation.

A full dislocation refers to a completely separated joint due to a covered accident. A partial dislocation means the joint is misaligned but not completely dislocated, as diagnosed by a physician.

If more than one dislocation benefit is payable resulting from the same covered accident, we will pay the lesser of:

1. The total of the benefit amounts shown for each applicable dislocation on the specifications page;
2. 2 times the highest dislocation benefit that would otherwise be payable for any one of the dislocations involved.

Eye Injury – with Surgery

If an insured is injured in a covered accident and the injury results in an eye injury that requires surgery, we will pay the amount shown on the specifications page. The insured must be seen by a physician within 60 days of the covered accident and surgery must be performed within 180 days of the covered accident. This benefit is limited to one payment per eye per insured per covered accident.

Eye Injury – Removal of Foreign Object without Surgery

If an insured is injured in a covered accident and the injury results in an eye injury that requires removal of a foreign object, but does not require surgery, we will pay the amount shown on the specifications page. The insured must be seen by a physician within 60 days of the covered accident and removal of the foreign object must be performed within 180 days of the covered accident. This benefit is limited to one payment per eye per insured per covered accident.

Fracture

If a bone is fractured in a covered accident, and it is diagnosed and treated by a physician within 90 days after the covered accident, we will pay the amount shown on the specifications page. The amount varies based on the bone that is fractured, whether or not the fracture is a chip fracture, and whether surgery is required to treat the fracture.

Fracture refers to a break in a bone that can be seen by x-ray. A chip fracture is a fracture in which a small fragment of the bone is broken off.

If more than one fracture benefit is payable resulting from the same covered accident, we will pay the lesser of:

1. The total of the benefit amounts shown for each applicable fracture on the specifications page;
2. 3 times the highest fracture benefit that would otherwise be payable for any one of the bones involved.

We will pay no more than one fracture benefit per bone, per covered accident per insured. In no event will multiple fracture benefits be paid for the same fracture benefit shown on the specifications page unless it is a bi-lateral fracture. Bi-lateral fracture means the fracture of the same bone on both the left and right sides of the body.

Lacerations

If an insured is injured in a covered accident and the injury results in a laceration, we will pay the proper amount shown on the specifications page based on the type of treatment provided.

The laceration must be treated by a physician within 72 hours after the covered accident. This benefit is limited to one payment per insured per covered accident. In no event will we pay more than one laceration benefit per calendar year.

Paralysis

If an insured is injured in a covered accident and the injury causes paralysis which lasts more than 180 days we will pay the appropriate amount shown on the specifications page. Paralysis refers to the total, permanent, and irrevocable loss of movement. The paralysis must be diagnosed by a physician within 180 days after the accident.

The amount payable will be based on the type of paralysis, as follows:

- Quadriplegia refers to paralysis of both upper limbs (from the shoulder down including total paralysis of both hands) and both lower limbs (from the waist down including total paralysis of both feet).
- Paraplegia refers to paralysis of both lower limbs (from the waist down including total paralysis of both feet).
- Hemiplegia refers to paralysis of both the upper limb (from the shoulder down including total paralysis of the hand) and lower limb (from the waist down including total paralysis of the foot) on one side of the body.
- Uniplegia refers to paralysis of one limb (from the shoulder down including total paralysis of the hand if claiming an upper limb and from the waist down including total paralysis of the foot if claiming a lower limb).

We will pay no more than one paralysis benefit per covered accident per insured. In the event that an insured qualifies under multiple types of paralysis, the highest benefit amount will be paid.
Traumatic Brain Injury

If an insured is injured in a covered accident and the injury results in a traumatic brain injury, we will pay the amount shown on the specifications page.

Traumatic brain injury means only the following: intracranial hemorrhage, cerebral contusion or cerebral laceration.

The insured must be treated by a physician within 72 hours after the covered accident. The traumatic brain injury must be diagnosed within 30 days after the accident by computer tomography (CT) scan or magnetic resonance imaging (MRI). This benefit is payable only once per insured per covered accident. Scalp hematomas and scalp lacerations are not covered under this benefit.

Emergency Care

Ambulance

If an insured is injured in a covered accident and requires transportation to a hospital (or between hospitals) we will pay the appropriate ambulance benefit shown on the specifications page. Ground or water transportation must be provided by a licensed professional ambulance service within 90 days of the covered accident. Air transportation must be provided by a licensed professional ambulance service within 72 hours. This benefit is limited to one payment per insured per covered accident. If an insured requires more than one ambulance transport, the highest benefit amount will be paid.

Ambulance means any publicly or privately owned surface, water or air vehicle, including a helicopter that is specifically designed and constructed or modified and equipped to be used, maintained or operated primarily for the transportation of individuals who are sick, injured or wounded.

Ambulance does not include a surface, water or air vehicle that is owned and operated to accommodate an incapacitated or disabled person who does not require medical monitoring, care or treatment during transport.

Blood, Plasma or Platelets Transfusion

If an insured is injured in a covered accident and requires a blood, plasma or platelets transfusion, we will pay the blood/plasma/platelets transfusion benefit shown on the specifications page. The transfusion must occur within 90 days of the covered accident. This benefit is limited to one payment per insured per covered accident.

Emergency Dental

If an insured has an injury to sound natural teeth as a result of a covered accident, we will pay the appropriate emergency dental benefit shown on the specifications page. A benefit is payable for a broken tooth repaired with crown(s) or a broken tooth requiring extraction. Treatment must occur within 60 days of the covered accident. The maximum number of crown benefits payable per insured per covered accident is two. The maximum number of extraction benefits payable per insured per covered accident is two.

Proof of the soundness of the injured tooth must be submitted with claims. Injuries resulting from biting or chewing are not covered under this benefit.

Sound natural teeth are defined as teeth that are free of active or chronic clinical decay, have at least 50% bone support and are functional in the arch.

Emergency Room Treatment

If an insured is injured in a covered accident and requires treatment in an emergency room, we will pay the emergency room treatment benefit shown on the specifications page. Treatment must occur within 72 hours of the covered accident.

This benefit is limited to one payment per insured per covered accident.

Initial Physician’s Office Visit

If an insured is injured in a covered accident, we will pay the initial physician’s office visit benefit shown on the specifications page.

Benefits are payable for the initial treatment received in a physician’s office or an urgent care center for injuries resulting from a covered accident. Treatment must occur within 72 hours of the covered accident. The maximum number of benefits per insured per calendar year is two. The benefit is not payable if the insured receives care in an emergency room within the same 72 hour period. Only one benefit is payable per covered accident.

Hospital Care

Hospital Stay

If an insured is injured in a covered accident and requires treatment in a hospital for the injury within 180 days of a covered accident, we will pay the hospital stay benefit shown on the specifications page subject to the following.

Initial Benefit

We will pay the initial benefit shown on the specifications page for the first day of a hospital stay provided the insured is receiving treatment for a covered accident in the hospital for a minimum of 18 continuous hours.

The benefit payment will be based on the type of room and level of care the insured receives. The Intensive Care Unit (ICU) benefit is payable if the insured is receiving treatment in an ICU room of a hospital.
The non-ICU benefit is payable if the insured is receiving treatment in a non-ICU room.

This benefit is limited to one payment per insured per covered accident.
In the event the insured receives treatment in both a non-ICU and an ICU room, the higher benefit will be payable as an initial benefit.

### Daily Benefit

If an initial benefit is payable, the insured will also receive a daily benefit for each day he or she is treated in the hospital, including the first day. The amount payable for the daily benefit is shown on the specifications page.

The daily benefit payment will be based on the type of room and level of care the insured receives. The ICU benefit is payable if the insured is receiving treatment in an ICU room of a hospital. The non-ICU benefit is payable if the insured is receiving treatment in a non-ICU room.

The ICU daily benefit will be limited to a maximum of 15 days per insured per covered accident. The combination of the both ICU and non-ICU benefits will be limited to a cumulative maximum of 120 days per insured per covered accident.

If an insured is released from the hospital and subsequently requires treatment in a hospital for injuries sustained in the same covered accident, the subsequent treatment will be considered a continuation of the same hospital stay for purposes of determining the cumulative maximum daily benefit so long as the treatment occurs within two years of the date of the covered accident.

### Surgery Benefits

#### Abdominal or Pelvic Surgery

If an insured is injured in a covered accident and requires abdominal or pelvic surgery to treat the injuries, we will pay the abdominal or pelvic surgery benefit shown on the specifications page. The surgery must be performed within 72 hours of the covered accident. This benefit is limited to one payment per insured per covered accident. Surgery required to treat a fracture or dislocation is payable under the fracture or dislocation benefit and is not covered under the abdominal or pelvic surgery benefit.

#### Cranial Surgery

If an insured is injured in a covered accident and requires cranial surgery to treat the injuries, we will pay the cranial surgery benefit shown on the specifications page. The surgery must be performed within 72 hours of the covered accident. This benefit is limited to one payment per insured per covered accident.

Surgery required to treat a skull fracture is payable under the fracture benefit and is not covered under the cranial surgery benefit.

#### Knee Cartilage Surgery

If an insured is injured in a covered accident and requires knee cartilage surgery to treat the injury, we will pay the knee cartilage surgery benefit shown on the specifications page. The insured must be treated by a physician within 60 days of the covered accident and surgery must be performed within 180 days of the covered accident. This benefit is limited to one payment per insured per covered accident.

If both open and arthroscopic surgeries are required for the same injury, only the open benefit will be paid.

#### Ruptured Disc Surgery

If an insured is injured in a covered accident and requires surgery for one or more ruptured discs to treat the injury, we will pay the ruptured disc surgery benefit shown on the specifications page. The insured must be treated by a physician within 60 days of the covered accident and surgery must be performed within 180 days of the covered accident. This benefit is limited to one payment per insured per covered accident.

#### Tendon, Ligament or Rotator Cuff Surgery

If an insured is injured in a covered accident and requires tendon, ligament or rotator cuff surgery to treat the injuries, we will pay the tendon,
benefit shown on the specifications page. The insured must be treated by a physician within 60 days of the covered accident and surgery must be performed within 180 days of the covered accident. This benefit is limited to one payment per insured per covered accident.

If both open and arthroscopic surgeries are required, only the open benefit will be paid.

**Thoracic Surgery**

If an insured is injured in a covered accident and requires thoracic surgery to treat the injuries, we will pay the thoracic surgery benefit shown on the specifications page. The surgery must be performed within 72 hours of the covered accident. This benefit is limited to one payment per insured per covered accident.

Surgery required to treat a fracture or dislocation is payable under the fracture or dislocation benefit and is not covered under the thoracic surgery benefit.

**Follow-Up Care**

**Adaptive Home and Vehicle Benefit**

If an insured is injured in a covered accident and requires adaptive modifications to his or her primary residence or private vehicle to be made drivable or rideable, we will pay the adaptive home and vehicle benefit shown on the specifications page subject to the following conditions:

1. a benefit is payable under the paralysis benefit of the Injury Benefits section of this certificate, or under the dismemberment benefit of the Accidental Death and Dismemberment Certificate Supplement; and
2. the modification must take place within two years of the covered accident; and
3. such home alterations are made by a person or persons with experience in such alterations and recommended by a recognized organization associated with the injury; and
4. such vehicle modifications are carried out by a person or persons with experience in such matters and approved by the Motor Vehicle Department.

This benefit is limited to one payment per insured per covered accident.

**Appliances**

If an insured is injured in a covered accident and a medical appliance is prescribed by a physician for mobility, we will pay the appliance benefit shown on the specifications page. The order for the appliance must be placed within 180 days of the covered accident. This benefit is limited to payment for two covered appliances per insured per covered accident.

Covered appliances means only the following: crutches, canes, walkers, wheelchairs/scooters, leg braces and back braces. This benefit does not cover replacement appliances.

**Follow-Up Physician’s Office Visit**

If an insured is injured in a covered accident and follow-up care for the injury is ordered by the treating physician, we will pay the follow-up physician’s office visit benefit shown on the specifications page. The follow-up visit(s) must occur within 180 days of the covered accident. This benefit is limited to three payments per insured per covered accident. Follow-up at an urgent care center is not covered under this benefit.

**Prosthetics**

If an insured is injured in a covered accident and sustains the loss of a limb, hand, foot or sight in an eye, we will pay the prosthetic benefit shown on the specifications page, subject to the following:

1. this benefit is limited to payment for two prosthetic devices per insured per covered accident; and
2. the prosthetic device(s) must be prescribed by a physician and ordered within 180 days after the covered accident.

Prosthetic device refers to an artificial device that replaces a missing limb, hand, foot or an eye. For purposes of this benefit, the term prosthetic device does not include corrective lenses or other cosmetic prostheses.

In addition, this benefit does not provide coverage for damaged prosthetics; more than one prosthetic device for the same limb, hand, foot or eye; the replacement of a prosthetic device; or a joint replacement.

**Transportation**

If an insured receives follow-up treatment ordered by a physician for an injury sustained in a covered accident and is required to travel more than 100 miles (one way) from the insured’s primary residence to a hospital or other treatment facility, we will pay the transportation benefit shown on the specifications page subject to the following:

1. a benefit is payable under this certificate for the same injury; and
2. the follow-up treatment is ordered by a physician and is not available within 100 miles (one way) of the insured’s primary residence; and
3. the Ambulance benefit is not payable for the same trip.

Mileage is measured from the insured’s primary residence to the hospital or treatment facility where the follow-up treatment is provided.
This benefit is limited to two payments per insured per covered accident.

Support Care

Adult Companion Lodging

If an insured is injured in a covered accident, we will pay the adult companion lodging benefit shown on the specifications page for each day the insured is receiving treatment in a hospital or rehabilitative facility for the injury, and for the 24 hours following the last day the insured is receiving treatment in a hospital or rehabilitative facility for the injury subject to the following conditions:

1. a companion who accompanies the insured stays in lodging for which a charge is made; and
2. either the hospital stay benefit or rehabilitative therapy (inpatient) benefit is payable for the same day the adult companion lodging benefit is payable; and
3. the companion is 18 or older.

Lodging refers to an establishment licensed under the laws applicable to where it is located, such as a motel, hotel, or other facility that provides sleeping accommodations to the general public in exchange for a fee and is located at least 100 miles from the insured’s primary residence.

This benefit is limited to 30 days per covered accident. Proof must be provided that the companion incurred an expense for staying at a lodging.

Exclusions and Limitations

Are there any other exclusions that apply?

Yes. In no event will we pay benefits where the insured’s accident, injury or loss is caused directly or indirectly by:

1. intentionally self-inflicted injury while sane; or
2. suicide or attempted suicide while sane; or
3. your participation in, or your attempt to commit, a crime, assault, felony, or any illegal activity, regardless of any legal proceedings thereto; or
4. the voluntary use of alcohol; or
5. the voluntary use of prescription drugs, non-prescription drugs, illegal drugs, medications, poisons, gases, fumes or other substances taken, absorbed, inhaled, ingested or injected; or
6. motor vehicle collision or accident where you are the operator of the motor vehicle and your blood alcohol level meets or exceeds the level at which intoxication is defined in the state where the collision or accident occurred, regardless of any legal proceedings thereto; or
7. war or any act of war, whether declared or undeclared; or
8. bodily or mental infirmity, illness or disease; or
9. infection, other than infection occurring simultaneously with, and as a direct and independent result of, the injury; or
10. repetitive stress syndromes including but not limited to rotator cuff syndrome, bursitis, tendonitis, carpal tunnel syndrome, ulnar nerve syndrome, stress fractures, neuropathy, epicondylitis or neuritis; or
11. medical or surgical treatment or diagnostic procedures including any resulting complications, or when the outcome is not as planned or expected, including claims of medical malpractice; or
12. travel in or descent from any aircraft, except as a fare-paying passenger on a regularly scheduled commercial flight on a licensed passenger aircraft carrier; or
13. participation in the following activities: scuba diving, bungee jumping, base jumping, hang gliding, sail gliding, parasailing, parakiting, or mountain climbing; or
14. riding or driving in any motor-driven vehicle in a race, stunt show or speed test; or
15. practicing for or participating in any semi-professional or professional competitive athletics.

Are there any additional limitations that apply?

Yes. Benefits are not payable for any care, treatment or diagnostic measures which were received outside of the United States or United States territory.

Claims

What notice of claim must be provided?

Written notice of claim must be given to us within 6 months of the occurrence or commencement of any loss resulting from a covered accident, or as soon thereafter as reasonably possible. Notice given by or on the insured’s behalf to us at our home office or to any authorized agent of ours, with information to identify the insured, shall be deemed notice to us.

Will claim forms be provided?

Upon receipt of notice of claim, we will provide a claim form. If the claim form is not provided within 15 days after the insured has given notice of claim, we will deem the insured to have complied with the requirements for filing proof of a loss resulting from a covered accident if the insured submits, within the time period for filing proof of the loss, written proof of the occurrence, character and extent of the loss for which claim is made which is satisfactory to us.

When is proof of a loss resulting from a covered accident required?

Written proof of a loss resulting from a covered accident satisfactory to us must be provided to us within 90 days of
the date of the loss. Failure to provide proof of the loss within this time will not invalidate or reduce a claim if it was not reasonably possible to provide proof within this 90 day period. However, proof must be provided within 1 year of the date of the loss, except in the absence of legal capacity.

When will the benefit be paid?

We will pay a benefit for a loss resulting from a covered accident no later than 30 days after receipt at our home office of written proof of the loss which meets all policy requirements and is satisfactory to us. You are responsible for all costs associated with claim form(s) completion, records, and the submission of your claim.

To whom will benefits be paid?

All benefits including dependent’s benefits will be paid to you, if you are living. If you die before the claim is paid, benefits will be paid to your estate.

Can you change your beneficiary?

Yes, you can change your beneficiary. The consent of a beneficiary or beneficiaries is not required for any change. A change will not affect any payment we make or action

What are our physical examination rights?

After an insured has filed a claim and provided at his or her expense all requested claim forms and records, we have the right to have the insured examined by a physician of our choice and at our expense. This right may be exercised as often as reasonably necessary while an insured has a claim pending with us.

Termination

When does your coverage terminate?

Coverage ends on the earliest of the following:

(1) the date you no longer meet the eligibility requirements; or
(2) 31 days (the grace period) after the due date of any premium which is not paid; or
(3) the last day for which premium contributions have been paid following your request to cancel your coverage; or
(4) the date the group policy ends.

When does an insured dependent’s coverage terminate?

An insured dependent’s coverage ends on the earliest of the following:

(1) the date the dependent no longer meets the eligibility requirements; or
(2) 31 days (the grace period) after the due date of any premium contribution which is not paid; or
(3) the last day for which premium contributions have been paid following your written request that

insurance on your eligible dependents be terminated; or
(4) the date you are no longer covered under the group policy.

You must notify us or your employer when you no longer have dependents eligible for coverage under this certificate so that premiums may be discontinued.

All premiums paid for dependents who are no longer eligible for coverage under this certificate will be refunded without any payment of claim.

Additional Information

Can your insurance coverage be contested?

Yes. If an insured experiences a loss resulting from a covered accident within two years of the original effective date of coverage or increase in coverage, we will verify the accuracy of the information provided during the application process. If we discover a material misrepresentation, the affected coverage will be rescinded and an otherwise valid claim will be denied. This two year period will be extended by fraud or as otherwise allowed by applicable laws.

Is the policyholder required to maintain records?

Yes. The policyholder is required to maintain adequate records of any information necessary for us to administer the policy, and shall provide access to such records when required for us to administer the policy. If a clerical error is made in keeping records on the insurance under the group policy, it will not affect otherwise valid insurance.

A clerical error does not continue insurance which is otherwise stopped, make insurance effective when it should not have been or change the benefit amount provided by the provisions of the policy and no claim shall be paid on amounts affected by a clerical error. If an error causes a change in premium payment, a fair adjustment will be made.

Will the provisions of this certificate conform with applicable state law?

Yes. The provisions of this certificate conform to the minimum requirements of Montana law and control over any conflicting statutes of any state in which the insured resides on or after the effective date of this certificate.

What if an insured’s age has been misstated?

If an insured’s age has been misstated, all amounts payable will be adjusted to that amount which the premium would have purchased at the correct age. This will be determined by applying the ratio of the paid premium over the required premium to the initial benefit amount.
Can this insurance be assigned?

No. Insurance coverage under the group policy cannot be assigned.
General Information

This certificate supplement is subject to every term, condition, exclusion, limitation and provision of the certificate unless otherwise expressly provided for herein.

What does this supplement provide?

This supplement provides for continuation of insurance if an insured no longer meets the eligibility requirements of the certificate, except as provided for herein.

To continue insurance the insured must make a written request and make the first premium payment within 31 days after insurance provided by the group policy would otherwise terminate. Coverage provided by this supplement will then be deemed effective retroactive to the beginning of the 31-day period. This date is considered to be the insured’s portability date and the insured is then considered to have portability status.

Who is eligible to continue insurance under this supplement?

An insured employee is eligible to continue group accident insurance under the terms of this supplement if he or she no longer meets the eligibility requirements of the certificate due to any of the following:

1. the employee terminates employment, including retirement; or
2. the employee is no longer in a class eligible for insurance or is on a leave or layoff; or
3. a class or group of employees insured under the policy are no longer considered eligible and there is no successor plan for that class or group. Successor plan means an insurance policy or policies provided by us or another insurer that replaces insurance provided under this policy.

Regardless of whether an insured is otherwise eligible under this supplement to continue, an insured will not be eligible to request coverage under this supplement if he or she:

1. has attained the age of 70; or
2. is an employee and was not actively at work due to sickness or injury on the date immediately preceding his or her portability date; or
3. loses eligibility due to a class or group of employees no longer being eligible under the policy and there is a successor plan for that class or group of employees; or
4. loses eligibility due to termination of the group policy.

What insurance can be continued under this supplement?

Group accident insurance may be continued under this supplement. If an employee elects to continue his or her own coverage according to the provisions of this supplement, he or she may also elect to continue insurance for any other individual insured under his or her certificate.

What benefit amounts can be continued under this supplement?

The benefit amounts that can be continued under this supplement shall be the amounts shown on the specifications page applicable to the insured based on the benefit plan selected by the insured employee.

Can an insured request a change in the benefit plan continued under this supplement?

Yes. The insured employee may change the benefit plan to one that provides lower benefit amounts, but may not change the benefit plan to one that provides higher benefit amounts.

How will premiums be paid?

Premiums will be paid directly to us on a monthly, quarterly, semi-annual, or annual basis and will be subject to an administrative charge per billing period.

Can the premium rate change?

Yes. The premium rates for ported coverage may be different than the premium rates for active employees, and are not subject to the premium rate provision of the policy.

What happens if an insured again becomes eligible under the certificate?

If an insured is continuing coverage under the terms of this supplement, and again meets the eligibility requirements of the certificate the insured shall no longer be considered to have portability status. Insurance may be continued only under the terms of the certificate, not including this supplement, unless and until the insured no longer meets the eligibility requirements of the certificate and again returns to portability status as provided for herein.

What happens to insurance provided under this supplement when the group policy terminates?

Any insurance continued under the terms of this supplement will remain in force until terminated by the provisions of the section entitled “When will insurance continued under this supplement terminate?”
No individual may elect coverage under this supplement on or after the date of termination of the group policy.

**When will insurance continued under this supplement terminate?**

An insured's insurance being continued under this supplement will terminate on the earliest of the following:

1. the insured’s 70th birthday;
2. the date the insured again meets the eligibility requirements of the certificate, not including the terms of this supplement;
3. in the case of a dependent child or a spouse, the date your coverage is no longer being continued under this supplement or the date the spouse or child ceases to be eligible as defined under the terms of your certificate; or
4. the date the group policy is terminated; or
5. 31 days after the due date of any premium contribution which is not made.

**Secretary**  
**President**
NOTICE OF PROTECTION PROVIDED BY
MONTANA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This Notice provides a brief summary description of the Montana Life and Health Insurance Guaranty Association (the Association) and the protection it provides for policyholders. This safety net was created under Montana law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Montana law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are:

Life Insurance
- $300,000 in death benefits
- $100,000 in cash surrender or withdrawal values

Health Insurance
- $500,000 in hospital, medical and surgical insurance benefits
- $300,000 in disability income insurance benefits
- $300,000 in long-term care insurance benefits
- $100,000 in other types of health insurance benefits

Annuities
- $250,000 in withdrawal and cash values

The maximum amount of protection is $300,000 in benefits with respect to any one life regardless of the number of policies or contracts, except with respect to hospital, medical and surgical insurance benefits.

NOTE: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Montana law.

To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website at www.mtlifega.org, or contact:

Montana Life and Health Insurance Guaranty Association
PO Box 951
Oconomowoc, WI 53066-0951
877-678-1048 or administrator@mtlifega.org

Montana Department of Insurance
State Auditor's Office
840 Helena Avenue
Helena, MT 59601
406-444-2040

Insurance companies and agents are not allowed by Montana law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage.

If there is any inconsistency between this notice and Montana law, then Montana will control.
THIS COVERAGE IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

(1) Read Your Certificate Carefully - This Outline of Coverage provides a very brief description of the important features of your certificate. This is not the insurance contract and only the actual certificate provisions shall control. The certificate sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR CERTIFICATE CAREFULLY!

(2) ACCIDENT ONLY COVERAGE is designed to provide, to persons insured, coverage for certain losses resulting from a covered accident ONLY, subject to any limitations contained in the certificate. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

(3) BENEFITS – The benefit amount payable will depend on whether the insured is enrolled in the Low Plan or High Plan, the number of benefits you qualify for, the care you receive and the terms and conditions of the policy.

