MADISON NATIONAL LIFE INSURANCE COMPANY, INC.

Home Office: 1241 John Q. Hammons Drive, Madison, WI 53717 • Phone: 1-800-356-9601
Administered By: North American Benefits Company • 20 Valley Stream Parkway, Suite 310, Malvern, PA 19355

GROUP ACCIDENT INSURANCE
CERTIFICATE OF INSURANCE

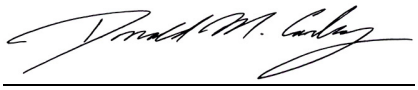
PLEASE READ THIS CERTIFICATE CAREFULLY.

This Certificate of Insurance (hereinafter referred to as "Certificate") is evidence of insurance provided under the Group Policy issued to, and held by, the Group Policyholder (as shown in the "Schedule Page"). If You have an Accident while insured under this Certificate, We will pay Benefits according to the terms of this Certificate. This Certificate describes the essential features of the insurance.

The Group Policy is the agreement between the Group Policyholder and Us. The Group Policy may be amended at any time without notice to You. Any amendment will not affect a claim occurring before the amendment takes effect. You may inspect the Group Policy at any time during business hours at the office of the Group Policyholder.

Executed by Madison National Life Insurance Company, Inc.

Marita Zuraitis
President



Donald M. Carley
Corporate Secretary

ACCIDENT ONLY INSURANCE

GUARANTEED ISSUE

THIS 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 CERTIFICATE IS NOT A MEDICARE SUPPLEMENT CERTIFICATE. If You are eligible for Medicare, review the Guide to Health Insurance for People with Medicare, which You can get from Us.

THIS IS NOT MEDICAL OR DISABILITY INSURANCE. RECEIPT OF BENEFITS UNDER THIS CERTIFICATE MAY AFFECT ELIGIBILITY FOR MEDICAID OR OTHER GOVERNMENT BENEFITS AND/OR ENTITLEMENTS.

NON-PARTICIPATING

Table of Contents

Schedule of Benefits
("Schedule Page")

Administrative
Group Policyholder: County of Flathead School District #5

Group number: WS00103

Group Effective Date: July 1, 2022

Insurance type: Non-Occupational, no Benefits are payable for Accidents occurring while an Insured Person is working at his or her occupation for wage or profit.

Eligible Class(es): Class 1- All Eligible Persons

Minimum Hourly Work Requirement: 25 hours per week

Waiting Period for insurance: Not Applicable

Annual enrollment period: Limited to one annual enrollment period in a 12-month period.
Special enrollment period: Included

Insured: Insurance to age 80
Dependent: Spouse insurance to age 80 and Child insurance to age 26

Premium Contribution
Insured: Applicable
Dependents: Applicable
Group Policyholder: Not Applicable

Benefit Payments
There is no lifetime maximum Benefit.
We will pay the following percentage of all Accident Benefits shown below:

Insured: 100%
Spouse: 100%
Child: 100%

Benefit Waiting Period: Not Applicable

Maximum Benefit Period: 365 days

Number of Accidents insured during each Group Policy year: 2

Benefit are payable per Accident, unless otherwise shown

Accident Benefits and Details
Initial Care and Treatment (must be received within 72 hours after the Accident)

Ambulance (ground) - $100 within 24 hours after the Accident

Ambulance (air) - $250 within 24 hours after the Accident

- If both air and ground transportation take place on the same day, only the Benefit with the higher Benefit amount is payable.

Initial Outpatient Physician Office or Urgent Care - $20 per visit, limited to 1 visit

Emergency Room - $250 per visit, limited to 1 per year (Treatment must be received within 24 hours of the Accident.)

Transfusion of blood, plasma and platelets - $75 per day, limited to 1 day

Medical appliances - $50 (must be purchased within 90 days of the Accident).

Therapy Services (physical, speech and occupational) - $15 per visit, limited to 1 visit

Outpatient X-Ray - $25

Outpatient Advanced Diagnostic Imaging - $150

Outpatient Surgery - $100

Inpatient Hospital Care

Hospital Stay - maximum Benefit $150 per day, limited to 30 days

- (stay must begin within 90 days of the Accident).

Intensive Care Unit (ICU) stay - $300 per day, limited to 30 days

- (stay must begin within 60 days of the Accident.)

Rehabilitation - $50 per day, limited to 5 days

First Day Hospital Admission - $100 per first day, limited to 1 per 12-month period

Miscellaneous Hospital Services - $50

Follow Up Care and Treatment:

Outpatient Physician Office and Urgent Care - $25 per visit, limited to 1 day

Home Health Care - $15 per visit, limited to 5 visits

Telemedicine consultation - $10 per encounter, limited to 1 encounter

Pain Management (epidural anesthesia) - $50

Prosthesis or artificial limb (one or multiple) - $250 minimum, $750 maximum per day

- (device must be received within 365 days following the Accident).

Lacerations

If multiple Lacerations are suffered in one Accident, then the largest single Laceration Benefit will be paid. Treatment must be received within 12 hours following the Accident.