<table>
<thead>
<tr>
<th>INJURY BENEFITS</th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Burn Benefit</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2nd degree burns</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 10% of the body</td>
<td>$100</td>
<td>$300</td>
</tr>
<tr>
<td>Between 10% and 20% of the body</td>
<td>$250</td>
<td>$750</td>
</tr>
<tr>
<td>20% or more of the body</td>
<td>$500</td>
<td>$1,500</td>
</tr>
<tr>
<td>3rd degree burns</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 10% of the body</td>
<td>$1,000</td>
<td>$3,000</td>
</tr>
<tr>
<td>Between 10% and 20% of the body</td>
<td>$2,500</td>
<td>$7,500</td>
</tr>
<tr>
<td>20% or more of the body</td>
<td>$5,000</td>
<td>$15,000</td>
</tr>
<tr>
<td><strong>Child Organized Sports Injury</strong></td>
<td>$50</td>
<td>$100</td>
</tr>
<tr>
<td><strong>Concussion</strong></td>
<td>$100</td>
<td>$200</td>
</tr>
<tr>
<td><strong>Dislocation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Principal Amount (Surgical)</strong></td>
<td>$2,000</td>
<td>$5,000</td>
</tr>
<tr>
<td>% of Principal Amount</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hip/Thigh</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Foot</td>
<td>40%</td>
<td>40%</td>
</tr>
<tr>
<td>Ankle</td>
<td>40%</td>
<td>40%</td>
</tr>
<tr>
<td>Knee</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Hand or wrist (excluding fingers)</td>
<td>Hand: 20%</td>
<td>Hand: 20%</td>
</tr>
<tr>
<td></td>
<td>Wrist: 30%</td>
<td>Wrist: 30%</td>
</tr>
<tr>
<td>Lower jaw</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Shoulder</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Collarbone</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Ribs</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Finger</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Toe</td>
<td>5%</td>
<td>5%</td>
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<tr>
<td>Elbow</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Non-surgical</td>
<td>50% of surgical benefit</td>
<td>50% of surgical benefit</td>
</tr>
<tr>
<td>Partial dislocation</td>
<td>25% of non-surgical benefit</td>
<td>25% of non-surgical benefit</td>
</tr>
<tr>
<td>INJURY BENEFITS</td>
<td>LOW PLAN</td>
<td>HIGH PLAN</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>----------</td>
<td>-----------</td>
</tr>
<tr>
<td>Eye Injury</td>
<td>$30</td>
<td>$75</td>
</tr>
<tr>
<td>Fracture</td>
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<td></td>
</tr>
<tr>
<td>Principal Amount (Surgical)</td>
<td>$2,000</td>
<td>$5,000</td>
</tr>
<tr>
<td></td>
<td>% of Principal Amount</td>
<td>% of Principal Amount</td>
</tr>
<tr>
<td>Hip/Thigh</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Vertebral body</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Vertebral processes</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Pelvis</td>
<td>75%</td>
<td>75%</td>
</tr>
<tr>
<td>Sternum</td>
<td>75%</td>
<td>75%</td>
</tr>
<tr>
<td>Coccyx</td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td>Skull – non depressed</td>
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<td>100%</td>
</tr>
<tr>
<td>Skull – depressed</td>
<td>150%</td>
<td>150%</td>
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<tr>
<td>Lower leg</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Foot</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Ankle</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Kneecap</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Upper arm</td>
<td>35%</td>
<td>35%</td>
</tr>
<tr>
<td>Facial excluding lower jaw</td>
<td>35%</td>
<td>35%</td>
</tr>
<tr>
<td>Forearm</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Hand or wrist (except fingers)</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Lower jaw</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Shoulder blade</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Collarbone</td>
<td>15%</td>
<td>15%</td>
</tr>
<tr>
<td>Ribs</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Finger</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Toe</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Nose</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Non-surgical</td>
<td>50% of surgical benefit</td>
<td>50% of surgical benefit</td>
</tr>
<tr>
<td>Chip fracture</td>
<td>25% of non-surgical benefit</td>
<td>25% of non-surgical benefit</td>
</tr>
<tr>
<td>Lacerations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>With stitches or staples</td>
<td>$100</td>
<td>$500</td>
</tr>
<tr>
<td>Without stitches or staples</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>25% of benefit provided with stitches or staples</td>
<td>25% of benefit provided with stitches or staples</td>
</tr>
<tr>
<td>Paralysis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Principal Amount</td>
<td>$20,000</td>
<td>$60,000</td>
</tr>
<tr>
<td></td>
<td>% of Principal Amount</td>
<td>% of Principal Amount</td>
</tr>
<tr>
<td>Quadriplegia</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Paraplegia</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Hemiplegia</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Uniplegia</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Traumatic Brain Injury</td>
<td>$200</td>
<td>$400</td>
</tr>
<tr>
<td>EMERGENCY CARE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ground or water</td>
<td>$100</td>
<td>$200</td>
</tr>
<tr>
<td>Air</td>
<td>$500</td>
<td>$1,000</td>
</tr>
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</table>
### INJURY BENEFITS

<table>
<thead>
<tr>
<th>Item</th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood, Plasma, Platelets or Other Non-Blood Substitute IV Solutions Transfusion</td>
<td>$300</td>
<td>$600</td>
</tr>
<tr>
<td>Emergency Dental</td>
<td>$50</td>
<td>$100</td>
</tr>
<tr>
<td>Emergency Room Treatment</td>
<td>$100</td>
<td>$300</td>
</tr>
<tr>
<td>Initial Physician’s Office Visit</td>
<td>$50</td>
<td>$100</td>
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</tbody>
</table>

### HOSPITAL CARE

<table>
<thead>
<tr>
<th>Item</th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Stay</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initial benefit, non-ICU</td>
<td>$400</td>
<td>$1,200</td>
</tr>
<tr>
<td>Initial benefit, ICU</td>
<td>$800</td>
<td>$2,400</td>
</tr>
<tr>
<td>Daily benefit, non-ICU</td>
<td>$100</td>
<td>$300</td>
</tr>
<tr>
<td>Daily benefit, ICU</td>
<td>$200</td>
<td>$600</td>
</tr>
</tbody>
</table>

### SURGERY

<table>
<thead>
<tr>
<th>Item</th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1</td>
<td>$1,000</td>
<td>$2,000</td>
</tr>
<tr>
<td>Tier 2</td>
<td>$250</td>
<td>$500</td>
</tr>
</tbody>
</table>

### FOLLOW-UP CARE

<table>
<thead>
<tr>
<th>Item</th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adaptive Home and Vehicle Benefit</td>
<td>$500</td>
<td>$1,000</td>
</tr>
<tr>
<td>Appliances</td>
<td>$50</td>
<td>$250</td>
</tr>
<tr>
<td>Follow-Up Physician’s Office Visit</td>
<td>$50</td>
<td>$100</td>
</tr>
<tr>
<td>Prosthetics (One prosthetic)</td>
<td>$500</td>
<td>$1,000</td>
</tr>
<tr>
<td>Prosthetics (Two or more prosthetics)</td>
<td>2x one prosthetic</td>
<td>2x one prosthetic</td>
</tr>
<tr>
<td>Transportation</td>
<td>$200 per visit</td>
<td>$500 per visit</td>
</tr>
</tbody>
</table>

### SUPPORT CARE

<table>
<thead>
<tr>
<th>Item</th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Companion Lodging</td>
<td>$75 per day</td>
<td>$150 per day</td>
</tr>
</tbody>
</table>

(4) **EXCLUSIONS AND LIMITATIONS** - In no event will we pay benefits where the insured’s accident, injury or loss is caused directly by any of the following:

1. intentionally self-inflicted injury while sane; or
2. suicide or attempted suicide while sane; or
3. your participation in a felony; or
4. alcoholism; or
5. drug addiction; or
(6) poisons, gases, fumes or other substances taken, absorbed, inhaled, ingested or injected; or
(7) motor vehicle collision or accident where you are the operator of the motor vehicle and your blood alcohol level meets or exceeds the level at which intoxication is defined in the state where the collision or accident occurred, regardless of any legal proceedings thereto; or
(8) war or any act of war, whether declared or undeclared; or
(9) bodily or mental infirmity, illness or disease; or
(10)infection, other than infection occurring simultaneously with, and as a direct and independent result of, the injury; or
(11)repetitive stress syndromes including but not limited to rotator cuff syndrome, bursitis, tendonitis, carpal tunnel syndrome, ulnar nerve syndrome, stress fractures, neuropathy, epicondylitis or neuritis; or
(12)medical or surgical treatment or diagnostic procedures including any resulting complications, or when the outcome is not as planned or expected, including claims of medical malpractice; or
(13)aviation; or
(14)participation in the following activities: scuba diving where the depth exceeds 60 feet, scuba diving where the insured is not scuba certified regardless of depth, bungee jumping, base jumping, hang gliding, sail gliding, parasailing, parakiting, technical mountain climbing involving the use of ropes or other climbing equipment, or rock climbing regardless of equipment used; or
(15)riding or driving in any motor-driven vehicle in a race, stunt show or speed test; or
(16)practicing for or participating in any semi-professional or professional competitive athletics.

(5) RENEWABILITY - The group policy will continue in force until it is canceled by either the group policyholder or Securian Life. Subject to the termination section of the certificate, the certificate may be renewed by making the required premium payments.

(6) PREMIUMS – Unless the policyholder and we have agreed to some other premium payment procedure, any premium contributions you are required to make for contributory insurance are to be paid by you to the policyholder on a regular periodic basis. We apply premiums consecutively to keep the insurance in force. We reserve the right to change premium rates on any premium due date, but not more than once in each policy year.

Secretary

President
This is a Limited Certificate – Read It Carefully

THIS CERTIFICATE IS NOT MAJOR MEDICAL INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL INSURANCE. IT DOES NOT QUALIFY AS MINIMUM ESSENTIAL HEALTH COVERAGE UNDER THE FEDERAL AFFORDABLE CARE ACT. THIS CERTIFICATE DOES NOT SATISFY THE FEDERAL REQUIREMENT THAT YOU HAVE HEALTH INSURANCE COVERAGE, WHICH BECAME EFFECTIVE JANUARY 1, 2014.

Notice to Buyer: This is an accident-only certificate and it does not pay benefits for loss from sickness. Review your certificate carefully.

This certificate provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses. Read your certificate carefully.

Read Your Certificate Carefully

If you meet the eligibility and enrollment requirements herein, you are insured under the group policy shown on the specifications page. This certificate summarizes the principal provisions of the group policy that affect you. The provisions summarized in this certificate are subject in every respect to the group policy. You may examine the group policy at the principal office of the policyholder during regular working hours.

Legal Actions

No legal action may be brought to recover on this certificate within the first sixty days after written proof of loss has been given as required by this certificate. No such action may be brought after two years from the time written proof of loss is required to be given.

Right to Return

The certificate holder shall have the right to return the coverage within 30 days of the its delivery and to have the premium refunded if, after examination of the policy, the certificate holder is not satisfied for any reason.

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GROUP ACCIDENT ONLY CERTIFICATE OF INSURANCE
GENERAL INFORMATION

POLICYHOLDER: Concordia Plan Services

POLICY NUMBER: 76013

ASSOCIATED COMPANIES: All subsidiaries and affiliates reported to Securian Life by the policyholder for inclusion in the policy.

POLICY SITUS: The policy was issued and delivered in Missouri.

POLICY EFFECTIVE DATE: January 1, 2019.

This certificate and/or certificate specifications page replaces any and all certificates and/or certificate specifications pages previously issued to you under the group policy. Please replace any certificate and/or certificate specifications page previously issued to you with this new certificate and/or specifications page.

GROUP:
The group is composed of all active employees of the policyholder and its associated companies working in the United States in the following classes:

Class 1: Active employees working at least 20 hours per week.

All new employees of the employer will be added to such group and classes for which they become eligible.

NO DOUBLE COVERAGE:
A person cannot be covered under more than one class. A person cannot be covered as both an active employee and a retiree. Any person who is eligible as an employee or retiree under the policy, or insured under the portability provisions, is not eligible as a dependent. Only one person can insure an eligible dependent child.

ENROLLMENT PERIOD: 90 days from the first day of eligibility for contributory insurance.

WAITING PERIOD: None

MINIMUM HOURS PER WEEK REQUIREMENT: 20 hours per week

PLAN OF INSURANCE

EMPLOYEE BENEFIT SCHEDULE

EMPLOYEE GROUP ACCIDENT INSURANCE:

Supplemental Group Accident Insurance

<table>
<thead>
<tr>
<th>Eligible Class</th>
<th>Employee Supplemental Group Accident Insurance Benefit Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class 1</td>
<td>Low Plan or High Plan as elected by the employee.</td>
</tr>
</tbody>
</table>
GENERAL PROVISIONS FOR EMPLOYEE INSURANCE

RETIREMENT REDUCTIONS: All insurance terminates at retirement, except as otherwise provided for under any applicable certificate supplement.

CONTRIBUTORY/NONCONTRIBUTORY: Supplemental insurance is contributory insurance.

PORTABILITY BENEFIT: Low Plan or High Plan as elected by the employee.

DEPENDENT BENEFIT SCHEDULE

An employee must be insured in order to elect dependent group accident insurance.

SPOUSE GROUP ACCIDENT INSURANCE

Supplemental Group Accident Insurance

<table>
<thead>
<tr>
<th>Eligible Class</th>
<th>Spouse Supplemental Group Accident Insurance Benefit Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class 1</td>
<td>Spouse benefit plan will match the employee’s Supplemental Group Accident Benefit Plan.</td>
</tr>
</tbody>
</table>

CHILD GROUP ACCIDENT INSURANCE

Supplemental Group Accident Insurance

<table>
<thead>
<tr>
<th>Eligible Class</th>
<th>Child Supplemental Group Accident Insurance Benefit Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class 1</td>
<td>Child benefit plan will match the employee’s supplemental Group Accident Benefit Plan.</td>
</tr>
</tbody>
</table>

GENERAL PROVISIONS FOR DEPENDENT INSURANCE

CONTRIBUTORY/NONCONTRIBUTORY: Supplemental insurance is contributory insurance.

SPOUSE AND CHILD PORTABILITY BENEFIT: Spouse benefit plan will match the employee’s Group Accident Benefit Plan. Child benefit plan will match the employee’s Group Accident Benefit Plan.

COVERED BENEFITS

Refer to the Injury Benefits, Emergency Care, Hospital Care, Surgery Benefits, and Follow-up Care and Support Care sections of the Certificate for additional benefit details.

<table>
<thead>
<tr>
<th>INJURY BENEFITS</th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burn Benefit</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2\textsuperscript{nd} degree burns

| Less than 10% of the body | $100 | $300 |
| Between 10% and 20% of the body | $250 | $750 |
| 20% or more of the body | $500 | $1,500 |

3\textsuperscript{rd} degree burns

| Less than 10% of the body | $1,000 | $3,000 |
| Between 10% and 20% of the body | $2,500 | $7,500 |
| 20% or more of the body | $5,000 | $15,000 |
## INJURY BENEFITS

<table>
<thead>
<tr>
<th>Injuries</th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Organized Sports Injury</td>
<td>$50</td>
<td>$100</td>
</tr>
<tr>
<td>Concussion</td>
<td>$100</td>
<td>$200</td>
</tr>
</tbody>
</table>

### Dislocation

#### Principal Amount (Surgical)

<table>
<thead>
<tr>
<th>Injuries</th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hip/Thigh</td>
<td>$2,000</td>
<td>$5,000</td>
</tr>
<tr>
<td>Foot</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Ankle</td>
<td>40%</td>
<td>40%</td>
</tr>
<tr>
<td>Knee</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Hand or wrist (excluding fingers)</td>
<td>Hand: 20% Wrist: 30%</td>
<td>Hand: 20% Wrist: 30%</td>
</tr>
<tr>
<td>Lower jaw</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Shoulder</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Collarbone</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Ribs</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Finger</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Toe</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Elbow</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Non-surgical</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Partial dislocation</td>
<td>25%</td>
<td>25%</td>
</tr>
</tbody>
</table>

### Eye Injury

<table>
<thead>
<tr>
<th>Injuries</th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eye Injury</td>
<td>$30</td>
<td>$75</td>
</tr>
</tbody>
</table>

### Fracture

#### Principal Amount (Surgical)

<table>
<thead>
<tr>
<th>Injuries</th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hip/Thigh</td>
<td>$2,000</td>
<td>$5,000</td>
</tr>
<tr>
<td>Vertebral body</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Vertebral processes</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Pelvis</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Sternum</td>
<td>75%</td>
<td>75%</td>
</tr>
<tr>
<td>Coccyx</td>
<td>75%</td>
<td>75%</td>
</tr>
<tr>
<td>Skull – non depressed</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Skull – depressed</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Lower leg</td>
<td>150%</td>
<td>150%</td>
</tr>
<tr>
<td>Foot</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Ankle</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Kneecap</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Upper arm</td>
<td>35%</td>
<td>35%</td>
</tr>
<tr>
<td>Facial excluding lower jaw</td>
<td>35%</td>
<td>35%</td>
</tr>
<tr>
<td>Forearm</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Hand or wrist (except fingers)</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Lower jaw</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Shoulder blade</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Collarbone</td>
<td>15%</td>
<td>15%</td>
</tr>
<tr>
<td>Ribs</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Finger</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Toe</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Nose</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Non-surgical</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Chip fracture</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Benefit</td>
<td>25%</td>
<td>25%</td>
</tr>
</tbody>
</table>
## INJURY BENEFITS

<table>
<thead>
<tr>
<th></th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lacerations</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>With stitches or staples</td>
<td>$100</td>
<td>$500</td>
</tr>
<tr>
<td>Without stitches or staples</td>
<td>25% of benefit provided with stitches or staples</td>
<td>25% of benefit provided with stitches or staples</td>
</tr>
<tr>
<td><strong>Paralysis</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Principal Amount</td>
<td>$20,000</td>
<td>$60,000</td>
</tr>
<tr>
<td>% of Principal Amount</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quadriplegia</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Paraplegia</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Hemiplegia</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Uniplegia</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td><strong>Traumatic Brain Injury</strong></td>
<td></td>
<td>$200</td>
</tr>
</tbody>
</table>

## EMERGENCY CARE

<table>
<thead>
<tr>
<th></th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ambulance</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ground or water</td>
<td>$100</td>
<td>$200</td>
</tr>
<tr>
<td>Air</td>
<td>$500</td>
<td>$1,000</td>
</tr>
<tr>
<td><strong>Blood, Plasma, Platelets or Other Non-Blood Substitute IV Solutions Transfusion</strong></td>
<td></td>
<td>$300</td>
</tr>
<tr>
<td><strong>Emergency Dental</strong></td>
<td>$50</td>
<td>$100</td>
</tr>
<tr>
<td><strong>Emergency Room Treatment</strong></td>
<td>$100</td>
<td>$300</td>
</tr>
<tr>
<td><strong>Initial Physician’s Office Visit</strong></td>
<td>$50</td>
<td>$100</td>
</tr>
</tbody>
</table>

## HOSPITAL CARE

<table>
<thead>
<tr>
<th></th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospital Stay</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initial benefit, non-ICU</td>
<td>$400</td>
<td>$1,200</td>
</tr>
<tr>
<td>Initial benefit, ICU</td>
<td>$800</td>
<td>$2,400</td>
</tr>
<tr>
<td>Daily benefit, non-ICU</td>
<td>$100</td>
<td>$300</td>
</tr>
<tr>
<td>Daily benefit, ICU</td>
<td>$200</td>
<td>$600</td>
</tr>
</tbody>
</table>

## SURGERY

<table>
<thead>
<tr>
<th></th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tier 1</strong></td>
<td>$1,000</td>
<td>$2,000</td>
</tr>
<tr>
<td><strong>Tier 2</strong></td>
<td>$250</td>
<td>$500</td>
</tr>
</tbody>
</table>

## FOLLOW-UP CARE

<table>
<thead>
<tr>
<th></th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adaptive Home and Vehicle Benefit</td>
<td>$500</td>
<td>$1,000</td>
</tr>
<tr>
<td>FOLLOW-UP CARE</td>
<td>LOW PLAN</td>
<td>HIGH PLAN</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>----------</td>
<td>-----------</td>
</tr>
<tr>
<td>Appliances</td>
<td>$50</td>
<td>$250</td>
</tr>
<tr>
<td>Follow-Up Physician’s Office Visit</td>
<td>$50</td>
<td>$100</td>
</tr>
<tr>
<td>Prosthetics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>One prosthetic</td>
<td>$500</td>
<td>$1,000</td>
</tr>
<tr>
<td>Two or more prosthetics</td>
<td>2x one prosthetic</td>
<td>2x one prosthetic</td>
</tr>
<tr>
<td>Transportation</td>
<td>$200 per visit</td>
<td>$500 per visit</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SUPPORT CARE</th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Companion Lodging</td>
<td>$75 per day</td>
<td>$150 per day</td>
</tr>
</tbody>
</table>

**ADDITIONAL INFORMATION**

**ANNUAL OPEN ENROLLMENTS:**

During the policyholder’s annual open enrollment an employee may elect or change employee and dependent accident insurance benefit plans.

Coverage will be effective on the January 1 following the annual enrollment, subject to the actively at work requirement for employees and the hospitalization/non-confinement provision for dependents (this does not apply to a newborn child).

**Special Enrollment Periods:** Upon mutual agreement between the Policyholder and Securian, one or more special enrollment periods may be offered to eligible employees. These special enrollment periods (if offered) will be in addition to the annual enrollment opportunities described above. In the event that a special enrollment period is offered, the details of the special enrollment, including enrollment dates, allowed changes, and evidence of insurability requirements, will be communicated to you in advance of the special enrollment period and documented in the group policy on file with the policyholder and Securian.

**QUALIFIED STATUS CHANGES:**

An employee who experiences a Qualified Status Changes as defined below may elect or change employee and dependent accident insurance benefit plans provided enrollment is made within 60 days of the status change.

- An active employee may elect accident insurance for the first time or increase coverage from the low plan to the high plan.
- An active employee may elect dependent coverage.

Coverage will be effective on the date of the election. All increases are subject to the actively at work requirement for employees and the hospitalization/non-confinement provision for dependents (this does not apply to a newborn child).

A qualified status change for the purpose of waiving the evidence of insurability requirement means marriage, birth or adoption.

**SUPPLEMENTS TO THE CERTIFICATE**

Portability
Definitions

Any use in this certificate of a term defined in this section is to be given the meaning defined in this section unless otherwise defined in another provision of this certificate.

Accident
An act or event which is:

(1) unintended, unexpected and unforeseen; and
(2) directly results in bodily injury to the insured.

Application
Your application or enrollment for insurance under the group policy.

Associated company
Any company which is a subsidiary or affiliate of the policyholder which is designated by the policyholder and agreed to by us to participate under the group policy.

Child or children
Your or your spouse’s child by blood or law, including natural, adopted, stepchild or foster child who is less than 26 years old. An adopted child includes a child legally placed for adoption with you. Eligibility begins at live birth (stillborn or unborn children are not eligible).

Coverage may continue after any child insured under this certificate attains age 26 and is both:

(1) incapable of self-sustaining employment due to intellectual disability or physical handicap, and
(2) primarily dependent upon you for support and maintenance.

Any child who continues coverage beyond age 26 due to incapacity will have the right to convert to an individual policy under the terms of the certificate upon termination of incapacity.

Contributory insurance
Insurance for which you are required to make premium contributions.

Covered accident
An accident which:

(1) is not excluded under the Exclusions and Limitations section or any other terms of this certificate; and
(2) occurs while the insured’s coverage is in force; and
(3) occurs in the United States or a United States territory.

Dependent
Your children or spouse.

If both parents of a child qualify as eligible employees under the group policy, the child shall be considered a dependent of only one parent for purposes of this certificate. If any child qualifies as an eligible employee under the group policy, he or she is not eligible to be insured as a dependent child.

Emergency room
A department of a hospital or a satellite emergency center that is designated for persons requiring immediate medical care. This area must be staffed and equipped to handle trauma, be supervised and provide treatment by physicians, and provide care seven days per week, 24 hours per day.

A satellite emergency center is a licensed facility providing outpatient care under the direction of a licensed physician on a 24-hour basis. Available services must include:

(1) diagnostic care, including laboratory services and diagnostic x-rays; and
(2) treatment or medical care, including availability of the means for stabilization of emergency medical conditions.

A satellite emergency center does not include a hospital or an office maintained by a licensed physician for the practice of medicine or dentistry.

Employee
An individual who is employed by the policyholder or by an associated company. A sole proprietor will be considered the employee of the proprietorship. A partner in a partnership will be considered an employee so long as the partner’s principal work is the conduct of the partnership’s business. The term employee does not include temporary employees nor corporate directors who are not otherwise employees.

Employer
The policyholder or any designated associated companies.

Family member
A parent, spouse, child, sibling, grandparent, aunt, uncle, first cousin, niece or nephew. This includes adopted, in-law and step relatives.

Hospital
A short-term, acute care general facility that:

(1) is legally licensed and operated as a hospital;
(2) provides overnight care of injured and sick people;
(3) requires that every patient be supervised by a physician;
(4) provides 24 hour nursing service by or under the supervision of a registered nurse;
(5) has on-site or pre-arranged use of x-ray equipment, laboratory, and surgical facilities; and
(6) maintains permanent medical history records.

A hospital is not a rehabilitation center, nursing home, rest home, extended-care facility, convalescent home, a place for alcoholics or drug addicts or a mental institution, even if such facilities are affiliated with or adjoined to a hospital.

injury or injuries
A bodily injury which is sustained as a direct result of a covered accident.

insured
An employee, spouse or child covered for insurance under this certificate.

noncontributory insurance
Insurance for which you are not required to make premium contributions.

non-work day
A day on which you are not regularly scheduled to work, including scheduled time off for vacations, personal holidays, weekends and holidays, and approved leaves of absence for non-medical reasons.

Non-work day does not include time off for medical leave of absence, temporary layoff, employer suspension of operations in total or in part, strike, and any time off due to sickness or injury including sick days, short-term disability, or long term disability.

physician
A medical doctor or other person recognized by law or regulation in the United States or United States territory where services are rendered as a physician. The person must be licensed as required by the United States jurisdiction where care is given and must be operating in the scope of his or her license.

A physician cannot be a person who:

(1) ordinarily resides in your household; or
(2) is a family member.

policyholder
The owner of the group policy as shown on the specifications page.

specifications page
The summary of the plan specifics available under the group policy.

spouse
Your legally married spouse, as recognized under the laws of the jurisdiction of celebration.

Spouse does not include any person who is eligible as an employee.

surgery
Medical treatment in which a physician cuts into someone’s body in order to repair or remove damaged parts as a result of a covered accident. The surgery must be performed solely because of injuries sustained in a covered accident.

urgent care center
A health care facility that is separate from a hospital or a separate unit within a hospital and whose primary purpose is the offering and provision of immediate, short term medical care, without appointment, for urgent care.

waiting period
The period, if any, of continuous employment with the employer that the employee must satisfy prior to becoming eligible for coverage under this certificate. You are not eligible to become insured until the first day following the waiting period. Any such waiting period is shown on the specifications page.

we, our, us
Securian Life Insurance Company.

you, your, certificate holder
An insured employee.

General Information

What is your agreement with us?
If you meet the eligibility and enrollment requirements, you are insured under the group policy shown on the specifications page. Your application is deemed a part of this certificate. This certificate summarizes the principal provisions of the group policy that affect your insurance coverage. The provisions summarized in this certificate are subject in every respect to the group policy.

Any statements made in your application will, in the absence of fraud, be considered representations and not warranties. Also, any statement made will not be used to void your insurance nor defend against a claim unless the statement is contained in the application.

Can this certificate be amended?
Yes. We retain the right to amend this certificate at any time without your consent. Any amendment will be without prejudice to any claim incurred for benefits prior to the date of the amendment.
Who is eligible for insurance?

You are eligible for group accident insurance if you:

1. are a member of the eligible group and of an eligible class as defined on the specifications page; and
2. work for the employer for at least the number of hours per week shown as the minimum hours per week requirement on the specifications page; and
3. have satisfied the waiting period as shown on the specifications page; and
4. meet the actively at work requirement described in the “What is the actively at work requirement?” provision of this section.

Are your dependents eligible for insurance?

Yes. If you are insured for group accident coverage, your dependents are eligible for insurance.

Are employees of associated companies eligible for insurance under the group policy?

Yes. Employees of associated companies may be eligible for insurance under the group policy. The policyholder represents any associated company in all transactions pertaining to the group policy. The policyholder’s acts or omissions and every notice given by us to the policyholder shall be binding on every associated company. When an associated company ceases its participation under the policy, the policy shall be considered to be terminated for all employees of the associated company. All provisions related to policy termination will apply to such employees.

What is the actively at work requirement?

To be eligible to become insured or to receive an increase in the benefit amount, you must be actively at work, fully performing your customary duties for your regularly scheduled number of hours at the employer’s normal place of business, or at other places the employer’s business requires you to travel.

If you are not working due to illness or injury, you do not meet the actively at work requirement. If you are receiving sick pay, short-term disability benefits or long-term disability benefits, you do not meet the actively at work requirement. If you are not actively at work on the date coverage would otherwise begin, or on the date an increase in your benefit amount would otherwise be effective, you will not be eligible for the coverage or increase until you return to active work. However, if the absence is on a non-work day, coverage will not be delayed provided you were actively at work on the work day immediately preceding the non-work day.

Except as otherwise provided for in this certificate, you are eligible to continue to be insured only while you remain actively at work.

Any insurance or increase in insurance which is elected or put in force while you are not actively at work will not be eligible for claim payment. You or your beneficiary will receive a refund of premium for any contributory insurance for which you were not eligible.

What is the dependent non-confinement requirement?

If a dependent is hospitalized or confined because of illness or disease on the date his or her insurance would otherwise become effective, his or her effective date shall be delayed until he or she is released from such hospitalization or confinement. This does not apply to a newborn child. In no event will insurance on a dependent be effective before your insurance is effective.

Can your coverage be continued during sickness, injury, leave of absence or temporary layoff?

Yes. Insurance may be continued on an insured employee who is not actively at work due to sickness, injury, leave of absence or temporary layoff, subject to the employer’s practices and procedures, including the employer’s limits on the length of continuation allowed for the type of absence. Continuation is contingent upon continued premium payment.

Coverage during a leave of absence and upon return from a leave of absence shall meet all state and federal requirements.

Enrollment

When can you elect or make changes to your insurance?

You must enroll in order to be insured for contributory coverage under the group policy. You can enroll for coverage within 90 days of when you first become eligible. After that period, you can only enroll for coverage or make changes during your annual open enrollment or within 60 days of a qualified status change event, as defined by the state and federal rules and regulations.

When does your insurance become effective?

Your insurance becomes effective on the date all of the following conditions have been met:

1. you meet all eligibility requirements, including the actively at work requirement; and
2. for contributory coverage, application is made in accordance with the application methods agreed upon by the policyholder and us

When does insurance for a dependent become effective?

Insurance on a dependent becomes effective on the date when all of the following conditions have been met:

1. your insurance becomes effective;
2. the dependent meets all eligibility requirements; and
(3) for contributory insurance, you apply for dependent coverage on forms which are approved by us.

When will changes in your coverage amount be effective?

Requested changes in the amount of your contributory insurance are effective on the first day of the month following receipt of your request for a change. However, elections made during an enrollment period will not become effective prior to the effective date for that enrollment.

Premiums

When and how often are your premium contributions due?

Unless the policyholder and we have agreed to some other premium payment procedure, any premium contributions you are required to make for contributory insurance are to be paid by you to the policyholder on a periodic basis. Premium rates are subject to change in accordance with the group policy.

How is the premium determined?

The premium will be the applicable premium rate in force on the date premiums are due. The premium may also be computed by any other method on which the policyholder and we agree.

Premium rates are subject to change according to the provisions of the group policy.

Can a premium be paid after the date it is due?

Yes. The group policy has a 31-day grace period. If a premium is not paid on or before the date it is due, that premium may be paid during the 31-day period following the due date. The insurance under the group policy will remain in effect during the 31-day grace period.

Injury Benefits

Burn Benefit

If an insured sustains a second or third degree burn in a covered accident, we will pay the appropriate amount shown on the specifications page based on the type of burn and the percentage of the body surface burned.

The burn must be treated by a physician within 72 hours after the covered accident. If the burn meets more than one of the burn classifications shown on the specifications page, the amount we pay will be based on the burn classification that pays the highest benefit.

We will pay the burn benefit no more than one time per insured per covered accident. No benefits are payable for sunburns or first degree burns.

Child Organized Sports Injury

The child organized sports injury benefit is subject to the following conditions.

(1) the insured dependent child suffers an injury in a covered accident while participating in an organized sport; and
(2) a benefit is payable for the insured dependent child under another provision of the group policy for the same covered accident; and
(3) the insured dependent child has not attained 19 years of age and is insured on the date the covered accident occurs;

A child organized sport refers to a sport activity that is governed by an organization and requires formal registration to participate. Adult supervision of practice and competition is required. Proof of registration must be submitted with claims.

The child organized sports injury benefit amount is shown on the specifications page.

This benefit is limited to one payment per insured dependent child per calendar year.

Concussion

If an insured is injured in a covered accident and the injury causes a concussion, we will pay the amount shown on the specifications page. The insured must be treated by a physician within 72 hours of a covered accident and the concussion must be diagnosed by a physician within 15 days of the covered accident.

Concussion refers to a disruption of brain function resulting from a traumatic blow to the head.

This benefit is limited to one payment per insured per covered accident per calendar year.

The concussion benefit is not payable if a traumatic brain injury benefit is payable under this certificate for the same accident.

Dislocation

If a joint is dislocated in a covered accident, and it is diagnosed and treated by a physician within 90 days after the covered accident, we will pay the amount shown on the specifications page. The amount varies based on the joint that is dislocated, whether the dislocation is a full or a partial dislocation, and whether surgery is required to treat the dislocation.

A full dislocation refers to a completely separated joint due to a covered accident. A partial dislocation means the joint is misaligned but not completely dislocated, as diagnosed by a physician.

If more than one dislocation benefit is payable resulting from the same covered accident, we will pay the lesser of:
the total of the benefit amounts shown for each applicable dislocation on the specifications page; or
2 times the highest dislocation benefit that would otherwise be payable for any one of the dislocations involved.

**Eye Injury**

If an insured is injured in a covered accident and the injury results in an eye injury we will pay the amount shown on the specifications page. The insured must be diagnosed by a physician within 60 days of the covered accident. This benefit is limited to one payment per eye per insured per covered accident.

If a surgery benefit is also payable for the same injury, only one benefit is payable. The benefit payable will be the higher of the surgery benefit or the eye injury benefit.

**Fracture**

If a bone is fractured in a covered accident, and it is diagnosed and treated by a physician within 90 days after the covered accident, we will pay the amount shown on the specifications page. The amount varies based on the bone that is fractured, whether or not the fracture is a chip fracture, and whether surgery is required to treat the fracture.

Fracture refers to a break in a bone that can be seen by x-ray. A chip fracture is a fracture in which a small fragment of the bone is broken off.

If more than one fracture benefit is payable resulting from the same covered accident, we will pay the lesser of:

(1) the total of the benefit amounts shown for each applicable fracture on the specifications page; or
(2) 3 times the highest fracture benefit that would otherwise be payable for any one of the bones involved.

We will pay no more than one fracture benefit per bone, per covered accident per insured.

In no event will multiple fracture benefits be paid for the same fracture benefit shown on the specifications page unless it is a bi-lateral fracture. Bi-lateral fracture means the fracture of the same bone on both the left and right sides of the body.

**Lacerations**

If an insured is injured in a covered accident and the injury results in a laceration, we will pay the appropriate amount shown on the specifications page based on the type of treatment provided.

The laceration must be treated by a physician within 72 hours after the covered accident. This benefit is limited to one payment per insured per covered accident. In no event will we pay more than one laceration benefit per calendar year.

**Paralysis**

If an insured is injured in a covered accident and the injury causes paralysis which lasts more than 180 days we will pay the appropriate amount shown on the specifications page. Paralysis refers to the total, permanent, and irrevocable loss of movement. The paralysis must be diagnosed by a physician within 180 days after the accident.

The amount payable will be based on the the type of paralysis, as follows:

- **Quadriplegia** refers to paralysis of both upper limbs (from the shoulder down including total paralysis of both hands) and both lower limbs (from the waist down including total paralysis of both feet).
- **Paraplegia** refers to paralysis of both lower limbs (from the waist down including total paralysis of both feet).
- **Hemiplegia** refers to paralysis of both the upper limb (from the shoulder down including total paralysis of the hand) and lower limb (from the waist down including total paralysis of the foot) on one side of the body.
- **Uniplegia** refers to paralysis of one limb (from the shoulder down including total paralysis of the hand if claiming an upper limb and from the waist down including total paralysis of the foot if claiming a lower limb).

**Traumatic Brain Injury**

If an insured is injured in a covered accident and the injury results in a traumatic brain injury, we will pay the amount shown on the specifications page.

Traumatic brain injury means only the following: intracranial hemorrhage, cerebral contusion or cerebral laceration.

The insured must be treated by a physician within 72 hours after the covered accident. The traumatic brain injury must be diagnosed within 30 days after the accident by computer tomography (CT) scan or magnetic resonance imaging (MRI).

This benefit is payable only once per insured per covered accident. Scalp hematomas and scalp lacerations are not covered under this benefit.

**Emergency Care**

**Ambulance**

If an insured is injured in a covered accident and requires transportation to a hospital (or between hospitals) we will pay the appropriate ambulance benefit shown on the specifications page. Ground or water transportation must be provided by a licensed professional ambulance service within 90 days of the covered accident. Air transportation must be provided by a licensed professional ambulance service within 72 hours.
This benefit is limited to one payment per insured per covered accident. If an insured requires more than one ambulance transport, the highest benefit amount will be paid.

Ambulance means any publicly or privately owned surface, water or air vehicle, including a helicopter that is specifically designed and constructed or modified and equipped to be used, maintained or operated primarily for the transportation of individuals who are sick, injured or wounded.

Ambulance does not include a surface, water or air vehicle that is owned and operated to accommodate an incapacitated or disabled person who does not require medical monitoring, care or treatment during transport.

Blood, Plasma, Platelets or Other Non-Blood Substitute IV Solution Transfusion

If an insured is injured in a covered accident and requires a blood, plasma, platelets or other non-blood substitute IV solution transfusion, we will pay the blood/plasma/platelets/other non-blood substitute IV solution transfusion benefit shown on the specifications page. The transfusion must occur within 90 days of the covered accident. This benefit is limited to one payment per insured per covered accident.

Emergency Dental

If an insured has an injury to sound natural teeth as a result of a covered accident, we will pay the amount shown on the specifications page. A benefit is payable for a broken tooth which requires a crown, extraction or other dental work. The insured must be seen by a dentist within 60 days of the covered accident. The maximum number of benefits payable per insured per covered accident is two.

If a surgery benefit is also payable for the same injury, the benefit payable will be the higher of the surgery benefit or the emergency dental benefit.

Proof of the soundness of the injured tooth must be submitted with claims. Injuries resulting from biting or chewing are not covered under this benefit. Sound natural teeth are defined as teeth that are free of active or chronic clinical decay, have at least 50% bone support and are functional in the arch.

Emergency Room Treatment

If an insured is injured in a covered accident and requires treatment in an emergency room, we will pay the emergency room treatment benefit shown on the specifications page. Treatment must occur within 72 hours of the covered accident.

This benefit is limited to one payment per insured per covered accident.
The ICU daily benefit will be limited to a maximum of 15 days per insured per covered accident. The combination of the both ICU and non-ICU benefits will be limited to a cumulative maximum of 120 days per insured per covered accident.

If an insured is released from the hospital and subsequently requires treatment in a hospital for injuries sustained in the same covered accident, the subsequent treatment will be considered a continuation of the same hospital stay for purposes of determining the cumulative maximum daily benefit so long as the treatment occurs within two years of the date of the covered accident.

Intensive Care Unit (ICU) refers to a specifically designated part of a hospital that provides the highest level of medical care and is restricted to patients who are critically ill or injured and who require intensive comprehensive observation and care. Hospital Intensive Care Units must be:

(1) separate and apart from the surgical recovery room; and
(2) separate and apart from rooms, beds, and wards customarily used for patient confinement; and
(3) permanently equipped with special life-saving equipment to care for the critically ill or injured; and
(4) under constant and continuous observation by nursing staffs assigned to the Intensive Care Unit.

Surgery Benefits

If an insured is injured in a covered accident and requires surgery to treat the injury, we will pay the surgery benefit shown on the specifications page.

**Tier 1**
The tier 1 benefit is paid for abdominal, cranial, pelvic or thoracic surgeries. The surgery must be performed within 72 hours of the covered accident.

**Tier 2**
The tier 2 benefit covers all surgeries not included under tier 1.
The insured must be treated by a physician within 60 days of the covered accident and surgery must be performed within 180 days of the covered accident.

This benefit is limited to one benefit per tier per insured per covered accident.

Surgery required to treat a fracture or dislocation is payable under the fracture or dislocation benefit and is not covered under the surgery benefit.

Follow-Up Care

Adaptive Home and Vehicle Benefit

If an insured is injured in a covered accident and requires adaptive modifications to his or her primary residence or private vehicle to be made drivable or rideable, we will pay the adaptive home and vehicle benefit shown on the specifications page subject to the following conditions:

(1) a benefit is payable under the paralysis benefit of the Injury Benefits section of this certificate, or under the dismemberment benefit of the Accidental Death and Dismemberment Certificate Supplement; and
(2) the modification must take place within two years of the covered accident; and
(3) such home alterations are made by a person or persons with experience in such alterations and recommended by a recognized organization associated with the injury; and
(4) such vehicle modifications are carried out by a person or persons with experience in such matters and approved by the Motor Vehicle Department.

This benefit is limited to one payment per insured per covered accident.

Appliances

If an insured is injured in a covered accident and a medical appliance is prescribed by a physician for mobility, we will pay the appliance benefit shown on the specifications page. The order for the appliance must be placed within 180 days of the covered accident. This benefit is limited to payment for two covered appliances per insured per covered accident.

Covered appliances means only the following: crutches, canes, walkers, wheelchairs/scooters, leg braces and back braces. This benefit does not cover replacement appliances.

Follow-Up Physician’s Office Visit

If an insured is injured in a covered accident and follow-up care for the injury is ordered by the treating physician, we will pay the follow-up physician’s office visit benefit shown on the specifications page. The follow-up visit(s) must occur within 180 days of the covered accident. This benefit is limited to three payments per insured per covered accident. Follow-up at an urgent care center is not covered under this benefit.

Prosthetics

If an insured is injured in a covered accident and sustains the loss of a limb, hand, foot or sight in an eye, we will pay the prosthetic benefit shown on the specifications page,
subject to the following:

(1) this benefit is limited to payment for two prosthetic devices per insured per covered accident; and
(2) the prosthetic device(s) must be prescribed by a physician and ordered within 180 days after the covered accident.

Prosthetic device refers to an artificial device that replaces a missing limb, hand, foot or an eye. For purposes of this benefit, the term prosthetic device does not include corrective lenses or other cosmetic prostheses.

In addition, this benefit does not provide coverage for damaged prosthetics; more than one prosthetic device for the same limb, hand, foot or eye; the replacement of a prosthetic device; or a joint replacement.

Transportation

If an insured receives follow-up treatment ordered by a physician for an injury sustained in a covered accident and is required to travel more than 100 miles (one way) from the insured’s primary residence to a hospital or other treatment facility, we will pay the transportation benefit shown on the specifications page subject to the following:

(1) a benefit is payable under this certificate for the same injury; and
(2) the follow-up treatment is ordered by a physician and is not available within 100 miles (one way) of the insured’s primary residence; and
(3) the Ambulance benefit is not payable for the same trip.

Mileage is measured from the insured’s primary residence to the hospital or treatment facility where the follow-up treatment is provided.

This benefit is limited to two payments per insured per covered accident.

Support Care

Adult Companion Lodging

If an insured is injured in a covered accident, we will pay the adult companion lodging benefit shown on the specifications page for each day the insured is receiving treatment in a hospital or rehabilitative facility for the injury, and for the 24 hours following the last day the insured is receiving treatment in a hospital or rehabilitative facility for the injury subject to the following conditions:

(1) a companion who accompanies the insured stays in lodging for which a charge is made; and
(2) either the hospital stay benefit or rehabilitative therapy (inpatient) benefit is payable for the same day the adult companion lodging benefit is payable; and
(3) the companion is 18 or older.

Exclusions and Limitations

Are there any other exclusions that apply?

Yes. In no event will we pay benefits where the insured’s accident, injury or loss is caused directly by any of the following:

(1) intentionally self-inflicted injury while sane; or
(2) suicide or attempted suicide, while sane; or
(3) your participation in a felony; or
(4) alcoholism; or
(5) drug addiction; or
(6) poisons, gases, fumes or other substances taken, absorbed, inhaled, ingested or injected; or
(7) motor vehicle collision or accident where you are the operator of the motor vehicle and your blood alcohol level meets or exceeds the level at which intoxication is defined in the state where the collision or accident occurred, regardless of any legal proceedings thereto; or
(8) war or any act of war, whether declared or undeclared; or
(9) bodily or mental infirmity, illness or disease; or
(10) infection, other than infection occurring simultaneously with, and as a direct and independent result of, the injury; or
(11) repetitive stress syndromes including but not limited to rotator cuff syndrome, bursitis, tendonitis, carpal tunnel syndrome, ulnar nerve syndrome, stress fractures, neuropathy, epicondylitis or neuritis; or
(12) medical or surgical treatment or diagnostic procedures including any resulting complications, or when the outcome is not as planned or expected, including claims of medical malpractice; or
(13) aviation, except as a fare-paying passenger; or
(14) participation in the following activities: scuba diving where the depth exceeds 60 feet, scuba diving where the insured is not scuba certified regardless of depth, bungee jumping, base jumping, hang gliding, sail gliding, parasailing, parakiting, technical mountain climbing involving the use of ropes or other equipment, or rock climbing regardless of equipment used; or
(15) riding or driving in any motor-driven vehicle in a race, stunt show or speed test; or
(16) practicing for or participating in any semi-professional or professional competitive athletics.
Are there any additional limitations that apply?

Yes. Benefits are not payable for any care, treatment or diagnostic measures which were received outside of the United States or United States territory.

Claims

What notice of claim must be provided?

Written notice of claim must be given to us within 20 days of the date of a loss resulting from a covered accident, or as soon thereafter as reasonably possible. Notice given by or on the insured’s behalf to us at our home office or to any authorized agent of ours, with information to identify the insured, shall be deemed notice to us.

Will claim forms be provided?

Upon receipt of notice of claim, we will provide a claim form. If the claim form is not provided within 15 days after the insured has given notice of claim, we will deem the insured to have complied with the requirements for filing proof of a loss resulting from a covered accident if the insured submits, within the time period for filing proof of the loss, written proof of the occurrence, character and extent of the loss for which claim is made which is satisfactory to us.

When is proof of a loss resulting from a covered accident required?

Written proof of a loss resulting from a covered accident satisfactory to us must be provided to us within 90 days of the date of the loss. Failure to provide proof of the loss within this time will not invalidate or reduce a claim if it was not reasonably possible to provide proof within this 90 day period. However, proof must be provided within 1 year of the date of the loss, except in the absence of legal capacity.

When will the benefit be paid?

We will pay a benefit for a loss resulting from a covered accident within 60 days after receipt at our home office of written proof of the loss which meets all policy requirements and is satisfactory to us. You are responsible for all costs associated with claim form(s) completion, records, and the submission of your claim.

To whom will benefits be paid?

All benefits including dependent’s benefits will be paid to you, if you are living. If you die before the claim is paid, benefits will be paid to your estate.

What are our physical examination rights?

After an insured has filed a claim and provided at his or her expense all requested claim forms and records, we have the right to have the insured examined by a physician of our choice and at our expense. This right may be exercised as often as reasonably necessary while an insured has a claim pending with us.

Termination

When does your coverage terminate?

Coverage ends on the earliest of the following:

1. the date you no longer meet the eligibility requirements;
2. 31 days (the grace period) after the due date of any premium which is not paid;
3. the last day for which premium contributions have been paid following your request to cancel your coverage;
4. the date the group policy ends.

When does an insured dependent’s coverage terminate?

An insured dependent’s coverage ends on the earliest of the following:

1. the date the dependent no longer meets the eligibility requirements;
2. 31 days (the grace period) after the due date of any premium contribution which is not paid;
3. the last day for which premium contributions have been paid following your written request that insurance on your eligible dependents be terminated;
4. the date you are no longer covered under the group policy.

You must notify us or your employer when you no longer have dependents eligible for coverage under this certificate so that premiums may be discontinued. All premiums paid for dependents who are no longer eligible for coverage under this certificate will be refunded without any payment of claim.

Additional Information

Can your insurance coverage be contested?

Yes. If an insured experiences a loss resulting from a covered accident within two years of the original effective date of coverage or increase in coverage, we will verify the accuracy of the information provided during the application process. If we discover a material misrepresentation, the affected coverage will be rescinded and an otherwise valid claim will be denied.

Is the policyholder required to maintain records?

Yes. The policyholder is required to maintain adequate records of any information necessary for us to administer the policy, and shall provide access to such records when required for us to administer the policy. If a clerical error is made in keeping records on the insurance under the group policy, it will not affect otherwise valid insurance.
A clerical error does not continue insurance which is otherwise stopped, make insurance effective when it should not have been or change the benefit amount provided by the provisions of the policy and no claim shall be paid on amounts affected by a clerical error. If an error causes a change in premium payment, a fair adjustment will be made.

**Will the provisions of this certificate conform with applicable state law?**

Yes. If any provision in this certificate, or in the provisions of the group policy, is in conflict with the applicable laws of the state governing the certificates or the group policy, the provision will be deemed to be amended to conform to such laws.

**What if an insured’s age has been misstated?**

If an insured’s age has been misstated, all amounts payable will be adjusted to that amount which the premium would have purchased at the correct age. This will be determined by applying the ratio of the paid premium over the required premium to the initial benefit amount.

**Can this insurance be assigned?**

No. Insurance coverage under the group policy cannot be assigned.
General Information

This certificate supplement is subject to every term, condition, exclusion, limitation and provision of the certificate unless otherwise expressly provided for herein.

What does this supplement provide?

This supplement provides for continuation of insurance if an insured no longer meets the eligibility requirements of the certificate, except as provided for herein.

To continue insurance the insured must make a written request and make the first premium payment within 31 days after insurance provided by the group policy would otherwise terminate. Coverage provided by this supplement will then be deemed effective retroactive to the beginning of the 31-day period. This date is considered to be the insured’s portability date and the insured is then considered to have portability status.

Who is eligible to continue insurance under this supplement?

An insured employee is eligible to continue group accident insurance under the terms of this supplement if he or she no longer meets the eligibility requirements of the certificate due to any of the following:

(1) the employee terminates employment, including retirement; or
(2) the employee is no longer in a class eligible for insurance or is on a leave or layoff; or
(3) a class or group of employees insured under the policy are no longer considered eligible and there is no successor plan for that class or group. Successor plan means an insurance policy or policies provided by us or another insurer that replaces insurance provided under this policy.

Regardless of whether an insured is otherwise eligible under this supplement to continue, an insured will not be eligible to request coverage under this supplement if he or she:

(1) has attained the age of 70; or
(2) is an employee and was not actively at work due to sickness or injury on the date immediately preceding his or her portability date; or
(3) loses eligibility due to a class or group of employees no longer being eligible under the policy and there is a successor plan for that class or group of employees; or
(4) loses eligibility due to termination of the group policy.

What insurance can be continued under this supplement?

Group accident insurance may be continued under this supplement. If an employee elects to continue his or her own coverage according to the provisions of this supplement, he or she may also elect to continue insurance for any other individual insured under his or her certificate.

What benefit amounts can be continued under this supplement?