Over 6 inches - $200

2 to 6 inches - $50

Under 2 inches - $25

Lacerations not requiring stitches - $25

Injuries

Concussions (once per a 12-month period) - $50 (must be Diagnosed within 24 hours following the Accident.)

Coma - $2,500

Emergency Dental Work, repair with crown - $50, extraction $25

- Emergency treatment must be received within 72 hours following the Accident.

Paralysis of four limbs (quadriplegia) - $5,000

Paralysis of two limbs (paraplegia) - $2,500

Paralysis of one side of body (hemiplegia) - $2,500

Injuries Requiring Surgery

Eye Injuries requiring surgical repair - $75; removal of foreign body $20

- If surgery and the removal of a foreign object is required on the same day for the same Injury, only the higher Benefit amount is paid.

Surgery (with repair):

Hernia - $100

- (must be Diagnosed within 90 days of the Accident and repaired through surgery within 180 days following the Accident.)

Ruptured/Herniated disc $100

Cranial, Abdominal and Thoracic (chest) - $250

Tendons, Ligaments, Rotator Cuff, and Knee Cartilage – single $200, multiple $400

Joint Replacement - $3,000

Exploratory Arthroscopic (without repair) - $100 (must occur within 180 days of the Accident)

Burns (Treatment must be received from a Physician within 72 hours following the Accident.)

Second Degree - Less than 10% - $50; at least 10%, but less than 35% - $100; 35% or more - $200

Third Degree - Less than 10% - $300; at least 10%, but less than 35% - $500; 35% or more - $2,500

Fractures (complete break of a bone)

If an Insured Person sustains multiple fractures to the same bone during the same Accident, We will pay only one Fracture Benefit. If an Insured Person sustains a Fracture of more than one bone, We will pay for each Fracture, but no more than 4 times the applicable Fracture Benefit for the bone involved with the highest Benefit amount.

Skull depressed (dented) - $3,500

Skull simple (cracked) - $1,500

Facial bones (except teeth) - $350

Lower jaw - $350

Upper arm or upper jaw - $350

Forearm, hand or wrist (except fingers) - $350

Finger - $50

Shoulder blade or collar bone - $350

Rib (one or more) - $250

Vertebrae - $700

Vertebral processes - $350

Hip or Thigh - $2,500

Pelvis (except the tailbone) - $700

Coccyx (the tailbone) - $250

Leg - $700

Foot, ankle, or knee cap - $350

Toe - $50

Dislocations (bone separation at the joint)

If an Insured Person sustains more than one Dislocation, We will pay for each Dislocation, but no more than 2 times the applicable Dislocation Benefit for the joint with the highest Benefit amount.

Lower jaw - $250

Collar bone (treated near the shoulder) - $100

Collar bone (treated near the center of chest) - $500

Shoulder - $250

Elbow - $250

Wrist - $250

Hand - $250

Finger or toe - $100

Hip - $1,000

Knee (not the knee cap) - $750

Foot or ankle - $500

Organized Sports (a Benefit for Dependent Children only) - $150 one-time fixed indemnity Benefit per Accident

Accidental Death - (within 90 days of the Accident.)
Insured: $20,000

Spouse: $12,500

Child(ren): $12,500

Accidental Death - Common Carrier (public transportation) (death must occur within 90 days of the Accident.
Insured, Spouse and Child – 2 times the Accidental Death Benefit

Accidental Dismemberment Loss – The Loss must occur within 90 days of the Accident.
One hand, foot or entire sight in one eye - $10,000 (each Loss)

One hand and foot, one hand and entire sight in one eye, one foot and entire sight in one eye, both hands, both feet or entire sight in both eyes - $20,000

Definitions

Accident means a sudden, unexpected and unforeseen, identifiable event causing bodily Injury. The Accident must occur while the Insured Person is insured under the Group Policy.

Accidental Death means death caused by an Accident.

Accidental Death Common Carrier (public transportation) means death by the following: traditional taxies, transportation network companies (referred to as "rideshare companies"); passenger trains, bus lines (inner city or between cities) and commercial airlines.

Active Work and **Actively at Work** mean performing all the material duties of Your own occupation and satisfying the Minimum Hourly Work Requirement. Actively at Work includes regularly scheduled days off, holidays, or vacation days, so long as You are capable of sustained Active Work on those days.

Ambulance means a vehicle equipped for transporting the injured or sick to or from a Hospital or between medical facilities for treatment of an Injury.

Annual enrollment period means a period pre-determined by the Group on an annual basis, limited to one annual enrollment in a 12-month period.

Benefit Waiting Period means the time period (as shown in the "Schedule Page") an Insured Person must wait before Benefits are payable.

Collar bone means a shoulder bone linking the scapula and sternum.

Coma means a profound state of unconsciousness from which an Insured Person cannot be aroused to consciousness, even by external stimulation, lasting for a continuous period of at least 4 consecutive days.

Concussion means a brain Injury resulting in temporary loss of normal brain function.