The benefit amounts that can be continued under this supplement shall be the amounts shown on the specifications page applicable to the insured based on the benefit plan selected by the insured employee.

Can an insured request a change in the benefit plan continued under this supplement?

Yes. The insured employee may change the benefit plan to one that provides lower benefit amounts, but may not change the benefit plan to one that provides higher benefit amounts.

How will premiums be paid?

Premiums will be paid directly to us on a monthly, quarterly, semi-annual, or annual basis and will be subject to an administrative charge per billing period.

Can the premium rate change?

Yes. The premium rates for ported coverage may be different than the premium rates for active employees, and are not subject to the premium rate provision of the policy.

What happens if an insured again becomes eligible under the certificate?

If an insured is continuing coverage under the terms of this supplement, and again meets the eligibility requirements of the certificate the insured shall no longer be considered to have portability status. Insurance may be continued only under the terms of the certificate, not including this supplement, unless and until the insured no longer meets the eligibility requirements of the certificate and again returns to portability status as provided for herein.

What happens to insurance provided under this supplement when the group policy terminates?

Any insurance continued under the terms of this supplement will remain in force until terminated by the provisions of the section entitled “When will insurance continued under this supplement terminate?”
No individual may elect coverage under this supplement on or after the date of termination of the group policy.

**When will insurance continued under this supplement terminate?**

An insured's insurance being continued under this supplement will terminate on the earliest of the following:

1. the insured’s 70th birthday;
2. the date the insured again meets the eligibility requirements of the certificate, not including the terms of this supplement;
3. in the case of a dependent child or a spouse, the date your coverage is no longer being continued under this supplement or the date the spouse or child ceases to be eligible as defined under the terms of your certificate; or
4. the date the group policy is terminated; or
5. 31 days after the due date of any premium contribution which is not made.

_Signed:_  
Secretary  
President
SUMMARY OF THE 1996 NEW HAMPSHIRE LIFE AND
HEALTH INSURANCE GUARANTY ASSOCIATION ACT (RSA 408-B)
AND NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS

Residents of New Hampshire who purchase life insurance, health insurance and annuities should know that the insurance companies licensed in New Hampshire to write these types of insurance are members of the New Hampshire 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 policy obligations. If this should happen, the Association will assess its other member insurance companies for the money to pay the covered claims of policyholders who live in New Hampshire and, in some cases, to keep coverage in force. This protection is not a substitute for consumers’ care in selecting companies that are well-managed and financially stable. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however, as noted below.

IMPORTANT DISCLAIMER

The New Hampshire Life and Health Insurance Guaranty Association 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 New Hampshire. Other conditions may preclude coverage.

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 Association to induce you to purchase any kind of insurance policy.

This information is provided by:

New Hampshire Life and Health Insurance Guaranty Association
10 Chestnut Drive, Unit B
Bedford, NH 03110
(603) 472-3734

New Hampshire Department of Insurance
21 South Fruit Street, Suite 14
Concord, NH 03301
(603) 271-2261

SUMMARY

The 1996 state law that provides for this safety-net coverage is called the New Hampshire Life and Health Insurance Guaranty Association Act. Below is a brief summary of this law’s coverage, 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 Association.

(Please Turn to Back of Page)
COVERAGE

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

Coverage provided under this Act may be different from coverage provided prior to 1996, as coverage is determined by the governing Act in effect on the date the Association becomes obligated.

EXCLUSIONS FROM COVERAGE

Persons holding such policies or contracts are NOT protected by this Association if:

- they are not residents of the State of New Hampshire, except under certain very specific circumstances;
- they are eligible for protection under the laws of another state;
- their policy was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or any entity that operates on an assessment basis, an insurance exchange, or any entity similar to any of the above.

The Association also does NOT provide coverage for:

- any policy or portion of a policy or contract not guaranteed by the insurer or under which the risk is borne by the policyholder or contractholder;
- any policy or contract of reinsurance, unless assumption certificates have been issued;
- interest rate guarantees that exceed certain statutory limitations;
- any plan or program of an employer, association, or similar entity to provide life, health, or annuity benefits to its employees or members to the extent that the plan or program is self-funded or uninsured, including, but not limited to, benefits payable by an employer, association, or similar entity;
- dividends, experience rating credits, or fees for services in connection with this policy;
- any policy or contract issued in this state by an insurer at a time when it was not licensed or authorized to do business in New Hampshire.
- any unallocated annuity contract issued to an employee benefit plan protected under the federal Pension Benefit Guaranty Corporation; and
- any portion of any unallocated annuity contract which is not issued to or in connection with a specific employee, union, or association of natural persons benefit plan or a government lottery;
- any portion of a policy or contract to the extent that the required assessments are preempted by federal or state law.

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Association is obligated to pay. The Association cannot pay more than what the insurance company would owe under a policy or contract.

With respect to any one life, the Association will pay a maximum of $300,000 -- no matter how many policies and contracts there were with the same company, even if they provided different types of coverages, except with respect to benefits for basic hospital, medical surgical insurance and major medical insurance in which case the aggregate liability of the Association shall not exceed $500,000 with respect to any one individual. For life insurance benefits the Association will not pay more than $300,000 in life insurance death benefits and will not pay more than $100,000 in net cash surrender or withdrawal values. For health insurance benefits the Association will not pay more than $100,000 in health insurance benefits not defined as liability insurance or basic hospital, medical and surgical insurance or long-term care insurance, $300,000 in disability coverage, $300,000 in long-term care benefits, and $500,000 for basic hospital, medical and surgical insurance or major medical insurance. For annuity benefits the Association will not pay more than $250,000 in present value of annuity benefits, including net cash surrender or withdrawal values.

The limit of coverage to one owner of multiple non-group policies of life insurance is $5,000,000.

With respect to any one contractholder of an unallocated annuity contract, not including a governmental retirement plan established under sections 401, 403(b), or 457 of the U. S. Internal Revenue Code, the Association will pay a maximum of $5,000,000 in benefits, irrespective of the number of such contracts held by that contractholder.

ADDITIONAL INFORMATION

Policyholders should contact the New Hampshire Insurance Department with questions they may have with regard to concerns about their rights under the Act and procedures for filing a complaint to allege a violation of the Act.

Policyholders may contact the New Hampshire Insurance Department for sources of information about the financial condition of insurers.
Important Notice
Securian Life Insurance Company
400 Robert Street North • St. Paul, Minnesota 55101-2098

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

PROBLEMS WITH YOUR INSURANCE? - If you are having problems with your insurance company or agent, do not hesitate to contact the insurance company or agent to resolve your problem.

SECURIAN LIFE INSURANCE COMPANY
400 ROBERT STREET NORTH
ST PAUL MN 55101-2098
(651) 665-3500

You can also contact the NEW HAMPSHIRE INSURANCE DEPARTMENT, a state agency which enforces New Hampshire's insurance laws, and file a complaint. Assistance is available by writing to:

NEW HAMPSHIRE INSURANCE DEPARTMENT
CONSUMER DIVISION
21 SOUTH FRUIT STREET, SUITE 14
CONCORD NH 03301-7317
PHONE: 1-800-852-3416 or 1-603-271-2261
FAX: 1-603-271-1406
This is a Limited Certificate – Read It Carefully

Securian Life Insurance Company • A Stock Company
400 Robert Street North • St. Paul, Minnesota 55101-2098
877-491-5265 • www.securian.com

GROUP ACCIDENT ONLY CERTIFICATE OF INSURANCE
Read Your Certificate Carefully

If you meet the eligibility and enrollment requirements herein, you are insured under the group policy shown on the specifications page. This certificate summarizes the principal provisions of the group policy that affect you. The provisions summarized in this certificate are subject in every respect to the group policy. You may examine the group policy at the principal office of the policyholder during regular working hours.

Legal Actions

No legal action may be brought to recover on this certificate within the first sixty days after written proof of loss has been given as required by this certificate. No such action may be brought after three years from the time written proof of loss is required to be given.

Secretary

President

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GROUP ACCIDENT CERTIFICATE OF INSURANCE
GENERAL INFORMATION

POLICYHOLDER: Concordia Plan Services

POLICY NUMBER: 76013

ASSOCIATED COMPANIES: All subsidiaries and affiliates reported to Securian Life by the policyholder for inclusion in the policy.

POLICY SITUS: The policy was issued and delivered in Missouri.

POLICY EFFECTIVE DATE: January 1, 2019.

This certificate and/or certificate specifications page replaces any and all certificates and/or certificate specifications pages previously issued to you under the group policy. Please replace any certificate and/or certificate specifications page previously issued to you with this new certificate and/or specifications page.

GROUP:
The group is composed of all active employees of the policyholder and its associated companies working in the United States in the following classes:

Class 1: Active employees working at least 20 hours per week.

All new employees of the employer will be added to such group and classes for which they become eligible.

NO DOUBLE COVERAGE:
A person cannot be covered under more than one class. A person cannot be covered as both an active employee and a retiree. Any person who is eligible as an employee or retiree under the policy, is not eligible as a dependent. Only one person can insure an eligible dependent child.

ENROLLMENT PERIOD: 90 days from the first day of eligibility for contributory insurance.

WAITING PERIOD: None

MINIMUM HOURS PER WEEK REQUIREMENT: 20 hours per week

PLAN OF INSURANCE

EMPLOYEE BENEFIT SCHEDULE

EMPLOYEE GROUP ACCIDENT INSURANCE:

Supplemental Group Accident Insurance

<table>
<thead>
<tr>
<th>Eligible Class</th>
<th>Employee Supplemental Group Accident Insurance Benefit Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class 1</td>
<td>Low or High Plan as elected by the employee</td>
</tr>
</tbody>
</table>
GENERAL PROVISIONS FOR EMPLOYEE INSURANCE

RETIREMENT REDUCTIONS: All insurance terminates at retirement, except as otherwise provided for under any applicable certificate supplement.

CONTRIBUTORY/NONCONTRIBUTORY: Supplemental insurance is contributory insurance.

DEPENDENT BENEFIT SCHEDULE

An employee must be insured in order to elect dependent group accident insurance.

SPOUSE GROUP ACCIDENT INSURANCE

Supplemental Group Accident Insurance

<table>
<thead>
<tr>
<th>Eligible Class</th>
<th>Spouse Supplemental Group Accident Insurance Benefit Plans</th>
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</thead>
<tbody>
<tr>
<td>Class 1</td>
<td>Spouse benefit plan will match the employee’s Supplemental Group Accident Benefit Plan.</td>
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CHILD GROUP ACCIDENT INSURANCE

Supplemental Group Accident Insurance

<table>
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<th>Eligible Class</th>
<th>Child Supplemental Group Accident Insurance Benefit Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class 1</td>
<td>Child benefit plan will match the employee’s supplemental Group Accident Benefit Plan.</td>
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</tbody>
</table>

GENERAL PROVISIONS FOR DEPENDENT INSURANCE

CONTRIBUTORY/NONCONTRIBUTORY: Supplemental insurance is contributory insurance.

COVERED BENEFITS

Refer to the Injury Benefits, Emergency Care, Hospital Care, Surgery Benefits, and Follow-up Care and Support Care sections of the Certificate for additional benefit details.

<table>
<thead>
<tr>
<th>INJURY BENEFITS</th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burn Benefit</td>
<td></td>
<td></td>
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<tr>
<td>2nd degree burns</td>
<td></td>
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<tr>
<td>Less than 10% of the body</td>
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<td>$300</td>
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<tr>
<td>Between 10% and 20% of the body</td>
<td>$250</td>
<td>$750</td>
</tr>
<tr>
<td>20% or more of the body</td>
<td>$500</td>
<td>$1,500</td>
</tr>
<tr>
<td>3rd degree burns</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 10% of the body</td>
<td>$1,000</td>
<td>$3,000</td>
</tr>
<tr>
<td>Between 10% and 20% of the body</td>
<td>$2,500</td>
<td>$7,500</td>
</tr>
<tr>
<td>20% or more of the body</td>
<td>$5,000</td>
<td>$15,000</td>
</tr>
<tr>
<td>Child Organized Sports Injury</td>
<td>$50</td>
<td>$100</td>
</tr>
<tr>
<td>Concussion</td>
<td>$100</td>
<td>$200</td>
</tr>
<tr>
<td>Injury Type</td>
<td>Low Plan</td>
<td>High Plan</td>
</tr>
<tr>
<td>-------------</td>
<td>----------</td>
<td>-----------</td>
</tr>
<tr>
<td><strong>Dislocation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Principal Amount (Surgical)</td>
<td>$2,000</td>
<td>$5,000</td>
</tr>
<tr>
<td>% of Principal Amount</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hip/Thigh</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Foot</td>
<td>40%</td>
<td>40%</td>
</tr>
<tr>
<td>Ankle</td>
<td>40%</td>
<td>40%</td>
</tr>
<tr>
<td>Knee</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Hand or wrist (excluding fingers)</td>
<td>Hand: 20%</td>
<td>Hand: 20%</td>
</tr>
<tr>
<td></td>
<td>Wrist: 30%</td>
<td>Wrist: 30%</td>
</tr>
<tr>
<td>Lower jaw</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Shoulder</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Collarbone</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Ribs</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Toe</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Elbow</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Non-surgical</td>
<td>50% of surgical benefit</td>
<td>50% of surgical benefit</td>
</tr>
<tr>
<td>Partial dislocation</td>
<td>25% of non-surgical benefit</td>
<td>25% of non-surgical benefit</td>
</tr>
<tr>
<td><strong>Eye Injury - with Surgery</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$120</td>
<td>$300</td>
</tr>
<tr>
<td><strong>Eye Injury – Removal of Foreign Object without Surgery</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$30</td>
<td>$75</td>
</tr>
<tr>
<td><strong>Fracture</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Principal Amount (Surgical)</td>
<td>$2000</td>
<td>$5,000</td>
</tr>
<tr>
<td>% of Principal Amount</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hip/Thigh</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Vertebral body</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Vertebral processes</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Pelvis</td>
<td>75%</td>
<td>75%</td>
</tr>
<tr>
<td>Sternum</td>
<td>75%</td>
<td>75%</td>
</tr>
<tr>
<td>Coccyx</td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td>Skull – non depressed</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Skull – depressed</td>
<td>150%</td>
<td>150%</td>
</tr>
<tr>
<td>Lower leg</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Foot</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Ankle</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Kneecap</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Upper arm</td>
<td>35%</td>
<td>35%</td>
</tr>
<tr>
<td>Facial excluding lower jaw</td>
<td>35%</td>
<td>35%</td>
</tr>
<tr>
<td>Forearm</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Hand or wrist (except fingers)</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Lower jaw</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Shoulder blade</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Collarbone</td>
<td>15%</td>
<td>15%</td>
</tr>
<tr>
<td>Ribs</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Finger</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Toe</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Nose</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Non-surgical</td>
<td>50% of surgical benefit</td>
<td>50% of surgical benefit</td>
</tr>
<tr>
<td>Chip fracture</td>
<td>25% of non-surgical benefit</td>
<td>25% of non-surgical benefit</td>
</tr>
<tr>
<td><strong>Lacerations</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>With stitches or staples</td>
<td>$100</td>
<td>$500</td>
</tr>
<tr>
<td>Without stitches or staples</td>
<td>25% of benefit provided with stitches or staples</td>
<td>25% of benefit provided with stitches or staples</td>
</tr>
<tr>
<td>INJURY BENEFITS</td>
<td>LOW PLAN</td>
<td>HIGH PLAN</td>
</tr>
<tr>
<td>-----------------</td>
<td>----------</td>
<td>-----------</td>
</tr>
<tr>
<td>Paralysis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Principal Amount</td>
<td>$20,000</td>
<td>$60,000</td>
</tr>
<tr>
<td>% of Principal Amount</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Quadruplegia</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Paraplegia</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Hemiplegia</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Uniplegia</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Traumatic Brain Injury</td>
<td>$200</td>
<td>$400</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EMERGENCY CARE</th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ground or water</td>
<td>$100</td>
<td>$200</td>
</tr>
<tr>
<td>Air</td>
<td>$500</td>
<td>$1,000</td>
</tr>
<tr>
<td>Blood, Plasma or Platelets Transfusion</td>
<td>$300</td>
<td>$600</td>
</tr>
<tr>
<td>Emergency Dental</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crown</td>
<td>$150</td>
<td>$300</td>
</tr>
<tr>
<td>Extraction</td>
<td>$50</td>
<td>$100</td>
</tr>
<tr>
<td>Emergency Room Treatment</td>
<td>$100</td>
<td>$300</td>
</tr>
<tr>
<td>Initial Physician’s Office Visit</td>
<td>$50</td>
<td>$100</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HOSPITAL CARE</th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Stay</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initial benefit, non-ICU</td>
<td>$400</td>
<td>$1,200</td>
</tr>
<tr>
<td>Initial benefit, ICU</td>
<td>$800</td>
<td>$2,400</td>
</tr>
<tr>
<td>Daily benefit, non-ICU</td>
<td>$100</td>
<td>$300</td>
</tr>
<tr>
<td>Daily benefit, ICU</td>
<td>$200</td>
<td>$600</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SURGERY</th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal or Pelvic Surgery</td>
<td>$1,000</td>
<td>$2,000</td>
</tr>
<tr>
<td>Cranial Surgery</td>
<td>$1,000</td>
<td>$2,000</td>
</tr>
<tr>
<td>Knee Cartilage Surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Open</td>
<td>$500</td>
<td>$1,000</td>
</tr>
<tr>
<td>Arthroscopic</td>
<td>$250</td>
<td>$500</td>
</tr>
<tr>
<td>Ruptured Disc Surgery</td>
<td>$500</td>
<td>$1,000</td>
</tr>
<tr>
<td>Tendon, Ligament or Rotator Cuff Surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Open</td>
<td>$500</td>
<td>$1,000</td>
</tr>
</tbody>
</table>
### SURGERY

<table>
<thead>
<tr>
<th></th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arthroscopic</td>
<td>$250</td>
<td>$500</td>
</tr>
<tr>
<td>Thoracic Surgery</td>
<td>$1,000</td>
<td>$2,000</td>
</tr>
</tbody>
</table>

### FOLLOW-UP CARE

<table>
<thead>
<tr>
<th></th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adaptive Home and Vehicle Benefit</td>
<td>$500</td>
<td>$1,000</td>
</tr>
<tr>
<td>Appliances</td>
<td>$50</td>
<td>$250</td>
</tr>
<tr>
<td>Follow-Up Physician’s Office Visit</td>
<td>$50</td>
<td>$100</td>
</tr>
<tr>
<td>Prosthetics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>One prosthetic</td>
<td>$500</td>
<td>$1,000</td>
</tr>
<tr>
<td>Two or more prosthetics</td>
<td>2x one prosthetic</td>
<td>2x one prosthetic</td>
</tr>
<tr>
<td>Transportation</td>
<td>$200 per visit</td>
<td>$500 per visit</td>
</tr>
</tbody>
</table>

### SUPPORT CARE

<table>
<thead>
<tr>
<th></th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Companion Lodging</td>
<td>$75 per day</td>
<td>$150 per day</td>
</tr>
</tbody>
</table>

### ADDITIONAL INFORMATION

#### ANNUAL OPEN ENROLLMENTS:

During the policyholder’s annual open enrollment an employee may elect or change employee and dependent accident insurance benefit plans. Coverage will be effective on the January 1 following the annual enrollment, subject to the actively at work requirement for employees and the hospitalization/non-confinement provision for dependents (this does not apply to a newborn child).

#### Special Enrollment Periods:

Upon mutual agreement between the Policyholder and Securian, one or more special enrollment periods may be offered to eligible employees. These special enrollment periods (if offered) will be in addition to the annual enrollment opportunities described above. In the event that a special enrollment period is offered, the details of the special enrollment, including enrollment dates, allowed changes, and evidence of insurability requirements, will be communicated to you in advance of the special enrollment period and documented in the group policy on file with the policyholder and Securian.

#### QUALIFIED STATUS CHANGES:

An employee who experiences a Qualified Status Changes as defined below may elect or change employee and dependent accident insurance benefit plans provided enrollment is made within 60 days of the status change.

- An active employee may elect accident insurance for the first time or increase coverage from the low plan to the high plan.
- An active employee may elect dependent coverage.

Coverage will be effective on the date of the election. All increases are subject to the actively at work requirement for employees and the hospitalization/non-confinement provision for dependents (this does not apply to a newborn child).

A qualified status change for the purpose of waiving the evidence of insurability requirement means marriage, birth or adoption.
Definitions

Any use in this certificate of a term defined in this section is to be given the meaning defined in this section unless otherwise defined in another provision of this certificate.

accident
An act or event which is:

(1) unintended, unexpected and unforeseen; and
(2) directly results in bodily injury to the insured.

application
Your application or enrollment for insurance under the group policy.

associated company
Any company which is a subsidiary or affiliate of the policyholder which is designated by the policyholder and agreed to by us to participate under the group policy.

child or children
Your or your spouse’s natural, adopted, stepchild or foster child who is less than 26 years old. An adopted child includes a child legally placed for adoption with you. Eligibility begins at live birth (stillborn or unborn children are not eligible). Children age 26 or older are also eligible so long as they are physically or mentally incapable of self-support, were incapable of self-support prior to age 26 and remain financially dependent on you for more than one-half of their support and maintenance.

dependent
Your children or spouse.

If both parents of a child qualify as eligible employees under the group policy, the child shall be considered a dependent of only one parent for purposes of this certificate. If any child qualifies as an eligible employee under the group policy, he or she is not eligible to be insured as a dependent child.

covered accident
An accident which:

(1) is not excluded under the Exclusions and Limitations section or any other terms of this certificate; and
(2) occurs while the insured’s coverage is in force; and
(3) occurs in the United States or a United States territory.

contributory insurance
Insurance for which you are required to make premium contributions.

emergency room
A department of a hospital or a satellite emergency center that is designated for persons requiring immediate medical care. This area must be staffed and equipped to handle trauma, be supervised and provide treatment by physicians, and provide care seven days per week, 24 hours per day.

A satellite emergency center is a licensed facility providing outpatient care under the direction of a licensed physician on a 24-hour basis. Available services must include:

(1) diagnostic care, including laboratory services and diagnostic x-rays; and
(2) treatment or medical care, including availability of the means for stabilization of emergency medical conditions.

A satellite emergency center does not include a hospital or an office maintained by a licensed physician for the practice of medicine or dentistry.

employee
An individual who is employed by the policyholder or by an associated company. A sole proprietor will be considered the employee of the proprietorship. A partner in a partnership will be considered an employee so long as the partner’s principal work is the conduct of the partnership’s business. The term employee does not include temporary employees nor corporate directors who are not otherwise employees.

employer
The policyholder or any designated associated companies.

family member
A parent, spouse, child, sibling, grandparent, aunt, uncle, first cousin, niece or nephew. This includes adopted, in-law and step relatives.

hospital
A short-term, acute care general facility that:

(1) is legally licensed and operated as a hospital;
(2) provides overnight care of injured and sick people;
(3) requires that every patient be supervised by a physician;
(4) provides 24 hour nursing service by or under the supervision of a registered nurse;
(5) has on-site or pre-arranged use of x-ray equipment, laboratory, and surgical facilities; and
(6) maintains permanent medical history records.

A hospital is not a rehabilitation center, nursing home, rest home, extended-care facility, convalescent home, a place for alcoholics or drug addicts or a mental institution, even if such facilities are affiliated with or joined to a hospital.
injury or injuries
A bodily injury which is sustained as a direct result of a covered accident.

insured
An employee, spouse or child covered for insurance under this certificate.

noncontributory insurance
Insurance for which you are not required to make premium contributions.

non-work day
A day on which you are not regularly scheduled to work, including scheduled time off for vacations, personal holidays, weekends and holidays, and approved leaves of absence for non-medical reasons.

Non-work day does not include time off for medical leave of absence, temporary layoff, employer suspension of operations in total or in part, strike, and any time off due to sickness or injury including sick days, short-term disability, or long term disability.

physician
A medical doctor or other person recognized by law or regulation in the United States or United States territory where services are rendered as a physician. The person must be licensed as required by the United States jurisdiction where care is given and must be operating in the scope of his or her license.

A physician cannot be a person who:

(1) ordinarily resides in your household; or
(2) is a family member.

policyholder
The owner of the group policy as shown on the specifications page.

specifications page
The summary of the plan specifics available under the group policy.

spouse
Your legally married spouse or civil union partner as recognized under the laws of the jurisdiction of celebration.

Spouse does not include any person who is eligible as an employee.

surgery
Medical treatment in which a physician cuts into someone’s body in order to repair or remove damaged parts as a result of a covered accident. The surgery must be performed solely because of injuries sustained in a covered accident.

urgent care center
A health care facility that is separate from a hospital or a separate unit within a hospital and whose primary purpose is the offering and provision of immediate, short term medical care, without appointment, for urgent care.

we, our, us
Securian Life Insurance Company.

you, your, certificate holder
An insured employee.

General Information

What is your agreement with us?
If you meet the eligibility and enrollment requirements, you are insured under the group policy shown on the specifications page. Your application is deemed a part of this certificate. This certificate summarizes the principal provisions of the group policy that affect your insurance coverage. The provisions summarized in this certificate are subject in every respect to the group policy.

Any statements made in your application will, in the absence of fraud, be considered representations and not warranties. Also, any statement made will not be used to void your insurance nor defend against a claim unless the statement is contained in the application.

Can this certificate be amended?
Yes. We retain the right to amend this certificate at any time without your consent. Any amendment will be without prejudice to any claim incurred for benefits prior to the date of the amendment.

Who is eligible for insurance?
You are eligible for group accident insurance if you:

(1) are a member of the eligible group and of an eligible class as defined on the specifications page; and
(2) work for the employer for at least the number of hours per week shown as the minimum hours per week requirement on the specifications page; and
(3) have satisfied the waiting period as shown on the specifications page; and
(4) meet the actively at work requirement described in the “What is the actively at work requirement?” provision of this section.
Are your dependents eligible for insurance?

Yes. If you are insured for group accident coverage, your dependents are eligible for insurance.

Are employees of associated companies eligible for insurance under the group policy?

Yes. Employees of associated companies may be eligible for insurance under the group policy. The policyholder represents any associated company in all transactions pertaining to the group policy. The policyholder’s acts or omissions and every notice given by us to the policyholder shall be binding on every associated company. When an associated company ceases its participation under the policy, the policy shall be considered to be terminated for all employees of the associated company. All provisions related to policy termination will apply to such employees.

What is the actively at work requirement?

To be eligible to become insured or to receive an increase in the benefit amount, you must be actively at work, fully performing your customary duties for your regularly scheduled number of hours at the employer’s normal place of business, or at other places the employer’s business requires you to travel.

If you are not working due to illness or injury, you do not meet the actively at work requirement. If you are receiving sick pay, short-term disability benefits or long-term disability benefits, you do not meet the actively at work requirement.

If you are not actively at work on the date coverage would otherwise begin, or on the date an increase in your benefit amount would otherwise be effective, you will not be eligible for the coverage or increase until you return to active work. However, if the absence is on a non-work day, coverage will not be delayed provided you were actively at work on the work day immediately preceding the non-work day.

Except as otherwise provided for in this certificate, you are eligible to continue to be insured only while you remain actively at work.

Any insurance or increase in insurance which is elected or put in force while you are not actively at work will not be eligible for claim payment. You or your beneficiary will receive a refund of premium for any contributory insurance for which you were not eligible.

What is the dependent non-confinement requirement?

If a dependent is hospitalized or confined because of illness or disease on the date his or her insurance would otherwise become effective, his or her effective date shall be delayed until he or she is released from such hospitalization or confinement. This does not apply to a newborn child.

In no event will insurance on a dependent be effective before your insurance is effective.

Can your coverage be continued during sickness, injury, leave of absence or temporary layoff?

Yes. Insurance may be continued on an insured employee who is not actively at work due to sickness, injury, leave of absence or temporary layoff, subject to the employer’s practices and procedures, including the employer’s limits on the length of continuation allowed for the type of absence. Continuation is contingent upon continued premium payment.

Coverage during a leave of absence and upon return from a leave of absence shall meet all state and federal requirements.

Enrollment

When can you elect or make changes to your insurance?

You must enroll in order to be insured for contributory coverage under the group policy. You can enroll for coverage within 90 days of when you first become eligible. After that period, you can only enroll for coverage or make changes during your annual open enrollment or within 60 days of a qualified status change event, as defined by the state and federal rules and regulations.

When does your insurance become effective?

Your insurance becomes effective on the date all of the following conditions have been met:

(1) you meet all eligibility requirements, including the actively at work requirement; and
(2) for contributory coverage, application is made in accordance with the application methods agreed upon by the policyholder and us.

When does insurance for a dependent become effective?

Insurance on a dependent becomes effective on the date when all of the following conditions have been met:

(1) your insurance becomes effective;
(2) the dependent meets all eligibility requirements; and
(3) for contributory insurance, you apply for dependent coverage on forms which are approved by us.

When will changes in your coverage amount be effective?

Requested changes in the amount of your contributory insurance are effective on the first day of the month following receipt of your request for a change.
However, elections made during an enrollment period will not become effective prior to the effective date for that enrollment.

## Premiums

**When and how often are your premium contributions due?**

Unless the policyholder and we have agreed to some other premium payment procedure, any premium contributions you are required to make for contributory insurance are to be paid by you to the policyholder on a periodic basis. Premium rates are subject to change in accordance with the group policy.

**How is the premium determined?**

The premium will be the applicable premium rate in force on the date premiums are due. The premium may also be computed by any other method on which the policyholder and we agree.

Premium rates are subject to change according to the provisions of the group policy.

**Can a premium be paid after the date it is due?**

Yes. The group policy has a 31-day grace period. If a premium is not paid on or before the date it is due, that premium may be paid during the 31-day period following the due date. The insurance under the group policy will remain in effect during the 31-day grace period.

## Injury Benefits

### Burn Benefit

If an insured sustains a second or third degree burn in a covered accident, we will pay the appropriate amount shown on the specifications page based on the type of burn and the percentage of the body surface burned.

The burn must be treated by a physician within 72 hours after the covered accident. If the burn meets more than one of the burn classifications shown on the specifications page, the amount we pay will be based on the burn classification that pays the highest benefit.

We will pay the burn benefit no more than one time per insured per covered accident. No benefits are payable for sunburns or first degree burns.

### Child Organized Sports Injury

The child organized sports injury benefit is subject to the following conditions.

1. the insured dependent child suffers an injury in a covered accident while participating in an organized sport; and

2. a benefit is payable for the insured dependent child under another provision of the group policy for the same covered accident; and

3. the insured dependent child has not attained 19 years of age and is insured on the date the covered accident occurs;

A child organized sport refers to a sport activity that is governed by an organization and requires formal registration to participate. Adult supervision of practice and competition is required. Proof of registration must be submitted with claims.

The child organized sports injury benefit amount is shown on the specifications page.

This benefit is limited to one payment per insured dependent child per calendar year.

### Concussion

If an insured is injured in a covered accident and the injury causes a concussion, we will pay the amount shown on the specifications page. The insured must be treated by a physician within 72 hours of a covered accident and the concussion must be diagnosed by a physician within 15 days of the covered accident.

Concussion refers to a disruption of brain function resulting from a traumatic blow to the head.

This benefit is limited to one payment per insured per covered accident per calendar year.

The concussion benefit is not payable if a traumatic brain injury benefit is payable under this certificate for the same accident.

### Dislocation

If a joint is dislocated in a covered accident, and it is diagnosed and treated by a physician within 90 days after the covered accident, we will pay the amount shown on the specifications page. The amount varies based on the joint that is dislocated, whether the dislocation is a full or a partial dislocation, and whether surgery is required to treat the dislocation.

A full dislocation refers to a completely separated joint due to a covered accident. A partial dislocation means the joint is misaligned but not completely dislocated, as diagnosed by a physician.

If more than one dislocation benefit is payable resulting from the same covered accident, we will pay the lesser of:

1. the total of the benefit amounts shown for each applicable dislocation on the specifications page; or

2. 2 times the highest dislocation benefit that would otherwise be payable for any one of the dislocations involved.
Eye Injury – with Surgery

If an insured is injured in a covered accident and the injury results in an eye injury that requires surgery, we will pay the amount shown on the specifications page. The insured must be seen by a physician within 60 days of the covered accident and surgery must be performed within 180 days of the covered accident. This benefit is limited to one payment per eye per insured per covered accident.

Eye Injury – Removal of Foreign Object without Surgery

If an insured is injured in a covered accident and the injury results in an eye injury that requires removal of a foreign object, but does not require surgery, we will pay the amount shown on the specifications page. The insured must be seen by a physician within 60 days of the covered accident and removal of the foreign object must be performed within 180 days of the covered accident. This benefit is limited to one payment per eye per insured per covered accident.

Fracture

If a bone is fractured in a covered accident, and it is diagnosed and treated by a physician within 90 days after the covered accident, we will pay the amount shown on the specifications page. The amount varies based on the bone that is fractured, whether or not the fracture is a chip fracture, and whether surgery is required to treat the fracture.

Fracture refers to a break in a bone that can be seen by x-ray. A chip fracture is a fracture in which a small fragment of the bone is broken off.

If more than one fracture benefit is payable resulting from the same covered accident, we will pay the lesser of:

1. the total of the benefit amounts shown for each applicable fracture on the specifications page; or
2. 3 times the highest fracture benefit that would otherwise be payable for any one of the bones involved.

We will pay no more than one fracture benefit per bone, per covered accident per insured. In no event will multiple fracture benefits be paid for the same fracture shown on the specifications page unless it is a bi-lateral fracture. Bi-lateral fracture means the fracture of the same bone on both the left and right sides of the body.

Lacerations

If an insured is injured in a covered accident and the injury results in a laceration, we will pay the appropriate amount shown on the specifications page based on the type of treatment provided.

The laceration must be treated by a physician within 72 hours after the covered accident. This benefit is limited to one payment per insured per covered accident. In no event will we pay more than one laceration benefit per calendar year.

Paralysis

If an insured is injured in a covered accident and the injury causes paralysis which lasts more than 180 days we will pay the appropriate amount shown on the specifications page. Paralysis refers to the total, permanent, and irrevocable loss of movement. The paralysis must be diagnosed by a physician within 180 days after the accident.

The amount payable will be based on the type of paralysis, as follows:

Quadriplegia refers to paralysis of both upper limbs (from the shoulder down including total paralysis of both hands) and both lower limbs (from the waist down including total paralysis of both feet).

Paraplegia refers to paralysis of both lower limbs (from the waist down including total paralysis of both feet).

Hemiplegia refers to paralysis of both the upper limb (from the shoulder down including total paralysis of both hands) and lower limb (from the waist down including total paralysis of the foot) on one side of the body.

Uniplegia refers to paralysis of one limb (from the shoulder down including total paralysis of the hand if claiming an upper limb and from the waist down including total paralysis of the foot if claiming a lower limb).

We will pay no more than one paralysis benefit per covered accident per insured. In the event that an insured qualifies under multiple types of paralysis, the highest benefit amount will be paid.

Traumatic Brain Injury

If an insured is injured in a covered accident and the injury results in a traumatic brain injury, we will pay the amount shown on the specifications page.

Traumatic brain injury means only the following: intracranial hemorrhage, cerebral contusion or cerebral laceration.

The insured must be treated by a physician within 72 hours after the covered accident. The traumatic brain injury must be diagnosed within 30 days after the accident by computer tomography (CT) scan or magnetic resonance imaging (MRI). This benefit is payable only once per insured per covered accident. Scalp hematomas and scalp lacerations are not covered under this benefit.

Emergency Care

Ambulance

If an insured is injured in a covered accident and requires transportation to a hospital (or between hospitals)
we will pay the appropriate ambulance benefit shown on
the specifications page. Ground or water transportation
must be provided by a licensed professional ambulance
service within 90 days of the covered accident. Air
transportation must be provided by a licensed professional
ambulance service within 72 hours. This benefit is limited
to one payment per insured per covered accident.
If an insured requires more than one ambulance transport,
the highest benefit amount will be paid.

Ambulance means any publicly or privately owned
surface, water or air vehicle, including a helicopter that is
specifically designed and constructed or modified and
equipped to be used, maintained or operated primarily for
the transportation of individuals who are sick, injured or
wounded.

Ambulance does not include a surface, water or air vehicle
that is owned and operated to accommodate an
incapacitated or disabled person who does not require
medical monitoring, care or treatment during transport.

Blood, Plasma or Platelets Transfusion

If an insured is injured in a covered accident and requires
a blood, plasma or platelets transfusion, we will pay the
blood/plasma/platelets transfusion benefit shown on the
specifications page. The transfusion must occur within 90
days of the covered accident. This benefit is limited to one
payment per insured per covered accident.

Emergency Dental

If an insured has an injury to sound natural teeth as a
result of a covered accident, we will pay the appropriate
emergency dental benefit shown on the specifications
page. A benefit is payable for a broken tooth repaired with
crown(s) or a broken tooth requiring extraction. Treatment
must occur within 60 days of the covered accident. The
maximum number of crown benefits payable per insured
per covered accident is two. The maximum number of
extraction benefits payable per insured per covered
accident is two.

Proof of the soundness of the injured tooth must be
submitted with claims. Injuries resulting from biting or
chewing are not covered under this benefit.

Sound natural teeth are defined as teeth that are free of
active or chronic clinical decay, have at least 50% bone
support and are functional in the arch.

Emergency Room Treatment

If an insured is injured in a covered accident and requires
treatment in an emergency room, we will pay the
emergency room treatment benefit shown on the
specifications page. Treatment must occur within 72
hours of the covered accident.

This benefit is limited to one payment per insured per
covered accident.

Initial Physician’s Office Visit

If an insured is injured in a covered accident, we will pay
the initial physician’s office visit benefit shown on the
specifications page. Benefits are payable for the initial treatment received in a
physician’s office or an urgent care center for injuries
resulting from a covered accident. Treatment must occur
within 72 hours of the covered accident. The maximum
number of benefits per insured per calendar year is two.
The benefit is not payable if the insured receives care in
an emergency room within the same 72 hour period. Only
one benefit is payable per covered accident.

Hospital Care

Hospital Stay

If an insured is injured in a covered accident and requires
treatment in a hospital for the injury within 180 days of a
covered accident, we will pay the hospital stay benefit
shown on the specifications page subject to the following.

Initial Benefit

We will pay the initial benefit shown on the
specifications page for the first day of a hospital stay
provided the insured is receiving treatment for a
covered accident in the hospital for a minimum of 18
continuous hours.

The benefit payment will be based on the type of room
and level of care the insured receives. The Intensive
Care Unit (ICU) benefit is payable if the insured is
receiving treatment in an ICU room of a hospital. The
non-ICU benefit is payable if the insured is receiving
treatment in a non-ICU room.

This benefit is limited to one payment per insured per
covered accident. In the event the insured receives
treatment in both a non-ICU and an ICU room, the
higher benefit will be payable as an initial benefit.

Daily Benefit

If an initial benefit is payable, the insured will also
receive a daily benefit for each day he or she is
treated in the hospital, including the first day.
The amount payable for the daily benefit is shown on
the specifications page.

The daily benefit payment will be based on the type of
room and level of care the insured receives. The ICU
benefit is payable if the insured is receiving treatment
in an ICU room of a hospital. The non-ICU benefit is
payable if the insured is receiving treatment in a non-
ICU room.
The ICU daily benefit will be limited to a maximum of 15 days per insured per covered accident. The combination of the both ICU and non-ICU benefits will be limited to a cumulative maximum of 120 days per insured per covered accident.

If an insured is released from the hospital and subsequently requires treatment in a hospital for injuries sustained in the same covered accident, the subsequent treatment will be considered a continuation of the same hospital stay for purposes of determining the cumulative maximum daily benefit so long as the treatment occurs within two years of the date of the covered accident.

Intensive Care Unit (ICU) refers to a specifically designated part of a hospital that provides the highest level of medical care and is restricted to patients who are critically ill or injured and who require intensive comprehensive observation and care. Hospital Intensive Care Units must be:

1. separate and apart from the surgical recovery room; and
2. separate and apart from rooms, beds, and wards customarily used for patient confinement; and
3. permanently equipped with special life-saving equipment to care for the critically ill or injured; and
4. under constant and continuous observation by nursing staffs assigned to the Intensive Care Unit.

**Surgery Benefits**

**Abdominal or Pelvic Surgery**

If an insured is injured in a covered accident and requires abdominal or pelvic surgery to treat the injuries, we will pay the abdominal or pelvic surgery benefit shown on the specifications page. The surgery must be performed within 72 hours of the covered accident. This benefit is limited to one payment per insured per covered accident. Surgery required to treat a fracture or dislocation is payable under the fracture or dislocation benefit and is not covered under the abdominal or pelvic surgery benefit.

**Cranial Surgery**

If an insured is injured in a covered accident and requires cranial surgery to treat the injuries, we will pay the cranial surgery benefit shown on the specifications page. The surgery must be performed within 72 hours of the covered accident. This benefit is limited to one payment per insured per covered accident. Surgery required to treat a skull fracture is payable under the fracture benefit and is not covered under the cranial surgery benefit.

**Knee Cartilage Surgery**

If an insured is injured in a covered accident and requires knee cartilage surgery to treat the injury, we will pay the knee cartilage surgery benefit shown on the specifications page. The insured must be treated by a physician within 60 days of the covered accident and surgery must be performed within 180 days of the covered accident. This benefit is limited to one payment per insured per covered accident. If both open and arthroscopic surgeries are required for the same injury, only the open benefit will be paid.

**Ruptured Disc Surgery**

If an insured is injured in a covered accident and requires surgery for one or more ruptured discs to treat the injury, we will pay the ruptured disc surgery benefit shown on the specifications page. The insured must be treated by a physician within 60 days of the covered accident and surgery must be performed within 180 days of the covered accident. This benefit is limited to one payment per insured per covered accident.

**Tendon, Ligament or Rotator Cuff Surgery**

If an insured is injured in a covered accident and requires tendon, ligament or rotator cuff surgery to treat the injuries, we will pay the tendon, ligament or rotator cuff surgery benefit shown on the specifications page. The insured must be treated by a physician within 60 days of the covered accident and surgery must be performed within 180 days of the covered accident. This benefit is limited to one payment per insured per covered accident. If both open and arthroscopic surgeries are required, only the open benefit will be paid.

**Thoracic Surgery**

If an insured is injured in a covered accident and requires thoracic surgery to treat the injuries, we will pay the thoracic surgery benefit shown on the specifications page. The surgery must be performed within 72 hours of the covered accident. This benefit is limited to one payment per insured per covered accident. Surgery required to treat a fracture or dislocation is payable under the fracture or dislocation benefit and is not covered under the thoracic surgery benefit.

**Follow-Up Care**

**Adaptive Home and Vehicle Benefit**

If an insured is injured in a covered accident and requires adaptive modifications to his or her primary residence or private vehicle to be made drivable or rideable, we will pay the adaptive home and vehicle benefit shown on the specifications page subject to the following conditions:
(1) a benefit is payable under the paralysis benefit of the Injury Benefits section of this certificate; and
(2) the modification must take place within two years of the covered accident; and
(3) such home alterations are made by a person or persons with experience in such alterations and recommended by a recognized organization associated with the injury; and
(4) such vehicle modifications are carried out by a person or persons with experience in such matters and approved by the Motor Vehicle Department.

This benefit is limited to one payment per insured per covered accident.

**Appliances**

If an insured is injured in a covered accident and a medical appliance is prescribed by a physician for mobility, we will pay the appliance benefit shown on the specifications page. The order for the appliance must be placed within 180 days of the covered accident. This benefit is limited to payment for two covered appliances per insured per covered accident.

Covered appliances means only the following: crutches, canes, walkers, wheelchairs/scooters, leg braces and back braces. This benefit does not cover replacement appliances.

**Follow-Up Physician’s Office Visit**

If an insured is injured in a covered accident and follow-up care for the injury is ordered by the treating physician, we will pay the follow-up physician’s office visit benefit shown on the specifications page. The follow-up visit(s) must occur within 180 days of the covered accident. This benefit is limited to three payments per insured per covered accident. Follow-up at an urgent care center is not covered under this benefit.

**Prosthetics**

If an insured is injured in a covered accident and sustains the loss of a limb, hand, foot or sight in an eye, we will pay the prosthetic benefit shown on the specifications page, subject to the following:

(1) this benefit is limited to payment for two prosthetic devices per insured per covered accident; and
(2) the prosthetic device(s) must be prescribed by a physician and ordered within 180 days after the covered accident.

Prosthetic device refers to an artificial device that replaces a missing limb, hand, foot or an eye. For purposes of this benefit, the term prosthetic device does not include corrective lenses or other cosmetic prostheses.

In addition, this benefit does not provide coverage for damaged prosthetics; more than one prosthetic device for the same limb, hand, foot or eye; the replacement of a prosthetic device; or a joint replacement.

**Transportation**

If an insured receives follow-up treatment ordered by a physician for an injury sustained in a covered accident and is required to travel more than 100 miles (one way) from the insured’s primary residence to a hospital or other treatment facility, we will pay the transportation benefit shown on the specifications page subject to the following:

(1) a benefit is payable under this certificate for the same injury; and
(2) the follow-up treatment is ordered by a physician and is not available within 100 miles (one way) of the insured’s primary residence; and
(3) the Ambulance benefit is not payable for the same trip.

Mileage is measured from the insured’s primary residence to the hospital or treatment facility where the follow-up treatment is provided.

This benefit is limited to two payments per insured per covered accident.

**Support Care**

**Adult Companion Lodging**

If an insured is injured in a covered accident, we will pay the adult companion lodging benefit shown on the specifications page for each day the insured is receiving treatment in a hospital or rehabilitative facility for the injury, and for the 24 hours following the last day the insured is receiving treatment in a hospital or rehabilitative facility for the injury subject to the following conditions:

(1) a companion who accompanies the insured stays in lodging for which a charge is made; and
(2) either the hospital stay benefit or rehabilitative therapy (inpatient) benefit is payable for the same day the adult companion lodging benefit is payable; and
(3) the companion is 18 or older.

Lodging refers to an establishment licensed under the laws applicable to where it is located, such as a motel, hotel, or other facility that provides sleeping accommodations to the general public in exchange for a fee and is located at least 100 miles from the insured’s primary residence.

This benefit is limited to 30 days per covered accident. Proof must be provided that the companion incurred an expense for staying at a lodging.
Exclusions and Limitations

Are there any other exclusions that apply?

Yes. In no event will we pay benefits where the insured’s accident, injury or loss is caused directly or indirectly by, results in whole or in part from or during, or there is contribution from, any of the following:

1. intentionally self-inflicted injury while sane; or
2. suicide or attempted suicide, while sane; or
3. your participation in, or your attempt to commit, a crime, assault, felony, or any illegal activity, regardless of any legal proceedings thereto; or
4. the use of alcohol; or
5. the use of prescription drugs (unless taken upon the advice of a licensed physician in the verifiable prescribed manner and dosage), non-prescription drugs, illegal drugs, medications, poisons, gases, fumes or other substances taken, absorbed, inhaled, ingested or injected; or
6. motor vehicle collision or accident where you are the operator of the motor vehicle and your blood alcohol level meets or exceeds the level at which intoxication is defined in the state where the collision or accident occurred, regardless of any legal proceedings thereto; or
7. war or any act of war, whether declared or undeclared; or
8. bodily or mental infirmity, illness or disease; or
9. infection, other than pyogenic infection occurring simultaneously with, and as a direct and independent result of, the injury, and other than bacterial infection due to accidental ingestion of a contaminated substance; or
10. repetitive stress syndromes including but not limited to rotator cuff syndrome, bursitis, tendonitis, carpal tunnel syndrome, ulnar nerve syndrome, stress fractures, neuropathy, epicondylitis or neuritis; or
11. medical or surgical treatment or diagnostic procedures including any resulting complications, or when the outcome is not as planned or expected, including claims of medical malpractice; or
12. travel in or descent from any aircraft, except as a fare-paying passenger on a regularly scheduled commercial flight on a licensed passenger aircraft carrier; or
13. participation in the following activities: scuba diving, bungee jumping, base jumping, hang gliding, sail gliding, parasailing, parakiting, or mountain climbing; or
14. riding or driving in any motor-driven vehicle in a race, stunt show or speed test; or
15. practicing for or participating in any semi-professional or professional competitive athletics.

Are there any additional limitations that apply?

Yes. Benefits are not payable for any care, treatment or diagnostic measures which were received outside of the United States or United States territory.

Claims

What notice of claim must be provided?

Written notice of claim must be given to us within 20 days of the date of a loss resulting from a covered accident, or as soon thereafter as reasonably possible.

Notice given by or on the insured’s behalf to us at our home office or to any authorized agent of ours, with information to identify the insured, shall be deemed notice to us.

Will claim forms be provided?

Upon receipt of notice of claim, we will provide a claim form. If the claim form is not provided within 15 days after the insured has given notice of claim, we will deem the insured to have complied with the requirements for filing proof of a loss resulting from a covered accident if the insured submits, within the time period for filing proof of the loss, written proof of the occurrence, character and extent of the loss for which claim is made which is satisfactory to us.

When is proof of a loss resulting from a covered accident required?

Written proof of a loss resulting from a covered accident satisfactory to us must be provided to us within 90 days of the date of the loss. Failure to provide proof of the loss within this time will not invalidate or reduce a claim if it was not reasonably possible to provide proof within this 90 day period. However, proof must be provided within 1 year of the date of the loss, except in the absence of legal capacity.

When will the benefit be paid?

We will pay a benefit for a loss resulting from a covered accident after receipt at our home office of written proof of the loss which meets all policy requirements and is satisfactory to us. You are responsible for all costs associated with claim form(s) completion, records, and the submission of your claim.

To whom will benefits be paid?

All benefits including dependent’s benefits will be paid to you, if you are living. If you die before the claim is paid, benefits will be paid to your estate.

What are our physical examination rights?

After an insured has filed a claim and provided at his or her expense all requested claim forms and records,
we have the right to have the insured examined by a physician of our choice and at our expense. This right may be exercised as often as reasonably necessary while an insured has a claim pending with us.

**Termination**

**When does your coverage terminate?**

Coverage ends on the earliest of the following:

1. the date you no longer meet the eligibility requirements; or
2. 31 days (the grace period) after the due date of any premium which is not paid; or
3. the last day for which premium contributions have been paid following your request to cancel your coverage; or
4. the date the group policy ends.

**When does an insured dependent's coverage terminate?**

An insured dependent's coverage ends on the earliest of the following:

1. the date the dependent no longer meets the eligibility requirements; or
2. 31 days (the grace period) after the due date of any premium contribution which is not paid; or
3. the last day for which premium contributions have been paid following your written request that insurance on your eligible dependents be terminated; or
4. the date you are no longer covered under the group policy.

You must notify us or your employer when you no longer have dependents eligible for coverage under this certificate so that premiums may be discontinued. All premiums paid for dependents who are no longer eligible for coverage under this certificate will be refunded without any payment of claim.

**Additional Information**

**Can your insurance coverage be contested?**

Yes. If an insured experiences a loss resulting from a covered accident within two years of the original effective date of coverage or increase in coverage, we will verify the accuracy of the information provided during the application process. If we discover a material misrepresentation, the affected coverage will be rescinded and an otherwise valid claim will be denied. This two year period will be extended by fraud or as otherwise allowed by applicable laws.

**Is the policyholder required to maintain records?**

Yes. The policyholder is required to maintain adequate records of any information necessary for us to administer the policy, and shall provide access to such records when required for us to administer the policy. If a clerical error is made in keeping records on the insurance under the group policy, it will not affect otherwise valid insurance.