Contributory means You pay all or a portion of Your insurance premium.

Diagnosed/Diagnosis means a definitive Diagnosis made by a Physician based upon the use of clinical and/or laboratory investigations as supported by an Insured Person's medical records and meeting any Diagnosis requirements set forth in this Certificate for the particular Accidental Injury being Diagnosed.

Diagnostic Imaging means a variety of machines and techniques that create pictures of the structures and activities inside the body. The type of imaging used depends on symptoms and the part of the body being examined. They include computerized tomography scan (CT scan), nuclear medicine scans (radioactive substances used to see structures and functions inside the body), magnetic resonance imaging (MRI) scan and diagnostic medical sonography (ultrasound).

Dislocation means a completely separated joint.

Eligible Class means a classification defined by the Group and shown in the "Schedule Page". You must be an Eligible Person of an Eligible Class in order to be eligible for this insurance.

Eligible Dependent (also referred to as "**Dependent**") means Your "Spouse" or "Child" (defined below) who is not in a Period of Limited Activity on their effective date of insurance or on any increase of insurance dates. Dependent does not include a person who is a full-time member of the armed forces of any country. No person may be considered a Dependent of more than one Insured Person. ***Period of Limited Activity*** *means any period of time a Dependent is confined in a hospital or nursing facility or if not confined, unable to carry on the regular and usual activities of a healthy person of the same age and gender.*

- **Spouse** means a person to whom the Insured is legally married to and from whom the Insured is not legally separated. "Spouse" includes state recognized domestic partners.

- **Child** (Children) means Your unmarried "Child" until the age shown in the "Schedule Page". "Child" includes stepchild, foster child or legal ward, a Child legally placed in the home for adoption and/or a legally adopted Child. Except where otherwise specified, a Child of a state recognized domestic partner will be the equivalent of a Child of a Spouse under this Certificate.

  Disabled Child means Your unmarried adult "Child" who is, on and after the date the insurance would end because of the Child's age, continuously incapable of self-sustaining employment because of intellectual disability or physical disability and chiefly dependent upon You for support and maintenance. You must provide proof of Your Disabled Child's status within 31 days after the date insurance would otherwise end because of the Child's age. Thereafter, We may require further proof of Your Disabled Child's status, but not more often than annually after the 2-year period following the Child's attainment of the limiting age. Costs associated with such proof will be Your responsibility.

Eligible Person means an individual in an Eligible Class (as shown in the "Schedule Page"), who is Actively at Work, and who is reported on the Group's records for Social Security and tax withholding purposes.

Emergency Dental Work means the repair or extraction of a tooth that is due to an Accident. No Benefit is payable for an Injury caused by biting or chewing.

Emergency Room means a Hospital room or area staffed and equipped for the reception and treatment of persons requiring emergency medical care.

Eye Injuries mean an Injury that requires surgery or the removal of a foreign object by a Physician. An exam with anesthesia is not surgery.

Follow-up Care and Treatment means treatment received due to an Accident.

Fracture means a break, rupture or crack in a bone Diagnosed by an X-ray.

Group Effective Date means the date (shown in the "Schedule Page") the Group Policy, with respect to the Group, became effective.

Group Policy means the group insurance policy We issued to the Group.

Group and Group Policyholder mean the "Group Policyholder" named in the "Schedule Page".

Hernia means tissue, or an internal organ or other body part, protrudes through a weak spot in the wall of muscle or tissue that surrounds it.

Herniated disc (a bulged, slipped or ruptured disc) means a fragment of the disc nucleus (a jelly-like material which is the inner core of the disc) that is pushed out of the annulus (a tough circular exterior of the disc that surrounds the nucleus), into the spinal canal through a tear or rupture in the annulus.

Home Health Care means clinical medical care provided by a registered nurse, occupational therapist, physical therapist or other skilled medical professionals, and is often prescribed as part of a care plan following a hospitalization.

Hospital means a legally constituted institution (or an institution which operates pursuant to law), having organized facilities for the care and treatment of sick and injured persons on a resident or inpatient basis, including facilities for Diagnosis and surgery under the supervision of a staff of one or more licensed physicians, and provides twenty-four (24)-hour nursing service by registered nurses on duty or call. It does not mean convalescent, nursing, rest or extended care facilities or facilities operated exclusively for treatment of the aged, drug addiction or alcoholism, even though the facilities are operated as a separate institution by a hospital**.**

Hospital Stay means a stay in a non-ICU room of a Hospital as a result of an Accident.

Initial Care and Treatment means the initial exam and treatment received for an Accident or Injury.

Injury means a bodily Injury sustained as a direct result of an Accident, independent of disease, bodily infirmity or any other causes, and results in medical expense. The accidental Injury must occur while the Insured Person is insured under the Group Policy.

Insured means an Eligible Person whose insurance is in effect under this Certificate.

Insured Person means an Insured or Eligible Dependent whose insurance is in effect under this Certificate.

Intensive Care Unit (ICU) means a designated area of a Hospital dedicated to the care of persons who are critically ill or injured and is separate from the surgical recovery room.

Laceration means a deep cut or tear in the skin or flesh.

Ligament means a fibrous connective tissue which attaches bone to bone, and usually serves to hold structures together and keep them stable.

Maximum Benefit Period means the maximum period of time (shown in the "Schedule Page") where treatment, services and supplies related to an Accident must be incurred.

Medical appliance (prescribed by a Physician) means (including, but not limited to) a cane, ankle brace, walking boot, walker, crutches, leg brace, wheelchair, knee scooter, body jacket, back brace, or cervical collar.

Minimum Hourly Work Requirement means the work hours over a given time period required of You by the Group in order to be eligible for insurance. Your Minimum Hourly Work Requirement is shown in the "Schedule Page".

Miscellaneous Hospital Services means medical supplies and services received to treat an Injury when Hospital confined.

Noncontributory means the Group pays the entire premium for insurance.

Organized Sports means any regularly scheduled, non-professional athletic event associated with school and non-school programs that are governed by an organization and require formal registration to participate. This includes (1) an exhibition game; (2) club, intramural and intercollegiate sports; (3) competitions; (4) team practice, training and workout session; try-out; and (5) any supervised or sponsored sports activity.

This does not include: (1) playing, coaching, or officiating for pay; (2) personal, non-team related practice, training, workout sessions; (3) unstructured play such as pick-up games or spontaneous play; (4) activity that is outside of the Child's membership role; (5) activities a Child is paid to play; and (5) travel to and from the organized sporting activity.

Paralysis means the (i) complete or partial loss of function that is expected to be permanent, especially when involving the motion or sensation in a part of the body' (ii) loss of the ability to move; or (iii) a state of powerlessness or incapacity to act.

Physician means any licensed physician, physician assistant, dentist, osteopath, chiropractor, optometrist, podiatrist, psychologist, licensed social worker, licensed professional counselor, licensed marriage and family therapist, acupuncturist, naturopathic physician, physical therapist, or advanced practice registered nurse, or registered nurse first assistant for treatment of any illness or injury within the scope and limitations of the person's practice. He or she must be properly licensed or certified by the laws of the state where he or she practices. For the purpose of this insurance, Physician does not include You or Your Spouse or the brother, sister, parent or child of either You or Your Spouse. .

Prior Plan means the Group's group accident insurance in effect on the day immediately preceding the Group Effective Date under the Group Policy**.**

Prosthesis means an artificial device to replace or augment a missing or impaired part of the body. This excludes hearing aids, dental aids or false teeth, eyeglasses or cosmetic prostheses, such as wigs.

Rehabilitation (inpatient Hospital) means free-standing rehabilitation Hospitals and Rehabilitation units in acute care Hospitals. They provide an intensive Rehabilitation program and persons who are admitted must be able to tolerate intense Rehabilitation services.

Rotator cuff means a group of muscles and tendons surrounding the shoulder joint, keeping the head of the upper arm bone firmly within the shallow shoulder socket.

Second Degree Burn means the epidermis (outer layer of skin) has been burned through and part of the dermal (second layer of skin) has been burned by heat, electricity, radiation, friction or chemicals. For the purpose of this Certificate, Second Degree Burns do not include burns that result from the skins exposure to the sun.

Special enrollment period (if applicable) means an enrollment period for Eligible Persons or Eligible Dependents to apply, subject to the "Special enrollment period" provision in section "Eligibility and Effective Dates".

Surgery means when a Physician cuts into the skin or other organ to: (1) implant mechanical or electronic devices; (2) make a Diagnosis; (3) redirect channels; (4) remove an obstruction, diseased tissue, or diseased organ(s); (5) repair an area that has been injured or affected by trauma, overuse, or disease; (6) repair an area to restore proper function; (7) reposition structures to their normal position; or (7) transplant tissue or whole organs.

Surgery without repair means arthroscopic or exploratory surgery without repair or if cartilage is torn or shaved (debridement).

Telemedicine means the remote Diagnosis and treatment of persons by means of telecommunications technology.

Tendon means a fibrous connective tissue which attaches muscle to bones and other structures (e.g. eyeball).

Therapy Services means speech, occupational or physical therapy required as a result of an Accident, that is prescribed and rendered by a Physician or a speech, occupational or physical therapist, and performed in an office setting or in a Hospital on an inpatient or outpatient basis.

Third Degree Burn means an area of tissue damage which there is destruction of the entire epidermis (outer layer of skin) and the dermal (second layer of skin) that is caused by heat, electricity, radiation or chemicals.

Urgent Care means a facility licensed as a freestanding medical facility by applicable state and federal laws to treat an urgent condition.

X-ray means a radiographic image formed using x-radiation to produce an image.

Vertebral (spinous) processes means bones that make up the spine are called vertebrae. Each vertebra has a bony section that points out toward the back called the spinal process. A spinous process fracture is a break in one or more of these sections.