A clerical error does not continue insurance which is otherwise stopped, make insurance effective when it should not have been or change the benefit amount provided by the provisions of the policy and no claim shall be paid on amounts affected by a clerical error. If an error causes a change in premium payment, a fair adjustment will be made.

**Will the provisions of this certificate conform with applicable state law?**

Yes. If any provision in this certificate, or in the provisions of the group policy, is in conflict with the applicable laws of the state governing the certificates or the group policy, the provision will be deemed to be amended to conform to such laws.

**What if an insured's age has been misstated?**

If an insured’s age has been misstated, all amounts payable will be adjusted to that amount which the premium would have purchased at the correct age. This will be determined by applying the ratio of the paid premium over the required premium to the initial benefit amount.

**Can this insurance be assigned?**

No. Insurance coverage under the group policy cannot be assigned.

**What is the policy interpretation right and authority?**

The following applies only when the administration of the policy is governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. 1001 et seq.:

Securian Life has the exclusive right and authority, in its sole discretion, to interpret the group policy and decide all matters arising thereunder. Securian Life's exercise of that authority shall be conclusive and binding on all persons unless it can be shown that the determination was arbitrary and capricious.
This Certificate Endorsement is a part of the certificate of insurance describing the benefits available to you under Group Policy No. 76013, issued by Securian Life Insurance Company to Concordia Plan Services. This endorsement is subject to every term, condition, exclusion and provision of the certificate unless otherwise expressly provided for herein.

The following applies to you if you were a resident of the state of Vermont at the time your coverage under this certificate became effective:

1. The definition of child or children under the Definitions section of the certificate is amended in its entirety and replaced with the following:

   child or children

   Your or your spouse/civil union partner’s natural, adopted, stepchild or foster child who is less than 26 years old. An adopted child includes a child legally placed for adoption with you. Eligibility begins at live birth (stillborn or unborn children are not eligible).

   Coverage for a child who reaches the limiting age does not terminate while the child continues to be both (1) incapable of self-sustaining employment by reason of a physical handicap or an intellectual disability; and (2) dependent on you for support and maintenance.

2. The definition of hospital under the Definitions section of the certificate is amended in its entirety and replaced with the following:

   hospital

   A short-term, acute care general facility that:

   (1) is legally licensed and operated as a hospital;
   (2) provides overnight care of injured and sick people;
   (3) requires that every patient be supervised by a physician;
   (4) provides 24 hour nursing service by or under the supervision of a registered nurse;
   (5) has on-site or pre-arranged use of x-ray equipment, laboratory, and surgical facilities; and
   (6) maintains permanent medical history records.

   A hospital is not a rehabilitation center, nursing home, rest home, extended-care facility, or convalescent home, even if such facilities are affiliated with or adjoined to a hospital.

3. The provision entitled What is your agreement with us? under the General Information section of the certificate is amended in its entirety and replaced with the following:

   What is your agreement with us?

   If you meet the eligibility and enrollment requirements, you are insured under the group policy shown on the specifications page. Your application is deemed a part of this certificate. This certificate summarizes the principal provisions of the group policy that affect your insurance coverage. The provisions summarized in this certificate are subject in every respect to the group policy.

   Any statements made in your application will, in the absence of fraud, be considered representations and not warranties. Also, any statement made will not be used to void your insurance nor defend against a claim unless the statement is contained in your signed application, and a copy containing the statement is furnished to you, your beneficiary, or your or your beneficiary’s personal representative.
4. The provision entitled **Are there any other exclusions that apply?** under the **Exclusions and Limitations** section of the certificate is amended in its entirety and replaced with the following:

**Are there any other exclusions that apply?**

Yes. In no event will we pay benefits where the insured’s accident, injury or loss is caused by, results from or during, or there is contribution from, any of the following:

1. intentionally self-inflicted injury; or
2. suicide or attempted suicide; or
3. your participation in a felony; or
4. motor vehicle collision or accident where you are the operator of the motor vehicle and your blood alcohol level meets or exceeds the level at which intoxication is defined in the state where the collision or accident occurred, regardless of any legal proceedings thereto; or
5. war or any act of war, whether declared or undeclared; or
6. bodily or mental infirmity, illness or disease; or
7. infection, other than infection occurring simultaneously with, and as a direct and independent result of, the injury; or
8. repetitive stress syndromes including but not limited to rotator cuff syndrome, bursitis, tendonitis, carpal tunnel syndrome, ulnar nerve syndrome, stress fractures, neuropathy, epicondylitis or neuritis; or
9. medical or surgical treatment or diagnostic procedures including any resulting complications, or when the outcome is not as planned or expected, including claims of medical malpractice; or
10. aviation; or
11. participation in the following activities: scuba diving, bungee jumping, base jumping, hang gliding, sail gliding, parasailing, parakiting, or mountain climbing; or
12. riding or driving in any motor-driven vehicle in a race, stunt show or speed test; or
13. practicing for or participating in any semi-professional or professional competitive athletics.

5. The provision entitled **When will the benefit be paid?** under the **Claims** section of the certificate is amended in its entirety and replaced with the following:

**When will the benefit be paid?**

We will pay a benefit for a loss resulting from a covered accident immediately after receipt at our home office of written proof of the loss which meets all policy requirements and is satisfactory to us. You are responsible for all costs associated with claim form(s) completion, records, and the submission of your claim.

6. The provision entitled **When does your coverage terminate?** under the **Termination** section of the certificate is amended in its entirety and replaced with the following:

**When does your coverage terminate?**

Coverage ends on the earliest of the following:

1. the date you no longer meet the eligibility requirements; or
2. 31 days (the grace period) after the due date of any premium which is not paid; or
3. the last day for which premium contributions have been paid following your request to cancel your coverage; or
4. the date the group policy ends.

If you are hospitalized on the date the group policy terminates, termination will not impact the daily benefit for the duration of the hospitalization. If you are totally disabled on the date the group policy terminates, your coverage will remain in effect for 90 days after the termination date.

7. The provision entitled **When does an insured dependent’s coverage terminate?** under the **Termination** section of the certificate is amended in its entirety and replaced with the following:

**When does an insured dependent’s coverage terminate?**

An insured dependent’s coverage ends on the earliest of the following:
(1) the last day for which premium contributions have been paid following the date we are notified the dependent no longer meets the eligibility requirements; or
(2) 31 days (the grace period) after the due date of any premium contribution which is not paid; or
(3) the last day for which premium contributions have been paid following your written request that insurance on your eligible dependents be terminated; or
(4) the date you are no longer covered under the group policy.

You must notify us or your employer when you no longer have dependents eligible for coverage under this certificate so that premiums may be discontinued.

8. The provision entitled Can your insurance coverage be contested? under the Additional Information section of the certificate is amended in its entirety and replaced with the following:

Can your insurance coverage be contested?

Yes. If an insured experiences a loss resulting from a covered accident within three years of the original effective date of coverage or increase in coverage, we will verify the accuracy of the information provided during the application process. If we discover a material misrepresentation, the affected coverage will be rescinded and an otherwise valid claim will be denied. This three year period will be extended by fraud or as otherwise allowed by applicable laws.

9. The provision entitled What is the policy interpretation right and authority? under the Additional Information section of the certificate is deleted in its entirety.
VERMONT MANDATORY CIVIL UNIONS ENDORSEMENT

PURPOSE:
Vermont law requires that health insurers offer coverage to parties to a civil union that is equivalent to coverage provided to married persons. This endorsement is part of and amends this policy, contract or certificate to comply with Vermont law.

DEFINITIONS, TERMS, CONDITIONS AND PROVISIONS:
The definitions, terms, conditions or any other provisions of the policy, contract, certificate and/or riders and endorsements to which this mandatory endorsement is attached are hereby amended and superseded as follows:

Terms that mean or refer to a marital relationship, or that may be construed to mean or refer to a marital relationship, such as "marriage", "spouse", "husband", "wife", "dependent", "next of kin", "relative", "beneficiary", "survivor", "immediate family" and any other such terms include the relationship created by a civil union established according to Vermont law.

Terms that mean or refer to the inception or dissolution of a marriage, such as "date of marriage", "divorce decree", "termination of marriage" and any other such terms include the inception or dissolution of a civil union established according to Vermont law.

Terms that mean or refer to family relationships arising from a marriage such as "family", "immediate family", "dependent", "children", "next of kin", "relative", "beneficiary", "survivor" and any other such terms include the family relationships created by a civil union established according to Vermont law.

"Dependent" means a spouse, a party to a civil union established according to Vermont law, and a child or children (natural, stepchild, legally adopted or a minor or disabled child who is dependent on the insured for support and maintenance) who is born to or brought to a marriage or to a civil union established according to Vermont law.

"Child or covered child" means a child (natural, stepchild, legally adopted or a minor or disabled child who is dependent on the insured for support and maintenance) who is born to or brought to a marriage or to a civil union established according to Vermont law.

CAUTION: FEDERAL LAW RIGHTS MAY OR MAY NOT BE AVAILABLE
Vermont law grants parties to a civil union the same benefits, protections and responsibilities that flow from marriage under state law. However, some or all of the benefits, protections and responsibilities related to health insurance that are available to married persons under federal law may not be available to parties to a civil union. For example, federal law, the Employee Income Retirement Security Act of 1974 known as "ERISA", controls the employer/employee relationship with regard to determining eligibility for enrollment in private employer health benefit plans. Because of ERISA, Act 91 does not state requirements pertaining to a private employer's enrollment of a party to a civil union in an ERISA employee welfare benefit plan. However, governmental employers (not federal government) are required to provide health benefits to the dependents of a party to a civil union if the public employer provides health benefits to the dependents of married persons. Federal law also controls group health insurance continuation rights under "COBRA" for employers with 20 or more employees as well as the Internal Revenue Code treatment of health insurance premiums. As a result, parties to a civil union and their families may or may not have access to certain benefits under this policy, contract, certificate, rider or endorsement that derive from federal law. You are advised to seek expert advice to determine your rights under this contract.

Secretary

President
VERMONT LIFE INSURANCE
MANDATORY CIVIL UNION ENDORSEMENT

PURPOSE:
This endorsement is part of the policy, contract, certificate and/or riders and endorsements to which it is attached and is intended to provide benefits for parties to a civil union. Vermont law requires that insurance contracts and policies offered to married persons and their families be made available to parties to a civil union and their families. In order to receive benefits in accordance with this endorsement, the civil union must have been established in the state of Vermont according to Vermont law.

GENERAL DEFINITIONS, TERMS, CONDITIONS AND PROVISIONS:
The general definitions, terms, conditions or any other provisions of the policy, contract, certificate and/or riders and endorsements to which this mandatory endorsement is attached are hereby amended and superseded as follows:

Terms that mean or refer to a marital relationship or that may be construed to mean or refer to a marital relationship: such as "marriage", "spouse", "husband", "wife", "dependent", "next of kin", "relative", "beneficiary", "survivor", "immediate family" and any other such terms include the relationship created by a civil union.

Terms that mean or refer to a family relationship arising from a marriage such as "family", "immediate family", "dependent", "children", "next of kin", "relative", "beneficiary", "survivor" and any other such terms include the family relationship created by a civil union.

Terms that mean or refer to the inception or dissolution of a marriage, such as "date of marriage", "divorce decree", "termination of marriage" and any other such terms include the inception or dissolution of a civil union.

"Dependent" means a spouse, a party to a civil union, and/or child or children (natural, stepchild, legally adopted or a minor who is dependent on the insured for support and maintenance) who is born to or brought to a marriage or to a civil union.

"Child or covered child" means a child (natural, stepchild, legally adopted or a minor who is dependent on the insured for support and maintenance) who is born to or brought to a marriage or to a civil union.

CAUTIONARY DISCLOSURE:
THIS ENDORSEMENT IS ISSUED TO MEET THE REQUIREMENTS OF VERMONT LAW AS EXPLAINED IN THE "PURPOSE" PARAGRAPH OF THE ENDORSEMENT. THE FEDERAL GOVERNMENT OR ANOTHER STATE GOVERNMENT MAY NOT RECOGNIZE THE BENEFITS GRANTED UNDER THIS ENDORSEMENT. YOU ARE ADVISED TO SEEK EXPERT ADVICE TO DETERMINE YOUR RIGHTS UNDER THIS CONTRACT.

Secretary

President
**IMPORTANT INFORMATION ABOUT THE COVERAGE YOU ARE BEING OFFERED**

Save this statement! It may be important to you in the future. The Washington State Insurance Commissioner requires that we give you the following information about fixed payment benefits.

This coverage is not comprehensive health care insurance and will not cover the cost of most hospital and other medical services.

This disclosure provides a very brief description of the important features of the coverage being considered. It is not an insurance contract and only the actual policy provisions will control. The policy itself will include in detail the rights and obligations of both the master policyholder and Securian Life Insurance Company.

This coverage is designed to pay you a fixed dollar amount regardless of the amount that the provider charges. Payments are not based on a percentage of the provider’s charge and are paid in addition to any other health plan coverage you may have.

**CAUTION: If you are also covered under a High Deductible Health Plan (HDHP) and are contributing to a Health Savings Account (HSA), you should check with your tax advisor or benefit advisor prior to purchasing this coverage to be sure that you will continue to be eligible to contribute to the HSA if this coverage is purchased.**

The benefits under this policy are summarized below:

**Type of Coverage: Group Accident Insurance Coverage.** The certificate is designed to provide, to certificate holders, coverage paying benefits ONLY when certain losses occur as a result of an injury sustained in a covered accident. This certificate does NOT provide general health insurance.

**Benefits:**

<table>
<thead>
<tr>
<th>INJURY BENEFITS</th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Burn Benefit</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2nd degree burns</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 10% of the body</td>
<td>$100</td>
<td>$300</td>
</tr>
<tr>
<td>Between 10% and 20% of the body</td>
<td>$250</td>
<td>$750</td>
</tr>
<tr>
<td>20% or more of the body</td>
<td>$500</td>
<td>$1,500</td>
</tr>
<tr>
<td>3rd degree burns</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 10% of the body</td>
<td>$1,000</td>
<td>$3,000</td>
</tr>
<tr>
<td>Between 10% and 20% of the body</td>
<td>$2,500</td>
<td>$7,500</td>
</tr>
<tr>
<td>20% or more of the body</td>
<td>$5,000</td>
<td>$15,000</td>
</tr>
<tr>
<td>Child Organized Sports Injury</td>
<td>$50</td>
<td>$100</td>
</tr>
<tr>
<td>Concussion</td>
<td>$100</td>
<td>$200</td>
</tr>
<tr>
<td><strong>Dislocation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Principal Amount (Surgical )</td>
<td>$2,000</td>
<td>$5,000</td>
</tr>
<tr>
<td>% of Principal Amount</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Hip/Thigh</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Foot</td>
<td>40%</td>
<td>40%</td>
</tr>
<tr>
<td>Ankle</td>
<td>40%</td>
<td>40%</td>
</tr>
<tr>
<td>INJURY BENEFITS</td>
<td>LOW PLAN</td>
<td>HIGH PLAN</td>
</tr>
<tr>
<td>------------------------------------</td>
<td>----------</td>
<td>-----------</td>
</tr>
<tr>
<td>Knee</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Hand or wrist (excluding fingers)</td>
<td>Hand: 20% Wrist: 30%</td>
<td>Hand: 20% Wrist: 30%</td>
</tr>
<tr>
<td>Lower jaw</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Shoulder</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Collarbone</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Ribs</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Finger</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Toe</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Elbow</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Non-surgical</td>
<td>50% of surgical benefit</td>
<td>50% of surgical benefit</td>
</tr>
<tr>
<td>Partial dislocation</td>
<td>25% of non-surgical benefit</td>
<td>25% of non-surgical benefit</td>
</tr>
<tr>
<td>Eye Injury - with Surgery</td>
<td>$120</td>
<td>$300</td>
</tr>
<tr>
<td>Eye Injury – Removal of Foreign Object without Surgery</td>
<td>$30</td>
<td>$75</td>
</tr>
<tr>
<td>Fracture</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Principal Amount (Surgical)</td>
<td>$2,000</td>
<td>$5,000</td>
</tr>
<tr>
<td>% of Principal Amount</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hip/Thigh</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Vertebral body</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Vertebral processes</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Pelvis</td>
<td>75%</td>
<td>75%</td>
</tr>
<tr>
<td>Sternum</td>
<td>75%</td>
<td>75%</td>
</tr>
<tr>
<td>Coccyx</td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td>Skull – non depressed</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Skull – depressed</td>
<td>150%</td>
<td>150%</td>
</tr>
<tr>
<td>Lower leg</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Foot</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Ankle</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Kneecap</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Upper arm</td>
<td>35%</td>
<td>35%</td>
</tr>
<tr>
<td>Facial excluding lower jaw</td>
<td>35%</td>
<td>35%</td>
</tr>
<tr>
<td>Forearm</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Hand or wrist (except fingers)</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Lower jaw</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Shoulder blade</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Collarbone</td>
<td>15%</td>
<td>15%</td>
</tr>
<tr>
<td>Ribs</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Finger</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Toe</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Nose</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Non-surgical</td>
<td>50% of surgical benefit</td>
<td>50% of surgical benefit</td>
</tr>
<tr>
<td>Chip fracture</td>
<td>25% of non-surgical Benefit</td>
<td>25% of non-surgical benefit</td>
</tr>
<tr>
<td>Lacerations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>With stitches or staples</td>
<td>$100</td>
<td>$500</td>
</tr>
<tr>
<td>Without stitches or staples</td>
<td>25% of benefit provided with stitches or staples</td>
<td>25% of benefit provided with stitches or staples</td>
</tr>
</tbody>
</table>
### INJURY BENEFITS

<table>
<thead>
<tr>
<th></th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Paralysis</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Principal Amount</td>
<td>$20,000</td>
<td>$60,000</td>
</tr>
<tr>
<td></td>
<td>% of Principal Amount</td>
<td>% of Principal Amount</td>
</tr>
<tr>
<td>Quadriplegia</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Paraplegia</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Hemiplegia</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Uniplegia</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Traumatic Brain Injury</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$200</td>
<td>$400</td>
</tr>
</tbody>
</table>

### EMERGENCY CARE

<table>
<thead>
<tr>
<th></th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ambulance</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ground or water</td>
<td>$100</td>
<td>$200</td>
</tr>
<tr>
<td>Air</td>
<td>$500</td>
<td>$1,000</td>
</tr>
<tr>
<td></td>
<td>$300</td>
<td>$600</td>
</tr>
<tr>
<td>Blood, Plasma or Platelets Transfusion</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Emergency Dental</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crown</td>
<td>$150</td>
<td>$300</td>
</tr>
<tr>
<td>Extraction</td>
<td>$50</td>
<td>$100</td>
</tr>
<tr>
<td></td>
<td>$100</td>
<td>$300</td>
</tr>
<tr>
<td><strong>Emergency Room Treatment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initial Physician’s Office Visit</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### HOSPITAL CARE

<table>
<thead>
<tr>
<th></th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospital Stay</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initial benefit, non-ICU</td>
<td>$400</td>
<td>$1,200</td>
</tr>
<tr>
<td>Initial benefit, ICU</td>
<td>$800</td>
<td>$2,400</td>
</tr>
<tr>
<td>Daily benefit, non-ICU</td>
<td>$100</td>
<td>$300</td>
</tr>
<tr>
<td>Daily benefit, ICU</td>
<td>$200</td>
<td>$600</td>
</tr>
</tbody>
</table>

### SURGERY

<table>
<thead>
<tr>
<th></th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Abdominal or Pelvic Surgery</strong></td>
<td>$1,000</td>
<td>$2,000</td>
</tr>
<tr>
<td><strong>Cranial Surgery</strong></td>
<td>$1,000</td>
<td>$2,000</td>
</tr>
<tr>
<td><strong>Knee Cartilage Surgery</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Open</td>
<td>$500</td>
<td>$1,000</td>
</tr>
<tr>
<td>Arthroscopic</td>
<td>$250</td>
<td>$500</td>
</tr>
<tr>
<td><strong>Ruptured Disc Surgery</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$500</td>
<td>$1,000</td>
</tr>
<tr>
<td>SURGERY</td>
<td>LOW PLAN</td>
<td>HIGH PLAN</td>
</tr>
<tr>
<td>-----------------------------------------</td>
<td>----------</td>
<td>-----------</td>
</tr>
<tr>
<td><strong>Tendon, Ligament or Rotator Cuff Surgery</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Open</td>
<td>$500</td>
<td>$1,000</td>
</tr>
<tr>
<td>Arthroscopic</td>
<td>$250</td>
<td>$500</td>
</tr>
<tr>
<td>Thoracic Surgery</td>
<td>$1,000</td>
<td>$2,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FOLLOW-UP CARE</th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adaptive Home and Vehicle Benefit</td>
<td>$500</td>
<td>$1,000</td>
</tr>
<tr>
<td>Appliances</td>
<td>$50</td>
<td>$250</td>
</tr>
<tr>
<td>Follow-Up Physician’s Office Visit</td>
<td>$50</td>
<td>$100</td>
</tr>
<tr>
<td>Prosthetics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>One prosthetic</td>
<td>$500</td>
<td>$1,000</td>
</tr>
<tr>
<td>Two or more prosthetics</td>
<td>2x one prosthetic</td>
<td>2x one prosthetic</td>
</tr>
<tr>
<td>Transportation</td>
<td>$200 per visit</td>
<td>$500 per visit</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SUPPORT CARE</th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Companion Lodging</td>
<td>$75 per day</td>
<td>$150 per day</td>
</tr>
</tbody>
</table>

**Duration of Coverage:**

Your coverage ends on the earliest of:

1. the date you no longer meet the eligibility requirements; or
2. 31 days (the grace period) after the due date of any premium which is not paid; or
3. the last day for which premium contributions have been paid following your request to cancel your coverage; or
4. the date the group policy ends.

An insured dependent’s coverage ends on the earliest of the following:

1. the date the dependent no longer meets the eligibility requirements; or
2. 31 days (the grace period) after the due date of any premium contribution which is not paid; or
3. the last day for which premium contributions have been paid following your written request that insurance on your eligible dependents be terminated; or
4. the date you are no longer covered under the group policy.

In the event that you lose eligibility under the group policy, you may continue your coverage according to the terms of the Group Accident Insurance Portability Certificate Supplement.

**Renewability:**
The group policy will continue in force until it is canceled by either the group policyholder or Securian Life. Subject to the termination section of the certificate, the certificate may be renewed by making the required premium payments.
**Exclusions and Limitations:**
In no event will we pay benefits where the insured’s accident, injury or loss is caused directly or indirectly by, results in whole or in part from or during, or there is contribution from, any of the following:

1. intentionally self-inflicted injury while sane; or
2. suicide or attempted suicide, while sane; or
3. your participation in, or your attempt to commit, a crime, assault, felony, or any illegal activity, regardless of any legal proceedings thereto; or
4. alcoholism and drug addiction; or
5. the use of poisons, gases, fumes or other substances unless taken, absorbed, inhaled, ingested or injected accidentally; or
6. war or any act of war, whether declared or undeclared; or
7. bodily or mental infirmity, illness or disease; or
8. infection, other than infection occurring simultaneously with, and as a direct and independent result of, the injury; or
9. repetitive stress syndromes including but not limited to rotator cuff syndrome, bursitis, tendonitis, carpal tunnel syndrome, ulnar nerve syndrome, stress fractures, neuropathy, epicondylitis or neuritis; or
10. medical or surgical treatment or diagnostic procedures including any resulting complications, or when the outcome is not as planned or expected, including claims of medical malpractice; or
11. travel in or descent from any aircraft, except as a fare-paying passenger on a regularly scheduled commercial flight on a licensed passenger aircraft carrier; or
12. participation in the following activities: scuba diving, bungee jumping, base jumping, hang gliding, sail gliding, parasailing, parakiting, or mountain climbing; or
13. riding or driving in any motor-driven vehicle in a race, stunt show or speed test; or
14. practicing for or participating in any semi-professional or professional competitive athletics.

Benefits are not payable for any care, treatment or diagnostic measures which were received outside of the United States or United States territory.

**Dependents**
If you are insured for group accident coverage, your dependents are eligible for insurance.

Insurance on a dependent becomes effective on the date when all of the following conditions have been met:

1. your insurance becomes effective;
2. the dependent meets all eligibility requirements; and
3. for contributory insurance, you apply for dependent coverage on forms which are approved by us.

**Premiums**
We reserve the right to change premium rates on any premium due date, but not more than once in each certificate year. We will provide you with at least 60 days advance notice of any change in premium rates.

[Signatures]
Secretary

[Signatures]
President
Group Accident Certificate of Insurance
Securian Life Insurance Company • A Stock Company
400 Robert Street North • St. Paul, Minnesota 55101-2098

Applies to Residents of Washington

POLICYHOLDER: Concordia Plan Services
POLICY NUMBER: 76013

THIS CERTIFICATE IS NOT MAJOR MEDICAL INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL INSURANCE. IT DOES NOT QUALIFY AS MINIMUM ESSENTIAL HEALTH COVERAGE UNDER THE FEDERAL AFFORDABLE CARE ACT. THIS CERTIFICATE DOES NOT SATISFY THE FEDERAL REQUIREMENT THAT YOU HAVE HEALTH INSURANCE COVERAGE, WHICH BECAME EFFECTIVE JANUARY 1, 2014.

THIS IS A LIMITED BENEFIT CERTIFICATE: This certificate provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses. Read your certificate carefully.

THIS CERTIFICATE IS NOT A MEDICARE SUPPLEMENT CONTRACT. If you are eligible for Medicare, review the Guide to Health Insurance for people with Medicare available from us.

Read Your Certificate Carefully
If you meet the eligibility and enrollment requirements herein, you are insured under the group policy shown on the specifications page. This certificate summarizes the principal provisions of the group policy that affect you. The provisions summarized in this certificate are subject in every respect to the group policy. You may examine the group policy at the principal office of the policyholder during regular working hours.

Legal Actions
No legal action may be brought to recover on this certificate within the first sixty days after written proof of loss has been given as required by this certificate. No such action may be brought after three years from the time written proof of loss is required to be given.