Waiting Period for insurance means the time period (as shown in the "Schedule Page") You must be an Eligible Person (and Actively at Work) before insurance is effective, unless You were insured under the Prior Plan.

We, Us and **Our** means Madison National Life Insurance Company, Inc.

You and **Your** means the Insured.

Eligibility and Effective Dates

Eligibility for Insurance

Eligible Person

Your eligibility date is the first day of the month following Your Waiting Period for insurance.

To be eligible You must satisfy the following requirements:

1. be an Eligible Person.
2. be a citizen or legal resident of the United States of America or one of its territories or Canada.
3. satisfy Your Waiting Period for insurance, if any.
4. You cannot be an Eligible Person of more than one Eligible Class.
5. be Actively at Work and capable of sustained Active Work on the effective date of Your insurance and the effective date of any subsequent increase in insurance.
6. You cannot be inpatient confined in a hospital or similar facility and must be able to perform routine activities of daily living. This means You must perform the following acts without direct assistance or continuous help or oversight from someone else: (i) wash or bathe Yourself in the tub or shower, or by sponge bath from a basin; (ii) dress or change clothes, including fastening and unfastening any braces or artificial limbs; (iii) eat or feed Yourself once food has been prepared and made available; (iv) transfer Yourself or move in and out of a chair or bed except with the aid of equipment (including support and other mechanical devices); and (v) get to and from, and on and off, the toilet to maintain a reasonable level of personal hygiene and to adjust clothing.)
7. You cannot be a part-time, temporary, seasonal or leased worker; or a full-time member of the armed forces of any country.
8. You cannot be insured under more than one group accident policy.

Eligible Dependent

You must apply for Dependent insurance and Your Dependent must meet the definition of "Dependent".

To be eligible an Eligible Dependent must satisfy the following requirements:

1. be an Eligible Dependent.
2. be a citizen or legal resident of the United States of America or one of its territories or Canada.
3. cannot be inpatient confined in a hospital or similar facility and must be able to perform routine activities of daily living. This means you must perform the following acts without direct assistance or continuous help or oversight from someone else: (i) wash or bathe yourself in the tub or shower, or by sponge bath from a basin; (ii) dress or change clothes, including fastening and unfastening any braces or artificial limbs; (iii) eat or feed yourself once food has been prepared and made available; (iv) transfer yourself or move in and out of a chair or bed except with the aid of equipment (including support and other mechanical devices); and (v) get to and from, and on and off, the toilet to maintain a reasonable level of personal hygiene and to adjust clothing.
4. cannot be insured under more than one group accident policy.

Effective Dates

Initial Enrollment

Insured: Insurance is effective if You apply prior to or within 31 days of the date You become an Insured Person.

Dependents: Insurance is effective when You apply for Your Dependent(s) prior to or within 31 days of their eligibility date (e.g. marriage, newborn or adoption). Newborn Children are automatically insured for the first 31 days from the moment of birth. If You do not apply within 31 days Your Dependent(s), including newborn Child, may not enroll until the next Annual or Special enrollment period.

Special enrollment period

This provision only applies if the Schedule Page indicates it is included.

If an Eligible Person or Eligible Dependent does not enroll when first eligible, he or she may enroll for insurance, other than at Annual enrollment, if at the time the Eligible Person or Eligible Dependent: (i) was insured by insurance providing similar accident Benefits and (ii) lost that insurance for one or more of the following reasons:

1. termination of eligibility;
2. changes from full-time to part-time employment;
3. termination of the other insurance referenced above;
4. death of a Spouse; or
5. legal separation or divorce from a Spouse.

In addition, You may apply for a Dependent Spouse who becomes eligible by reason of marriage, or children who become eligible as shown in the definition of "Child", after Your effective date.

Increases in Insurance
An increase in insurance can only occur during a Special enrollment period or Annual enrollment period. An increase in insurance is effective on the first day of the month immediately following the month You are eligible for such insurance, except if You are eligible on the first day of a month, insurance is effective on that day.

Leaves of Absence
Approved FMLA Leave of Absence
Contributory or Noncontributory Premiums: If You are on leave with the Federal Family and Medical Leave Act of 1993 (FMLA), as amended, insurance will continue until the later of the required FMLA leave period or the leave period required by applicable state law, if:

1. FMLA Leaves, and the right to continue insurance during FMLA Leaves, are available to all Insureds in the same Eligible Class under the Group Policy;
2. the Group remits the required insurance premium; and
3. the FMLA Leave is approved in advance by the Group and the approval includes documentation with the beginning and ending dates of the leave. Documentation about Your leave must be available to Us at Our request.

If You cease to be an Eligible Person and insurance ends, and then You again become an Eligible Person in all respects within 3 months, the Waiting Period for insurance will be waived on the first day of Your return to Active Work.

Accident Benefit Payments

Benefits are payable for Accidents that occur after the Benefit Waiting Period, as shown in the Schedule Page, when an Insured Person has experienced an Accident.

Emergency medical care must be obtained or incurred within 72 hours of the Accident. Non-emergency medical care must be obtained within 90 days after the Accident, subject to the Maximum Benefit Period. Medical treatments, procedures and equipment must be Diagnosed, treated and recommended by a Physician.

Benefit Payments upon an Accident are subject to the Accident occurring within the United States and while the Insured Person's insurance is in effect under this Certificate. Available Benefits must not be precluded by any general or specific Certificate Exclusion or any failure to meet any condition precedent set out herein. Benefit payments are made accordingly to the "Schedule Page" and paid directly to You, unless otherwise specified.

Exclusions

No Benefits are payable for non-medically documented or non-verifiable Injuries or Accidents. In addition, no Benefits are payable if the Accident is caused by or contributed to:

1. war or act of war. War means a state or period of declared or undeclared war whether civil or international, or any substantial armed conflict with organized forces of a military nature between nations, states or parties.
2. being on active duty or training in the Armed Forces, National Guard or Reserves of any state or country.
3. committing or attempting to commit a felony or being engaged in an illegal occupation.
4. an intentional self-inflicted injury, attempted suicide or suicide or voluntarily taking poison or inhaling gas.
5. being intoxicated during the commission of a crime.
6. being under the influence of any narcotic unless administered on the advice of a Physician.
7. medical negligence and malpractice.
8. being confined, for any reason, in a penal or correctional facility.
9. cosmetic surgery or other elective procedures or having dental treatment except as a result of an injury.
10. flying in an ultralight, hang or sail gliding, parachuting or bungi-cord jumping, or by flight in a space craft or any craft designed for navigation above or beyond the earth's atmosphere.
11. operating, riding in or descending from any aircraft, except as a fare-paying passenger on a commercial aircraft.
12. driving or riding in a motor-driven vehicle in a race, stunt show, speed test or while testing any vehicle on any racecourse or speedway.
13. ballooning, boarding (self-balancing or hovering), mountaineering (using ropes and/or equipment), parasailing and skydiving.
14. handling or using an illegal weapon.
15. participating in any organized interscholastic or collegiate sport.
16. participating in any organized professional or semi-professional sport.
17. participating in any sporting event for pay or prize money.
18. participating in a rodeo.
19. medical treatment, services and supplies received outside the United States, unless incurred while an Insured Person is on a trip of not more than 90 days.

Claims Provisions

Notice of Claim
To file a claim for Benefits under this Certificate, You must provide Us with Proof of Loss sent to our address shown on this Certificate's cover page. Notice given by You, or on Your behalf, to Us with information sufficient to identify You, is deemed notice to Us. Notice should be made within 180 days after any loss covered by the Group Policy. If it is not reasonably possible to give notice within that time, the claim may not be denied or reduced due to the delay.

Claims Forms
Upon receipt of written notice of claim We will send You a Claim Form for filing Proof of Loss. If You do not receive forms within 15 days after giving notice You can send Us, without the Claim Form, written Proof of Loss.

Proof of Loss
"Proof of Loss" means satisfactory written proof to determine if a loss occurred for Benefits, not subject to any Exclusion, and meets all other conditions for Benefits. Proof of Loss includes any other information We reasonably require in support of a claim for Benefits.

Proof of Loss must be provided in writing to Us, at Your expense, within 90 days after the date of the loss, if reasonably possible. Proof of Loss must be provided no later than one year after expiration of that 90-day period. The time limits under this section shall not apply while the Insured Person lacks legal capacity.

Proof of Loss includes any items We reasonably require in support of a claim, such as completed claims statements and a signed authorization for Us to obtain information. If the required documentation is not provided within 45 days after You receive Our request, Your claim may be denied. The time period for Our decision will be tolled while We are waiting for You to provide the requested information. No Benefits will be paid until We receive Proof of Loss satisfactory to Us.

Physical Examination and Autopsy. We may examine, at Our own expense, an Insured Person when a claim is made and when and so often as We reasonably require during the pendency of the claim, and to request an autopsy in case of death, where it is not prohibited by law.

Claim Decision
We will notify You of Our claim decision within a reasonable period of time, but not later than 45 days after We receive Proof of Loss. If We request additional information from You to assist Us in making the claim decision, We will notify You of Our decision within 30 days after We receive the information.

We may extend these time periods up to 30 days if We determine an extension is necessary due to matters beyond Our control. We will notify You prior to the end of the initial 45-day period of the circumstances requiring the extension of time and the date We expect to render a decision.

If, prior to the end of the first 30-day extension period, We determine that due to matters beyond Our control, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days. We must notify You of the second 30-day extension period prior to the expiration of the first 30-day extension period.

In the case of an extension, the notice of extension will specifically explain the standards which entitlement to a Benefit is based. It will also explain the unresolved issues that prevent a decision on the claim, any additional information needed to resolve those issues, and the date We expect to render a decision.

Time Payment of Claims and Payment of Claims
We will pay Benefits within 20 days after We receive Proof of Loss. Payment will be made in one lump sum to You or to the payee You appropriately assign.