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GROUP ACCIDENT CERTIFICATE OF INSURANCE
GENERAL INFORMATION

POLICYHOLDER: Concordia Plan Services

POLICY NUMBER: 76013

ASSOCIATED COMPANIES: All subsidiaries and affiliates reported to Securian Life by the policyholder for inclusion in the policy.

POLICY SITUS: The policy was issued and delivered in Missouri.

POLICY EFFECTIVE DATE: January 1, 2019.

This certificate and/or certificate specifications page replaces any and all certificates and/or certificate specifications pages previously issued to you under the group policy. Please replace any certificate and/or certificate specifications page previously issued to you with this new certificate and/or specifications page.

GROUP: The group is composed of all active employees of the policyholder and its associated companies working in the United States in the following classes:

Class 1: Active employees working at least 20 hours per week.

All new employees of the employer will be added to such group and classes for which they become eligible.

NO DOUBLE COVERAGE: A person cannot be covered under more than one class. A person cannot be covered as both an active employee and a retiree. Any person who is eligible as an employee or retiree under the policy, or insured under the portability provisions, is not eligible as a dependent. Only one person can insure an eligible dependent child.

ENROLLMENT PERIOD: 90 days from the first day of eligibility for contributory insurance.

WAITING PERIOD: None

MINIMUM HOURS PER WEEK REQUIREMENT: 20 hours per week

PLAN OF INSURANCE

EMPLOYEE BENEFIT SCHEDULE

EMPLOYEE GROUP ACCIDENT INSURANCE:

Supplemental Group Accident Insurance

<table>
<thead>
<tr>
<th>Eligible Class</th>
<th>Employee Supplemental Group Accident Insurance Benefit Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class 1</td>
<td>Low Plan or High Plan as elected by the employee.</td>
</tr>
</tbody>
</table>

GENERAL PROVISIONS FOR EMPLOYEE INSURANCE

RETIREMENT REDUCTIONS: All insurance terminates at retirement, except as otherwise provided for under any applicable certificate supplement.

CONTRIBUTORY/NONCONTRIBUTORY: Supplemental insurance is contributory insurance.

PORTABILITY BENEFIT: Low Plan or High Plan as elected by the employee.

DEPENDENT BENEFIT SCHEDULE

An employee must be insured in order to elect dependent group accident insurance.

SPOUSE GROUP ACCIDENT INSURANCE

Supplemental Group Accident Insurance

<table>
<thead>
<tr>
<th>Eligible Class</th>
<th>Spouse Supplemental Group Accident Insurance Benefit Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class 1</td>
<td>Spouse benefit plan will match the employee’s Supplemental Group Accident Benefit Plan.</td>
</tr>
</tbody>
</table>

CHILD GROUP ACCIDENT INSURANCE

Supplemental Group Accident Insurance

<table>
<thead>
<tr>
<th>Eligible Class</th>
<th>Child Supplemental Group Accident Insurance Benefit Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class 1</td>
<td>Child benefit plan will match the employee’s supplemental Group Accident Benefit Plan.</td>
</tr>
</tbody>
</table>

GENERAL PROVISIONS FOR DEPENDENT INSURANCE

CONTRIBUTORY/NONCONTRIBUTORY: Supplemental insurance is contributory insurance.

SPOUSE AND CHILD PORTABILITY BENEFIT: Spouse benefit plan will match the employee’s Group Accident Benefit Plan. Child benefit plan will match the employee’s Group Accident Benefit Plan.

COVERED BENEFITS

Refer to the Injury Benefits, Emergency Care, Hospital Care, Surgery Benefits, Follow-up Care and Support Care sections of the Certificate for additional benefit details.

<table>
<thead>
<tr>
<th>INJURY BENEFITS</th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burn Benefit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2nd degree burns</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 10% of the body</td>
<td>$100</td>
<td>$300</td>
</tr>
<tr>
<td>Between 10% and 20% of the body</td>
<td>$250</td>
<td>$750</td>
</tr>
<tr>
<td>20% or more of the body</td>
<td>$500</td>
<td>$1,500</td>
</tr>
<tr>
<td>3rd degree burns</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 10% of the body</td>
<td>$1,000</td>
<td>$3,000</td>
</tr>
<tr>
<td>Between 10% and 20% of the body</td>
<td>$2,500</td>
<td>$7,500</td>
</tr>
<tr>
<td>20% or more of the body</td>
<td>$5,000</td>
<td>$15,000</td>
</tr>
<tr>
<td>Child Organized Sports Injury</td>
<td>$50</td>
<td>$100</td>
</tr>
<tr>
<td>INJURY BENEFITS</td>
<td>LOW PLAN</td>
<td>HIGH PLAN</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>----------</td>
<td>-----------</td>
</tr>
<tr>
<td>Concussion</td>
<td>$100</td>
<td>$200</td>
</tr>
<tr>
<td>Dislocation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Principal Amount (Surgical)</td>
<td>$2,000</td>
<td>$5,000</td>
</tr>
<tr>
<td>% of Principal Amount</td>
<td>% of Principal Amount</td>
<td></td>
</tr>
<tr>
<td>Hip/Thigh</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Foot</td>
<td>40%</td>
<td>40%</td>
</tr>
<tr>
<td>Ankle</td>
<td>40%</td>
<td>40%</td>
</tr>
<tr>
<td>Knee</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Hand or wrist (excluding fingers)</td>
<td>Hand: 20%</td>
<td>Hand: 20%</td>
</tr>
<tr>
<td>Wrist: 30%</td>
<td>Wrist: 30%</td>
<td></td>
</tr>
<tr>
<td>Lower jaw</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Shoulder</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Collarbone</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Ribs</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Finger</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Toe</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Elbow</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Non-surgical</td>
<td>50% of surgical benefit</td>
<td>50% of surgical benefit</td>
</tr>
<tr>
<td>Partial dislocation</td>
<td>25% of non-surgical benefit</td>
<td>25% of non-surgical benefit</td>
</tr>
<tr>
<td>Eye Injury - with Surgery</td>
<td>$120</td>
<td>$300</td>
</tr>
<tr>
<td>Eye Injury – Removal of Foreign Object without Surgery</td>
<td>$30</td>
<td>$75</td>
</tr>
<tr>
<td>Fracture</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Principal Amount (Surgical)</td>
<td>$2,000</td>
<td>$5,000</td>
</tr>
<tr>
<td>% of Principal Amount</td>
<td>% of Principal Amount</td>
<td></td>
</tr>
<tr>
<td>Hip/Thigh</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Vertebral body</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Vertebral processes</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Pelvis</td>
<td>75%</td>
<td>75%</td>
</tr>
<tr>
<td>Sternum</td>
<td>75%</td>
<td>75%</td>
</tr>
<tr>
<td>Coccyx</td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td>Skull – non depressed</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Skull – depressed</td>
<td>150%</td>
<td>150%</td>
</tr>
<tr>
<td>Lower leg</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Foot</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Ankle</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Kneecap</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Upper arm</td>
<td>35%</td>
<td>35%</td>
</tr>
<tr>
<td>Facial excluding lower jaw</td>
<td>35%</td>
<td>35%</td>
</tr>
<tr>
<td>Forearm</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Hand or wrist (except fingers)</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Lower jaw</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Shoulder blade</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Collarbone</td>
<td>15%</td>
<td>15%</td>
</tr>
<tr>
<td>Ribs</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Finger</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Toe</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Nose</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Non-surgical</td>
<td>50% of surgical benefit</td>
<td>50% of surgical benefit</td>
</tr>
<tr>
<td>Chip fracture</td>
<td>25% of non-surgical Benefit</td>
<td>25% of non-surgical benefit</td>
</tr>
</tbody>
</table>
### INJURY BENEFITS

<table>
<thead>
<tr>
<th></th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lacerations</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>With stitches or staples</td>
<td>$100</td>
<td>$500</td>
</tr>
<tr>
<td>Without stitches or staples</td>
<td>25% of benefit provided with stitches or staples</td>
<td>25% of benefit provided with stitches or staples</td>
</tr>
<tr>
<td><strong>Paralysis</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Principal Amount</td>
<td>$20,000</td>
<td>$60,000</td>
</tr>
<tr>
<td>% of Principal Amount</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quadriplegia</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Paraplegia</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Hemiplegia</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Uniplegia</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td><strong>Traumatic Brain Injury</strong></td>
<td>$200</td>
<td>$400</td>
</tr>
</tbody>
</table>

### EMERGENCY CARE

<table>
<thead>
<tr>
<th></th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ambulance</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ground or water</td>
<td>$100</td>
<td>$200</td>
</tr>
<tr>
<td>Air</td>
<td>$500</td>
<td>$1,000</td>
</tr>
<tr>
<td><strong>Blood, Plasma or Platelets Transfusion</strong></td>
<td>$300</td>
<td>$600</td>
</tr>
<tr>
<td><strong>Emergency Dental</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crown</td>
<td>$150</td>
<td>$300</td>
</tr>
<tr>
<td>Extraction</td>
<td>$50</td>
<td>$100</td>
</tr>
<tr>
<td><strong>Emergency Room Treatment</strong></td>
<td>$100</td>
<td>$300</td>
</tr>
<tr>
<td><strong>Initial Physician’s Office Visit</strong></td>
<td>$50</td>
<td>$100</td>
</tr>
<tr>
<td><strong>Hospital Stay</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initial benefit, non-ICU</td>
<td>$400</td>
<td>$1,200</td>
</tr>
<tr>
<td>Initial benefit, ICU</td>
<td>$800</td>
<td>$2,400</td>
</tr>
<tr>
<td>Daily benefit, non-ICU</td>
<td>$100</td>
<td>$300</td>
</tr>
<tr>
<td>Daily benefit, ICU</td>
<td>$200</td>
<td>$600</td>
</tr>
</tbody>
</table>

### SURGERY

<table>
<thead>
<tr>
<th></th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Abdominal or Pelvic Surgery</strong></td>
<td>$1,000</td>
<td>$2,000</td>
</tr>
<tr>
<td><strong>Cranial Surgery</strong></td>
<td>$1,000</td>
<td>$2,000</td>
</tr>
<tr>
<td><strong>Knee Cartilage Surgery</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Open</td>
<td>$500</td>
<td>$1,000</td>
</tr>
<tr>
<td>Arthroscopic</td>
<td>$250</td>
<td>$500</td>
</tr>
<tr>
<td><strong>Ruptured Disc Surgery</strong></td>
<td>$500</td>
<td>$1,000</td>
</tr>
<tr>
<td><strong>Tendon, Ligament or Rotator Cuff Surgery</strong></td>
<td>$500</td>
<td>$1,000</td>
</tr>
</tbody>
</table>
### INJURY BENEFITS

<table>
<thead>
<tr>
<th>Procedure</th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arthroscopic</td>
<td>$250</td>
<td>$500</td>
</tr>
<tr>
<td>Thoracic Surgery</td>
<td>$1,000</td>
<td>$2,000</td>
</tr>
</tbody>
</table>

### FOLLOW-UP CARE

<table>
<thead>
<tr>
<th>Benefit</th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adaptive Home and Vehicle Benefit</td>
<td>$500</td>
<td>$1,000</td>
</tr>
<tr>
<td>Appliances</td>
<td>$50</td>
<td>$250</td>
</tr>
<tr>
<td>Follow-Up Physician’s Office Visit</td>
<td>$50</td>
<td>$100</td>
</tr>
<tr>
<td>Prosthetics</td>
<td>$500</td>
<td>$1,000</td>
</tr>
<tr>
<td>Transportation</td>
<td>$200 per visit</td>
<td>$500 per visit</td>
</tr>
</tbody>
</table>

### SUPPORT CARE

<table>
<thead>
<tr>
<th>Benefit</th>
<th>LOW PLAN</th>
<th>HIGH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Companion Lodging</td>
<td>$75 per day</td>
<td>$150 per day</td>
</tr>
</tbody>
</table>

### ADDITIONAL INFORMATION

#### ANNUAL OPEN ENROLLMENTS:

During the policyholder’s annual open enrollment an employee may elect or change employee and dependent accident insurance benefit plans.

Coverage will be effective on the January 1 following the annual enrollment, subject to the actively at work requirement for employees and the hospitalization/non-confinement provision for dependents (this does not apply to a newborn child).

**Special Enrollment Periods:** Upon mutual agreement between the Policyholder and Securian, one or more special enrollment periods may be offered to eligible employees. These special enrollment periods (if offered) will be in addition to the annual enrollment opportunities described above. In the event that a special enrollment period is offered, the details of the special enrollment, including enrollment dates, allowed changes, and evidence of insurability requirements, will be communicated to you in advance of the special enrollment period and documented in the group policy on file with the policyholder and Securian.

#### QUALIFIED STATUS CHANGES:

An employee who experiences a Qualified Status Changes as defined below may elect or change employee and dependent accident insurance benefit plans provided enrollment is made within 60 days of the status change.

- An active employee may elect accident insurance for the first time or increase coverage from the low plan to the high plan.
- An active employee may elect dependent coverage.

Coverage will be effective on the date of the election. All increases are subject to the actively at work requirement for employees and the hospitalization/non-confinement provision for dependents (this does not apply to a newborn child)

A qualified status change for the purpose of waiving the evidence of insurability requirement means marriage, birth or adoption.
SUPPLEMENTS TO THE CERTIFICATE

Portability
Definitions

Any use in this certificate of a term defined in this section is to be given the meaning defined in this section unless otherwise defined in another provision of this certificate.

accident
An act or event which is:

(1) unintended, unexpected and unforeseen; and
(2) directly results in bodily injury to the insured.

application
Your application or enrollment for insurance under the group policy.

associated company
Any company which is a subsidiary or affiliate of the policyholder which is designated by the policyholder and agreed to by us to participate under the group policy.

child or children
Your or your spouse’s natural, adopted, stepchild or foster child who is less than 26 years old. An adopted child includes a child legally placed for adoption with you. Eligibility begins at live birth (stillborn or unborn children are not eligible). Children age 26 or older are also eligible so long as they are physically or mentally incapable of self-support, were incapable of self-support prior to age 26 and remain financially dependent on you for more than one-half of their support and maintenance.

contributory insurance
Insurance for which you are required to make premium contributions.

covered accident
An accident which:

(1) is not excluded under the Exclusions and Limitations section or any other terms of this certificate; and
(2) occurs while the insured’s coverage is in force; and
(3) occurs in the United States or a United States territory.

dependent
Your children or spouse.

If both parents of a child qualify as eligible employees under the group policy, the child shall be considered a dependent of only one parent for purposes of this certificate. If any child qualifies as an eligible employee under the group policy, he or she is not eligible to be insured as a dependent child.

emergency room
A department of a hospital or a satellite emergency center that is designated for persons requiring immediate medical care. This area must be staffed and equipped to handle trauma, be supervised and provide treatment by physicians, and provide care seven days per week, 24 hours per day.

A satellite emergency center is a licensed facility providing outpatient care under the direction of a licensed physician on a 24-hour basis. Available services must include:

(1) diagnostic care, including laboratory services and diagnostic x-rays; and
(2) treatment or medical care, including availability of the means for stabilization of emergency medical conditions.

A satellite emergency center does not include a hospital or an office maintained by a licensed physician for the practice of medicine or dentistry.

employee
An individual who is employed by the policyholder or by an associated company. A sole proprietor will be considered the employee of the proprietorship. A partner in a partnership will be considered an employee so long as the partner’s principal work is the conduct of the partnership’s business. The term employee does not include temporary employees nor corporate directors who are not otherwise employees.

employer
The policyholder or any designated associated companies.

family member
A parent, spouse, child, sibling, grandparent, aunt, uncle, first cousin, niece or nephew. This includes adopted, in-law and step relatives.

hospital
A short-term, acute care general facility that:

(1) is legally licensed and operated as a hospital;
(2) provides overnight care of injured and sick people;
(3) requires that every patient be supervised by a physician;
(4) provides 24 hour nursing service by or under the supervision of a registered nurse;
(5) has on-site or pre-arranged use of x-ray equipment, laboratory, and surgical facilities; and
(6) maintains permanent medical history records.

A hospital is not a rehabilitation center, nursing home, rest home, extended-care facility, convalescent home, a place for alcoholics or drug addicts or a mental institution, even if such facilities are affiliated with or adjoining to a hospital.
injury or injuries
A bodily injury which is sustained as a direct result of a covered accident.

insured
An employee, spouse or child covered for insurance under this certificate.

noncontributory insurance
Insurance for which you are not required to make premium contributions.

non-work day
A day on which you are not regularly scheduled to work, including scheduled time off for vacations, personal holidays, weekends and holidays, and approved leaves of absence for non-medical reasons.

Non-work day does not include time off for medical leave of absence, temporary layoff, employer suspension of operations in total or in part, strike, and any time off due to sickness or injury including sick days, short-term disability, or long term disability.

physician
A medical doctor or other person recognized by law or regulation in the United States or United States territory where services are rendered as a physician. The person must be licensed as required by the United States jurisdiction where care is given and must be operating in the scope of his or her license.

A physician cannot be a person who:

(1) ordinarily resides in your household; or
(2) is a family member.

policyholder
The owner of the group policy as shown on the specifications page.

specifications page
The summary of the plan specifics available under the group policy.

spouse
Your legally married spouse as recognized under the laws of the jurisdiction of celebration.

Spouse does not include any person who is eligible as an employee.

surgery
Medical treatment in which a physician cuts into someone's body in order to repair or remove damaged parts as a result of a covered accident. The surgery must be performed solely because of injuries sustained in a covered accident.

urgent care center
A health care facility that is separate from a hospital or a separate unit within a hospital and whose primary purpose is the offering and provision of immediate, short term medical care, without appointment, for urgent care.

we, our, us
Securian Life Insurance Company.

you, your, certificate holder
An insured employee.

General Information

What is your agreement with us?
If you meet the eligibility and enrollment requirements, you are insured under the group policy shown on the specifications page. Your application is deemed a part of this certificate. This certificate summarizes the principal provisions of the group policy that affect your insurance coverage. The provisions summarized in this certificate are subject in every respect to the group policy.

Any statements made in your application will, in the absence of fraud, be considered representations and not warranties. Also, any statement made will not be used to void your insurance nor defend against a claim unless the statement is contained in the application.

Can this certificate be amended?
Yes. We retain the right to amend this certificate at any time without your consent. Any amendment will be without prejudice to any claim incurred for benefits prior to the date of the amendment.

Who is eligible for insurance?
You are eligible for group accident insurance if you:

(1) are a member of the eligible group and of an eligible class as defined on the specifications page; and
(2) work for the employer for at least the number of hours per week shown as the minimum hours per week requirement on the specifications page; and
(3) have satisfied the waiting period as shown on the specifications page; and
(4) meet the actively at work requirement described in the “What is the actively at work requirement?” provision of this section.
Are your dependents eligible for insurance?

Yes. If you are insured for group accident coverage, your dependents are eligible for insurance.

Are employees of associated companies eligible for insurance under the group policy?

Yes. Employees of associated companies may be eligible for insurance under the group policy. The policyholder represents any associated company in all transactions pertaining to the group policy. The policyholder’s acts or omissions and every notice given by us to the policyholder shall be binding on every associated company. When an associated company ceases its participation under the policy, the policy shall be considered to be terminated for all employees of the associated company. All provisions related to policy termination will apply to such employees.

What is the actively at work requirement?

To be eligible to become insured or to receive an increase in the benefit amount, you must be actively at work, fully performing your customary duties for your regularly scheduled number of hours at the employer’s normal place of business, or at other places the employer’s business requires you to travel.

If you are not working due to illness or injury, you do not meet the actively at work requirement. If you are receiving sick pay, short-term disability benefits or long-term disability benefits, you do not meet the actively at work requirement.

If you are not actively at work on the date coverage would otherwise begin, or on the date an increase in your benefit amount would otherwise be effective, you will not be eligible for the coverage or increase until you return to active work. However, if the absence is on a non-work day, coverage will not be delayed provided you were actively at work on the work day immediately preceding the non-work day.

Except as otherwise provided for in this certificate, you are eligible to continue to be insured only while you remain actively at work.

Any insurance or increase in insurance which is elected or put in force while you are not actively at work will not be eligible for claim payment. You or your beneficiary will receive a refund of premium for any contributory insurance for which you were not eligible.

What is the dependent non-confinement requirement?

If a dependent is hospitalized or confined because of illness or disease on the date his or her insurance would otherwise become effective, his or her effective date shall be delayed until he or she is released from such hospitalization or confinement. This does not apply to a newborn child.

In no event will insurance on a dependent be effective before your insurance is effective.

Can your coverage be continued during sickness, injury, leave of absence or temporary layoff?

Yes. Insurance may be continued on an insured employee who is not actively at work due to sickness, injury, leave of absence or temporary layoff, subject to the employer's practices and procedures, including the employer's limits on the length of continuation allowed for the type of absence. Continuation is contingent upon continued premium payment.

Coverage during a leave of absence and upon return from a leave of absence shall meet all state and federal requirements.

Enrollment

When can you elect or make changes to your insurance?

You must enroll in order to be insured for contributory coverage under the group policy. You can enroll for coverage within 90 days of when you first become eligible. After that period, you can only enroll for coverage or make changes during your annual open enrollment or within 60 days of a qualified status change event, as defined by the state and federal rules and regulations.

When does your insurance become effective?

Your insurance becomes effective on the date all of the following conditions have been met:

1. you meet all eligibility requirements, including the actively at work requirement; and
2. for contributory coverage, application is made in accordance with the application methods agreed upon by the policyholder and us

When does insurance for a dependent become effective?

Insurance on a dependent becomes effective on the date when all of the following conditions have been met:

1. your insurance becomes effective;
2. the dependent meets all eligibility requirements; and
3. for contributory insurance, you apply for dependent coverage on forms which are approved by us.

When will changes in your coverage amount be effective?

Requested changes in the amount of your contributory insurance are effective on the first day of the month following receipt of your request for a change.
However, elections made during an enrollment period will not become effective prior to the effective date for that enrollment.

**Premiums**

*When and how often are your premium contributions due?*

Unless the policyholder and we have agreed to some other premium payment procedure, any premium contributions you are required to make for contributory insurance are to be paid by you to the policyholder on a periodic basis. Premium rates are subject to change in accordance with the group policy.

*How is the premium determined?*

The premium will be the applicable premium rate in force on the date premiums are due. The premium may also be computed by any other method on which the policyholder and we agree.

Premium rates are subject to change according to the provisions of the group policy.

*Can a premium be paid after the date it is due?*

Yes. The group policy has a 31-day grace period. If a premium is not paid on or before the date it is due, that premium may be paid during the 31-day period following the due date. The insurance under the group policy will remain in effect during the 31-day grace period.

**Injury Benefits**

**Burn Benefit**

If an insured sustains a second or third degree burn in a covered accident, we will pay the appropriate amount shown on the specifications page based on the type of burn and the percentage of the body surface burned.

The burn must be treated by a physician within 72 hours after the covered accident. If the burn meets more than one of the burn classifications shown on the specifications page, the amount we pay will be based on the burn classification that pays the highest benefit.

We will pay the burn benefit no more than one time per covered accident. No benefits are payable for sunburns or first degree burns.

**Child Organized Sports Injury**

The child organized sports injury benefit is subject to the following conditions.

1. the insured dependent child suffers an injury in a covered accident while participating in an organized sport; and
2. a benefit is payable for the insured dependent child under another provision of the group policy for the same covered accident; and
3. the insured dependent child has not attained 19 years of age and is insured on the date the covered accident occurs;

A child organized sport refers to a sport activity that is governed by an organization and requires formal registration to participate. Adult supervision of practice and competition is required. Proof of registration must be submitted with claims.

The child organized sports injury benefit amount is shown on the specifications page.

This benefit is limited to one payment per insured dependent child per calendar year.

**Concussion**

If an insured is injured in a covered accident and the injury causes a concussion, we will pay the amount shown on the specifications page. The insured must be treated by a physician within 72 hours of a covered accident and the concussion must be diagnosed by a physician within 15 days of the covered accident.

Concussion refers to a disruption of brain function resulting from a traumatic blow to the head.

This benefit is limited to one payment per insured per covered accident per calendar year.

The concussion benefit is not payable if a traumatic brain injury benefit is payable under this certificate for the same accident.

**Dislocation**

If a joint is dislocated in a covered accident, and it is diagnosed and treated by a physician within 90 days after the covered accident, we will pay the amount shown on the specifications page. The amount varies based on the joint that is dislocated, whether the dislocation is a full or a partial dislocation, and whether surgery is required to treat the dislocation.

A full dislocation refers to a completely separated joint due to a covered accident. A partial dislocation means the joint is misaligned but not completely dislocated, as diagnosed by a physician.

If more than one dislocation benefit is payable resulting from the same covered accident, we will pay the lesser of:

1. the total of the benefit amounts shown for each applicable dislocation on the specifications page; or
2. 2 times the highest dislocation benefit that would otherwise be payable for any one of the dislocations involved.
Eye Injury – with Surgery

If an insured is injured in a covered accident and the injury results in an eye injury that requires surgery, we will pay the amount shown on the specifications page. The insured must be seen by a physician within 60 days of the covered accident and surgery must be performed within 180 days of the covered accident. This benefit is limited to one payment per eye per insured per covered accident.

Eye Injury – Removal of Foreign Object without Surgery

If an insured is injured in a covered accident and the injury results in an eye injury that requires removal of a foreign object, but does not require surgery, we will pay the amount shown on the specifications page. The insured must be seen by a physician within 60 days of the covered accident and removal of the foreign object must be performed within 180 days of the covered accident. This benefit is limited to one payment per eye per insured per covered accident.

Fracture

If a bone is fractured in a covered accident, and it is diagnosed and treated by a physician within 90 days after the covered accident, we will pay the amount shown on the specifications page. The amount varies based on the bone that is fractured, whether or not the fracture is a chip fracture, and whether surgery is required to treat the fracture.