Benefits are paid to You, as shown in the "Schedule Page. Benefits payable at the time of Your death are paid to the first surviving class of Your following living relatives: Spouse, children, parents, brothers and sisters or to the executors or administrators of Your estate. Any payment will fulfill Our responsibility for the amount paid. All other Benefits under this Certificate are payable to You.

Facility of Payment. We may pay part of the Benefit, up to $500, to any person appearing to Us to be equitably entitled to the amount by having incurred funeral or other expenses incident to the last illness or death of an Insured Person. Any Benefit payment made before Our home office received written notice of a valid claim, by some other person, releases Us from further obligation.

Notice of Adverse Decision on Claim
If We deny any part of Your claim You will receive a written notice of denial containing the following:
1. the specific reasons for Our decision;
2. specific reference to the provisions of this Certificate which Our decision is based;

3. a description of any additional information needed to perfect Your claim and an explanation of why the information is necessary;
4. information concerning Your right to appeal Our decision; and
5. if an internal rule, guideline, protocol or other similar criterion is relied upon in making the adverse decision, We will either provide a copy of the internal rule, guideline, protocol or other similar criterion or information as to how You may obtain a copy of it free of charge upon request.

Review Procedure
If all or part of a claim is denied You may request a review in writing and send Your request to Us within 120 days after You receive notice of the denial. You may send us written comments or other items to support the claim. We will review the claim promptly after We receive the request. We will send You a notice of our decision within 45 days after We receive the request, unless special circumstances require an extension. If We determine that an extension in our review time is required, written notice of the extension will be furnished to You prior to the expiration of the initial 45-day period. In no event will such extension exceed a period of 60 days from the end of the initial period, after We receive the required Proof of Loss.

When Insurance Ends

Insured Person
Except as otherwise provided for under this Certificate, insurance will cease on the earliest of the following to occur:

1. upon Your request;
2. the date You cease to be an Eligible Person or the premium due date on or next following the date You cease to be an Eligible Person.
3. the date a Dependent ceases to be an Eligible Dependent;
4. the date the Group Policy terminates; or
5. the date Your required premium payment is not paid.

Termination or Amendment of the Group Policy
The Group Policy may be terminated, changed or amended by Us or the Group according to the terms of the Group Policy. Any change or amendment may apply to Insureds or to any separate classes or categories thereof. We may change the Group Policy when any change or clarification in law or governmental regulation affects Our obligations under the Group Policy, or with the Group's consent.

If We terminate this Group insurance according to the terms of the Policy, We will give the Group not less than a 60-day notice. A Group may terminate insurance under the Group Policy in whole or may terminate insurance for any class or group of Insureds, at any time by giving Us advanced written notice at least 60 days prior to termination. Insurance will terminate automatically for nonpayment of premium, subject to the Group Policy's grace period and reinstatement provisions.

<u>Reinstatement of Insurance</u>
If Your insurance ends because You fail to make the required contribution while on an approved Family Medical Leave Act (FMLA) Leave of Absence, and then You return to Active Work and enroll in insurance within 31 days of the earlier of the end of the period of leave You and the Group agreed upon, or the end of the 12-week period following the date Your leave began, then the Benefit Waiting Period will be waived.

General Provisions

Assignment
An Insured Person may assign his or her rights, privileges or Benefits under this Certificate, when approved by Us.

Clerical Error
Clerical error by Us, the Group, or their respective representatives will not: (i) cause a person to become insured under the Group Policy or a provision of it, (ii) invalidate insurance otherwise validly in force, (iii) continue insurance otherwise validly terminated, or (iv) cause a Group to obtain insurance under the Group Policy or a provision of it.

In the event that a clerical error results in an incorrect premium rate, We may adjust the premium rate accordingly. The payment of premium, by itself, does not obligate Us to provide Benefits to anyone who is not eligible for insurance under the Group Policy.

The Group acts on its own behalf as Your agent and not as Our agent. The Group has no authority to alter, expand or extend Our liability or to waive, modify or compromise any defense or right We may have under the Group Policy.

Conformity With Montana Statutes
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 Person resides on or after the effective date of this Certificate.

Entire Contract, Changes
This Certificate, including the Enrollment Form, Group Policy and any Endorsement, amendment or rider, if any, constitutes the entire contract of insurance. No change in this Certificate shall be valid until approved by one of Our executive officers and unless approval is endorsed hereon or attached hereto. No agent has authority to change this Certificate or waive any of its provisions.

Legal Actions
No legal action may be brought to recover on this Certificate until at least 60 days after written Proof of Loss has been given as required. No legal action will be brought after the expiration of any applicable statutes of limitations.

Misstatement
If the enrollment information of an Insured Person has been misstated We will make an equitable adjustment of premiums, Benefits or both. The adjustment is based on the amount of insurance based on the correct enrollment information and the difference between the premiums paid or would have been paid if the enrollment information had been correctly stated.

Time Limit On Certain Defenses
Insured Person: Any statement made to obtain or to increase insurance, in the absence of fraud, is a representation and not a warranty. No misrepresentation will be used as a basis for reducing or denying a claim or contesting the validity of insurance unless We have given the Insured Person a copy of the written instrument he or she signed containing the misrepresentation.

- After insurance has been in effect for 2 years, during the lifetime of an Insured Person, We will not use a misrepresentation as a basis for reducing or denying a claim.

Group Policyholder: Any statement made by the Group to obtain the Group Policy, in the absence of fraud, is a representation and not a warranty. No misrepresentation by the Group will be used as a basis for denying the validity of the Group Policy, unless We have given the Group a copy of a written instrument signed by the Group, containing the misrepresentation.

- We will not contest the validity of the Group Policy after it has been in force for 2 years, except for nonpayment of premiums.

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.
Mailing: PO Box 5008, Madison, WI 53705 • Phone: 1-800-356-9601

INSURANCE PORTABILITY BENEFIT ENDORSEMENT GROUP ACCIDENT INSURANCE

This is an Insured Person's Insurance Portability Benefit Endorsement (hereafter referred to as "Endorsement"). **This Endorsement provides for an additional insurance benefit under the Group Accident Certificate of Insurance** (hereafter referred to as "Certificate").

This Endorsement, including the Certificate, constitutes the Entire Contract of insurance. No change in this Endorsement shall be valid until approved by one of Our executive officers. No agent has authority to change this Endorsement or waive any of its provisions.

Provisions under this Endorsement are subject to all definitions, terms and conditions, limitations and exclusions of the Entire Contract, unless otherwise stated herein. Please refer to the Certificate.

When Your insurance ends under the Certificate because You cease to be an Eligible Person, You may elect to continue the insurance You had (including Dependent insurance) if You have been continuously insured for at least 12 months, under the Group Policy or its Prior Plan, just before Your insurance ended, and You are under the age of 60. Your insurance must end for a reason other than retirement or gross misconduct or You did not make Your required premium contribution. You must not be insured under any other group accident insurance and You must not be Disabled.

To continue Your insurance under the Certificate with this Endorsement, You must apply in writing and pay the first premium to Us within 31 days after the date Your insurance terminated. If You do not purchase portable insurance for Yourself You cannot purchase it for any Dependent, if applicable. You will receive further information when You purchase this portable insurance.

Your portable insurance is governed by the Group Policy and can be reduced or terminated. Insurance under this Endorsement will end the earlier of the date the Insured fails to pay any required premium, the Insured attains age 80, or the Group Policy terminates.

Executed by Madison National Life Insurance Company, Inc.

Marita Zuraitis
President

NOTICE OF PROTECTION PROVIDED BY MONTANA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a **brief summary** of the Montana Life and Health Insurance Guaranty Association (Association) and the protection it provides for policyholders. The Association was established under Montana law to provide protection in the unlikely event that a life, annuity or health insurance issuer becomes financially unable to meet its obligations and is placed into liquidation. 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. In the event a company is placed into liquidation, benefits provided by the Association are payable according to the insurance policy or certificate, and subject to the following maximum limits:

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

- Health Insurance
  - $500,000 in health 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 present value, including net cash surrender and net cash withdrawal 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 the $500,000 maximum in health insurance benefits but not including disability, long term care or other types of health insurance benefits.

Note: Other restrictions to coverage apply. 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 8247, Missoula, MT 59807
1-877-678-1048 or administrator@mtlifega.org

Office of the Montana State Auditor, Commissioner of Securities and Insurance
840 Helena Ave.
Helena, MT 59601
1-406-444-2040

IF YOUR INSURANCE COMPANY IS IN GOOD STANDING AND NOT IN LIQUIDATION, PLEASE DIRECT QUESTIONS ABOUT YOUR POLICY TO YOUR INSURANCE COMPANY!

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 law will control.

NOTICE

This notice describes identities of and relationships among the insurer, administrator, and policyholder/certificate holder of this insurance.

Insurer: The insurance underwriter of your policy/certificate of insurance is as follows:

Madison National Life Insurance Company, Inc. (MNL)
1241 John Q. Hammons Drive
Madison, WI 53717

Third Party Administrator (TPA): The TPA of your policy/certificate of insurance is as follows:

North American Benefits Company (NABCO)
20 Valley Stream Parkway, Suite 310
Malvern, PA 19355

NABCO provides administrative services for insurance issued to policyholders/certificate holders including, but not limited to, claims, underwriting, premium billing, premium collection, client service, contract and policy/certificate issuance.

There is no ownership affiliation between MNL and NABCO.

Policyholder/Certificate Holder: The policyholder/certificate holder is listed in the Schedule of Benefits.

The TPA administers the insurer's policy/certificates in accordance with all contract provisions and pays benefits to the policyholders/certificate holders. All rights and responsibilities of the parties are outlined in the policy/certificate.

Your policy/certificate is fully insured which means the covered risk(s) is the responsibility of the insurer whereas the risk of a self-insured policy/certificate is the responsibility of the employer or company.