Fracture refers to a break in a bone that can be seen by x-ray. A chip fracture is a fracture in which a small fragment of the bone is broken off.

If more than one fracture benefit is payable resulting from the same covered accident, we will pay the lesser of:

1. the total of the benefit amounts shown for each applicable fracture on the specifications page; or
2. 3 times the highest fracture benefit that would otherwise be payable for any one of the bones involved.

We will pay no more than one fracture benefit per bone, per covered accident per insured. In no event will multiple fracture benefits be paid for the same fracture benefit shown on the specifications page unless it is a bilateral fracture. Bilateral fracture means the fracture of the same bone on both the left and right sides of the body.

Lacerations

If an insured is injured in a covered accident and the injury results in a laceration, we will pay the appropriate amount shown on the specifications page based on the type of treatment provided.

The laceration must be treated by a physician within 72 hours after the covered accident. This benefit is limited to one payment per insured per covered accident. In no event will we pay more than one laceration benefit per calendar year.

Paralysis

If an insured is injured in a covered accident and the injury causes paralysis which lasts more than 180 days we will pay the appropriate amount shown on the specifications page. Paralysis refers to the total, permanent, and irrevocable loss of movement. The paralysis must be diagnosed by a physician within 180 days after the accident.

The amount payable will be based on the type of paralysis, as follows:

- Quadriplegia refers to paralysis of both upper limbs (from the shoulder down including total paralysis of both hands) and both lower limbs (from the waist down including total paralysis of both feet).
- Paraplegia refers to paralysis of both lower limbs (from the waist down including total paralysis of both feet).
- Hemiplegia refers to paralysis of both the upper limb (from the shoulder down including total paralysis of both hands) and lower limb (from the waist down including total paralysis of the foot) on one side of the body.
- Uniplegia refers to paralysis of one limb (from the shoulder down including total paralysis of the hand if claiming an upper limb and from the waist down including total paralysis of the foot if claiming a lower limb).

We will pay no more than one paralysis benefit per covered accident per insured. In the event that an insured qualifies under multiple types of paralysis, the highest benefit amount will be paid.

Traumatic Brain Injury

If an insured is injured in a covered accident and the injury results in a traumatic brain injury, we will pay the amount shown on the specifications page.

Traumatic brain injury means only the following: intracranial hemorrhage, cerebral contusion or cerebral laceration.

The insured must be treated by a physician within 72 hours after the covered accident. The traumatic brain injury must be diagnosed within 30 days after the accident by computer tomography (CT) scan or magnetic resonance imaging (MRI). This benefit is payable only once per insured per covered accident. Scalp hematomas and scalp lacerations are not covered under this benefit.

Emergency Care

Ambulance

If an insured is injured in a covered accident and requires transportation to a hospital (or between hospitals) we will pay the appropriate ambulance benefit shown on the
Ground or water transportation must be provided by a licensed professional ambulance service within 90 days of the covered accident. Air transportation must be provided by a licensed professional ambulance service within 72 hours. This benefit is limited to one payment per insured per covered accident.

If an insured requires more than one ambulance transport, the highest benefit amount will be paid.

Ambulance means any publicly or privately owned surface, water or air vehicle, including a helicopter that is specifically designed and constructed or modified and equipped to be used, maintained or operated primarily for the transportation of individuals who are sick, injured or wounded.

Ambulance does not include a surface, water or air vehicle that is owned and operated to accommodate an incapacitated or disabled person who does not require medical monitoring, care or treatment during transport.

Blood, Plasma or Platelets Transfusion

If an insured is injured in a covered accident and requires a blood, plasma or platelets transfusion, we will pay the blood/plasma/platelets transfusion benefit shown on the specifications page. The transfusion must occur within 90 days of the covered accident. This benefit is limited to one payment per insured per covered accident.

Emergency Dental

If an insured has an injury to sound natural teeth as a result of a covered accident, we will pay the appropriate emergency dental benefit shown on the specifications page. A benefit is payable for a broken tooth repaired with crown(s) or a broken tooth requiring extraction. Treatment must occur within 60 days of the covered accident. The maximum number of crown benefits payable per insured per covered accident is two. The maximum number of extraction benefits payable per insured per covered accident is two.

Proof of the soundness of the injured tooth must be submitted with claims. Injuries resulting from biting or chewing are not covered under this benefit.

Sound natural teeth are defined as teeth that are free of active or chronic clinical decay, have at least 50% bone support and are functional in the arch.

Emergency Room Treatment

If an insured is injured in a covered accident and requires treatment in an emergency room, we will pay the emergency room treatment benefit shown on the specifications page. Treatment must occur within 72 hours of the covered accident.

This benefit is limited to one payment per insured per covered accident.

Initial Physician’s Office Visit

If an insured is injured in a covered accident, we will pay the initial physician’s office visit benefit shown on the specifications page. Benefits are payable for the initial treatment received in a physician’s office or an urgent care center for injuries resulting from a covered accident. Treatment must occur within 72 hours of the covered accident. The maximum number of benefits per insured per calendar year is two. The benefit is not payable if the insured receives care in an emergency room within the same 72 hour period. Only one benefit is payable per covered accident.

Hospital Care

Hospital Stay

If an insured is injured in a covered accident and requires treatment in a hospital for the injury within 180 days of a covered accident, we will pay the hospital stay benefit shown on the specifications page subject to the following.

Initial Benefit

We will pay the initial benefit shown on the specifications page for the first day of a hospital stay provided the insured is receiving treatment for a covered accident in the hospital for a minimum of 18 continuous hours.

The benefit payment will be based on the type of room and level of care the insured receives. The Intensive Care Unit (ICU) benefit is payable if the insured is receiving treatment in an ICU room of a hospital. The non-ICU benefit is payable if the insured is receiving treatment in a non-ICU room.

This benefit is limited to one payment per insured per covered accident. In the event the insured receives treatment in both a non-ICU and an ICU room, the higher benefit will be payable as an initial benefit.

Daily Benefit

If an initial benefit is payable, the insured will also receive a daily benefit for each day he or she is treated in the hospital, including the first day. The amount payable for the daily benefit is shown on the specifications page.

The daily benefit payment will be based on the type of room and level of care the insured receives. The ICU benefit is payable if the insured is receiving treatment in an ICU room of a hospital. The non-ICU benefit is payable if the insured is receiving treatment in a non-ICU room.

The ICU daily benefit will be limited to a maximum of 15 days per insured per covered accident.
The combination of the both ICU and non-ICU benefits will be limited to a cumulative maximum of 120 days per insured per covered accident.

If an insured is released from the hospital and subsequently requires treatment in a hospital for injuries sustained in the same covered accident, the subsequent treatment will be considered a continuation of the same hospital stay for purposes of determining the cumulative maximum daily benefit so long as the treatment occurs within two years of the date of the covered accident.

Intensive Care Unit (ICU) refers to a specifically designated part of a hospital that provides the highest level of medical care and is restricted to patients who are critically ill or injured and who require intensive comprehensive observation and care. Hospital Intensive Care Units must be:

1. separate and apart from the surgical recovery room; and
2. separate and apart from rooms, beds, and wards customarily used for patient confinement; and
3. permanently equipped with special life-saving equipment to care for the critically ill or injured; and
4. under constant and continuous observation by nursing staffs assigned to the Intensive Care Unit.

Surgery Benefits

Abdominal or Pelvic Surgery
If an insured is injured in a covered accident and requires abdominal or pelvic surgery to treat the injuries, we will pay the abdominal or pelvic surgery benefit shown on the specifications page. The surgery must be performed within 72 hours of the covered accident. This benefit is limited to one payment per insured per covered accident. Surgery required to treat a fracture or dislocation is payable under the fracture or dislocation benefit and is not covered under the abdominal or pelvic surgery benefit.

Cranial Surgery
If an insured is injured in a covered accident and requires cranial surgery to treat the injuries, we will pay the cranial surgery benefit shown on the specifications page. The surgery must be performed within 72 hours of the covered accident. This benefit is limited to one payment per insured per covered accident.

Knee Cartilage Surgery
If an insured is injured in a covered accident and requires knee cartilage surgery to treat the injury, we will pay the knee cartilage surgery benefit shown on the specifications page. The insured must be treated by a physician within 60 days of the covered accident and surgery must be performed within 180 days of the covered accident. This benefit is limited to one payment per insured per covered accident.

Ruptured Disc Surgery
If an insured is injured in a covered accident and requires surgery for one or more ruptured discs to treat the injury, we will pay the ruptured disc surgery benefit shown on the specifications page. The surgery must be performed within 180 days of the covered accident. This benefit is limited to one payment per insured per covered accident.

Tendon, Ligament or Rotator Cuff Surgery
If an insured is injured in a covered accident and requires tendon, ligament or rotator cuff surgery to treat the injuries, we will pay the tendon, ligament or rotator cuff surgery benefit shown on the specifications page. The surgery must be performed within 180 days of the covered accident. This benefit is limited to one payment per insured per covered accident.

Thoracic Surgery
If an insured is injured in a covered accident and requires thoracic surgery to treat the injuries, we will pay the thoracic surgery benefit shown on the specifications page. The surgery must be performed within 72 hours of the covered accident. This benefit is limited to one payment per insured per covered accident.

Surgery required to treat a fracture or dislocation is payable under the fracture or dislocation benefit and is not covered under the thoracic surgery benefit.

Follow-Up Care

Adaptive Home and Vehicle Benefit
If an insured is injured in a covered accident and requires adaptive modifications to his or her primary residence or private vehicle to be made drivable or rideable, we will pay the adaptive home and vehicle benefit shown on the specifications page subject to the following conditions:

1. a benefit is payable under the paralysis benefit of the Injury Benefits section of this certificate; and
(2) the modification must take place within two years of the covered accident; and
(3) such home alterations are made by a person or persons with experience in such alterations and recommended by a recognized organization associated with the injury; and
(4) such vehicle modifications are carried out by a person or persons with experience in such matters and approved by the Motor Vehicle Department.

This benefit is limited to one payment per insured per covered accident.

**Appliances**

If an insured is injured in a covered accident and a medical appliance is prescribed by a physician for mobility, we will pay the appliance benefit shown on the specifications page. The order for the appliance must be placed within 180 days of the covered accident. This benefit is limited to payment for two covered appliances per insured per covered accident.

Covered appliances means only the following: crutches, canes, walkers, wheelchairs/scooters, leg braces and back braces. This benefit does not cover replacement appliances.

**Follow-Up Physician’s Office Visit**

If an insured is injured in a covered accident and follow-up care for the injury is ordered by the treating physician, we will pay the follow-up physician’s office visit benefit shown on the specifications page. The follow-up visit(s) must occur within 180 days of the covered accident. This benefit is limited to three payments per insured per covered accident. Follow-up at an urgent care center is not covered under this benefit.

**Prosthetics**

If an insured is injured in a covered accident and sustains the loss of a limb, hand, foot or sight in an eye, we will pay the prosthetic benefit shown on the specifications page, subject to the following:

(1) this benefit is limited to payment for two prosthetic devices per insured per covered accident; and
(2) the prosthetic device(s) must be prescribed by a physician and ordered within 180 days after the covered accident.

Prosthetic device refers to an artificial device that replaces a missing limb, hand, foot or an eye. For purposes of this benefit, the term prosthetic device does not include corrective lenses or other cosmetic prostheses.

In addition, this benefit does not provide coverage for damaged prosthetics; more than one prosthetic device for the same limb, hand, foot or eye; the replacement of a prosthetic device; or a joint replacement.

**Transportation**

If an insured receives follow-up treatment ordered by a physician for an injury sustained in a covered accident and is required to travel more than 100 miles (one way) from the insured’s primary residence to a hospital or other treatment facility, we will pay the transportation benefit shown on the specifications page subject to the following:

(1) a benefit is payable under this certificate for the same injury; and
(2) the follow-up treatment is ordered by a physician and is not available within 100 miles (one way) of the insured’s primary residence; and
(3) the Ambulance benefit is not payable for the same trip.

Mileage is measured from the insured’s primary residence to the hospital or treatment facility where the follow-up treatment is provided.

This benefit is limited to two payments per insured per covered accident.

**Support Care**

**Adult Companion Lodging**

If an insured is injured in a covered accident, we will pay the adult companion lodging benefit shown on the specifications page for each day the insured is receiving treatment in a hospital or rehabilitative facility for the injury, and for the 24 hours following the last day the insured is receiving treatment in a hospital or rehabilitative facility for the injury subject to the following conditions:

(1) a companion who accompanies the insured stays in lodging for which a charge is made; and
(2) either the hospital stay benefit or rehabilitative therapy (inpatient) benefit is payable for the same day the adult companion lodging benefit is payable; and
(3) the companion is 18 or older.

Lodging refers to an establishment licensed under the laws applicable to where it is located, such as a motel, hotel, or other facility that provides sleeping accommodations to the general public in exchange for a fee and is located at least 100 miles from the insured’s primary residence.

This benefit is limited to 30 days per covered accident. Proof must be provided that the companion incurred an expense for staying at a lodging.
Exclusions and Limitations

Are there any other exclusions that apply?

Yes. In no event will we pay benefits where the insured's accident, injury or loss is caused directly or indirectly by, results in whole or in part from or during, or there is contribution from, any of the following:

1. intentionally self-inflicted injury while sane; or
2. suicide or attempted suicide, while sane; or
3. your participation in, or your attempt to commit, a crime, assault, felony, or any illegal activity, regardless of any legal proceedings thereto; or
4. the use of alcohol; or
5. the use of prescription drugs (unless taken upon the advice of a licensed physician in the verifiable prescribed manner and dosage), non-prescription drugs, illegal drugs, medications, poisons, gases, fumes or other substances taken, absorbed, inhaled, ingested or injected; or
6. motor vehicle collision or accident where you are the operator of the motor vehicle and your blood alcohol level meets or exceeds the level at which intoxication is defined in the state where the collision or accident occurred, regardless of any legal proceedings thereto; or
7. war or any act of war, whether declared or undeclared; or
8. bodily or mental infirmity, illness or disease; or
9. infection, other than pyogenic infection occurring simultaneously with, and as a direct and independent result of, the injury, and other than bacterial infection due to accidental ingestion of a contaminated substance; or
10. repetitive stress syndromes including but not limited to rotator cuff syndrome, bursitis, tendonitis, carpal tunnel syndrome, ulnar nerve syndrome, stress fractures, neuropathy, epicondylitis or neuritis; or
11. medical or surgical treatment or diagnostic procedures including any resulting complications, or when the outcome is not as planned or expected, including claims of medical malpractice; or
12. travel in or descent from any aircraft, except as a fare-paying passenger on a regularly scheduled commercial flight on a licensed passenger aircraft carrier; or
13. participation in the following activities: scuba diving, bungee jumping, base jumping, hang gliding, sail gliding, parasailing, parakiting, or mountain climbing; or
14. riding or driving in any motor-driven vehicle in a race, stunt show or speed test; or
15. practicing for or participating in any semi-professional or professional competitive athletics.

Are there any additional limitations that apply?

Yes. Benefits are not payable for any care, treatment or diagnostic measures which were received outside of the United States or United States territory.

Claims

What notice of claim must be provided?

Written notice of claim must be given to us within 20 days of the date of a loss resulting from a covered accident, or as soon thereafter as reasonably possible.

Notice given by or on the insured’s behalf to us at our home office or to any authorized agent of ours, with information to identify the insured, shall be deemed notice to us.

Will claim forms be provided?

Upon receipt of notice of claim, we will provide a claim form. If the claim form is not provided within 15 days after the insured has given notice of claim, we will deem the insured to have complied with the requirements for filing proof of a loss resulting from a covered accident if the insured submits, within the time period for filing proof of the loss, written proof of the occurrence, character and extent of the loss for which claim is made which is satisfactory to us.

When is proof of a loss resulting from a covered accident required?

Written proof of a loss resulting from a covered accident satisfactory to us must be provided to us within 90 days of the date of the loss. Failure to provide proof of the loss within this time will not invalidate or reduce a claim if it was not reasonably possible to provide proof within this 90 day period. However, proof must be provided within 1 year of the date of the loss, except in the absence of legal capacity.

When will the benefit be paid?

We will pay a benefit for a loss resulting from a covered accident after receipt at our home office of written proof of the loss which meets all policy requirements and is satisfactory to us. You are responsible for all costs associated with claim form(s) completion, records, and the submission of your claim.

To whom will benefits be paid?

All benefits including dependent’s benefits will be paid to you, if you are living. If you die before the claim is paid, benefits will be paid to your estate.

What are our physical examination rights?

After an insured has filed a claim and provided at his or her expense all requested claim forms and records,
we have the right to have the insured examined by a physician of our choice and at our expense. This right may be exercised as often as reasonably necessary while an insured has a claim pending with us.

**Termination**

*When does your coverage terminate?*

Coverage ends on the earliest of the following:

1. the date you no longer meet the eligibility requirements; or
2. 31 days (the grace period) after the due date of any premium which is not paid; or
3. the last day for which premium contributions have been paid following your request to cancel your coverage; or
4. the date the group policy ends.

*When does an insured dependent's coverage terminate?*

An insured dependent's coverage ends on the earliest of the following:

1. the date the dependent no longer meets the eligibility requirements; or
2. 31 days (the grace period) after the due date of any premium contribution which is not paid; or
3. the last day for which premium contributions have been paid following your written request that insurance on your eligible dependents be terminated; or
4. the date you are no longer covered under the group policy.

You must notify us or your employer when you no longer have dependents eligible for coverage under this certificate so that premiums may be discontinued. All premiums paid for dependents who are no longer eligible for coverage under this certificate will be refunded without any payment of claim.

**Additional Information**

*Can your insurance coverage be contested?*

Yes. If an insured experiences a loss resulting from a covered accident within two years of the original effective date of coverage or increase in coverage, we will verify the accuracy of the information provided during the application process. If we discover a material misrepresentation, the affected coverage will be rescinded and an otherwise valid claim will be denied. This two year period will be extended by fraud or as otherwise allowed by applicable laws.

*Is the policyholder required to maintain records?*

Yes. The policyholder is required to maintain adequate records of any information necessary for us to administer the policy, and shall provide access to such records when required for us to administer the policy. If a clerical error is made in keeping records on the insurance under the group policy, it will not affect otherwise valid insurance.

A clerical error does not continue insurance which is otherwise stopped, make insurance effective when it should not have been or change the benefit amount provided by the provisions of the policy and no claim shall be paid on amounts affected by a clerical error. If an error causes a change in premium payment, a fair adjustment will be made.

*Will the provisions of this certificate conform with applicable state law?*

Yes. If any provision in this certificate, or in the provisions of the group policy, is in conflict with the applicable laws of the state governing the certificates or the group policy, the provision will be deemed to be amended to conform to such laws.

*What if an insured's age has been misstated?*

If an insured's age has been misstated, all amounts payable will be adjusted to that amount which the premium would have purchased at the correct age. This will be determined by applying the ratio of the paid premium over the required premium to the initial benefit amount.

*Can this insurance be assigned?*

No. Insurance coverage under the group policy cannot be assigned.

*What is the policy interpretation right and authority?*

The following applies only when the administration of the policy is governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. 1001 et seq.:

Securian Life has the exclusive right and authority, in its sole discretion, to interpret the group policy and decide all matters arising thereunder. Securian Life's exercise of that authority shall be conclusive and binding on all persons unless it can be shown that the determination was arbitrary and capricious.
General Information

This certificate supplement is subject to every term, condition, exclusion, limitation and provision of the certificate unless otherwise expressly provided for herein.

What does this supplement provide?

This supplement provides for continuation of insurance if an insured no longer meets the eligibility requirements of the certificate, except as provided for herein.

To continue insurance the insured must make a written request and make the first premium payment within 31 days after insurance provided by the group policy would otherwise terminate. Coverage provided by this supplement will then be deemed effective retroactive to the beginning of the 31-day period. This date is considered to be the insured’s portability date and the insured is then considered to have portability status.

Who is eligible to continue insurance under this supplement?

An insured employee is eligible to continue group accident insurance under the terms of this supplement if he or she no longer meets the eligibility requirements of the certificate due to any of the following:

1. the employee terminates employment, including retirement; or
2. the employee is no longer in a class eligible for insurance or is on a leave or layoff; or
3. a class or group of employees insured under the policy are no longer considered eligible and there is no successor plan for that class or group. Successor plan means an insurance policy or policies provided by us or another insurer that replaces insurance provided under this policy.

Regardless of whether an insured is otherwise eligible under this supplement to continue, an insured will not be eligible to request coverage under this supplement if he or she:

1. has attained the age of 70; or
2. is an employee and was not actively at work due to sickness or injury on the date immediately preceding his or her portability date; or
3. loses eligibility due to a class or group of employees no longer being eligible under the policy and there is a successor plan for that class or group of employees; or
4. loses eligibility due to termination of the group policy.

What insurance can be continued under this supplement?

Group accident insurance may be continued under this supplement. If an employee elects to continue his or her own coverage according to the provisions of this supplement, he or she may also elect to continue insurance for any other individual insured under his or her certificate.

What benefit amounts can be continued under this supplement?

The benefit amounts that can be continued under this supplement shall be the amounts shown on the specifications page applicable to the insured based on the benefit plan selected by the insured employee.

Can an insured request a change in the benefit plan continued under this supplement?

Yes. The insured employee may change the benefit plan to one that provides lower benefit amounts, but may not change the benefit plan to one that provides higher benefit amounts.

How will premiums be paid?

Premiums will be paid directly to us on a monthly, quarterly, semi-annual, or annual basis and will be subject to an administrative charge per billing period.

Can the premium rate change?

Yes. The premium rates for ported coverage may be different than the premium rates for active employees, and are not subject to the premium rate provision of the policy.

What happens if an insured again becomes eligible under the certificate?

If an insured is continuing coverage under the terms of this supplement, and again meets the eligibility requirements of the certificate the insured shall no longer be considered to have portability status. Insurance may be continued only under the terms of the certificate, not including this supplement, unless and until the insured no longer meets the eligibility requirements of the certificate and again returns to portability status as provided for herein.

What happens to insurance provided under this supplement when the group policy terminates?

Any insurance continued under the terms of this supplement will remain in force until terminated by the provisions of the section entitled “When will insurance continued under this supplement terminate?”
No individual may elect coverage under this supplement on or after the date of termination of the group policy.

**When will insurance continued under this supplement terminate?**

An insured's insurance being continued under this supplement will terminate on the earliest of the following:

1. the insured's 70th birthday;
2. the date the insured again meets the eligibility requirements of the certificate, not including the terms of this supplement;
3. in the case of a dependent child or a spouse, the date your coverage is no longer being continued under this supplement or the date the spouse or child ceases to be eligible as defined under the terms of your certificate; or
4. the date the group policy is terminated; or
5. 31 days after the due date of any premium contribution which is not made.

Secretary  
President

15-32405  
EdF91291  03-2018
This Certificate Endorsement is a part of the certificate of insurance describing the benefits available to you under Group Policy No. 76013, issued by Securian Life Insurance Company to Concordia Plan Services. This endorsement is subject to every term, condition, exclusion and provision of the certificate unless otherwise expressly provided for herein.

The following applies to you if you were a resident of the state of Washington at the time your coverage under this certificate became effective:

1. The definition of **child or children** under the Definitions section of the certificate is amended in its entirety and replaced with the following:

   **child or children**

   Your or your spouse’s natural, adopted, stepchild or foster child who is unmarried and less than 26 years old. An adopted child includes a child legally placed for adoption with you. Eligibility begins at live birth (stillborn or unborn children are not eligible). Children age 26 or older are also eligible so long as they are physically or mentally incapable of self-support, were incapable of self-support prior to age 26 and remain financially dependent on you for more than one-half of their support and maintenance.

2. The definition of **covered accident** under the Definitions section of the certificate is amended in its entirety and replaced with the following:

   **covered accident**

   An accident which:

   (1) is not excluded under the Exclusions and Limitations section or any other terms of this certificate; and
   (2) occurs within 365 days of the date of the injury; and
   (3) occurs in the United States or a United States territory.

3. The provision entitled **How is the premium determined?** under the Premiums section of the certificate is amended in its entirety and replaced with the following:

   **How is the premium determined?**

   The premium will be the applicable premium rate in force on the date premiums are due. The premium may also be computed by any other method on which the policyholder and we agree.

   Premium rates are subject to change according to the provisions of the group policy. Any change in the premium rate will be subject to the approval of the Washington State Office of the Insurance Commissioner.

4. The numbered exclusions under the provision entitled **Are there any other exclusions that apply?** under the Exclusions and Limitations section of the certificate are amended in their entirety and replaced with the following:

   (1) intentionally self-inflicted injury while sane; or
   (2) suicide or attempted suicide while sane; or
   (3) your participation in, or your attempt to commit, a crime, assault, felony, or any illegal activity, regardless of any legal proceedings thereto; or
   (4) alcoholism and drug addiction; or
   (5) the use of poisons, gases, fumes or other substances unless taken, absorbed, inhaled, ingested or injected accidentally; or
   (6) war or any act of war, whether declared or undeclared; or
   (7) bodily or mental infirmity, illness or disease; or
   (8) infection, other than infection occurring simultaneously with, and as a direct and independent result of, the injury; or
(9) repetitive stress syndromes including but not limited to rotator cuff syndrome, bursitis, tendonitis, carpal tunnel syndrome, ulnar nerve syndrome, stress fractures, neuropathy, epicondylitis or neuritis; or
(10) medical or surgical treatment or diagnostic procedures including any resulting complications, or when the outcome is not as planned or expected, including claims of medical malpractice; or
(11) travel in or descent from any aircraft, except as a fare-paying passenger on a regularly scheduled commercial flight on a licensed passenger aircraft carrier; or
(12) participation in the following activities: scuba diving, bungee jumping, base jumping, hang gliding, sail gliding, parasailing, parakiting, or mountain climbing; or
(13) riding or driving in any motor-driven vehicle in a race, stunt show or speed test; or
(14) practicing for or participating in any semi-professional or professional competitive athletics.

Secretary

President