MADISON NATIONAL LIFE INSURANCE COMPANY, INC.

1241 John Q. Hammons Drive, Madison, WI 53717● PO Box 5008, Madison, WI 53705
(800) 356-9601 ● www.madisonlife.com

Accident Insurance Certificate

The Policy has been issued to the Policyholder.

This Certificate of insurance is evidence of the Covered Person's coverage under the Policy and of its benefits. Everything contained in this Certificate is subject to the provisions, definitions, and exceptions in the Policy, if any. The Policy is on file with the Policyholder and may be examined at any reasonable time. Only one of Our executive officers may authorize a change to the Policy.

This Certificate replaces all certificates and certificate riders, if any, previously issued to the Primary Insured under the Policy. The Policy was delivered in the State of Issue and is governed by its laws and, to the extent applicable, the Employee Retirement Income Security Act of 1974 (ERISA) and any of its amendments.

NOTICE OF RIGHT TO EXAMINE CERTIFICATE. If the Primary Insured is not satisfied with the Certificate for any reason, the Primary Insured may return it to Us within 30 days after it is received. Once returned, We will refund the premiums paid, and the Certificate will be voided from the Primary Insured's Coverage Effective Date.

This Certificate is signed for us by:

President and Chief Executive Officer

Executive Vice President and Corporate Secretary

THIS IS AN ACCIDENT ONLY CERTIFICATE, AND IT DOES NOT PROVIDE BENEFITS FOR SICKNESS. IT PROVIDES LIMITED BENEFITS. BENEFITS ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES. PLEASE READ THIS CERTIFICATE CAREFULLY. THIS CERTIFICATE IS NOT A MEDICARE SUPPLEMENT CERTIFICATE. IF A COVERED PERSON IS ELIGIBLE FOR MEDICARE, THE COVERED PERSON SHOULD REVIEW A GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE AVAILABLE FROM US.

CERTIFICATE INDEX GUIDE

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Madison National Life
a Horace Mann company

CERTIFICATE SCHEDULE PAGE

Policyholder:	West Des Moines CSD	**Certificate Issue Date:**	7/1/26
Policy Number:	013781GA	**Types of Certificate Coverage:**	
Policy Effective Date:	July 1, 2026	Primary Insured	
Policy Anniversary:	July 1	Primary Insured and Spouse	
Policy State of Issue:	Iowa	Primary Insured and Child(ren)	
		Primary Insured and Family	

Eligible Class(es):

Class 1: All full-time employees that are Actively at Work for the Policyholder.

Eligibility Waiting Period 0 days

BENEFITS SCHEDULE

THIS IS ONLY A SUMMARY. SEE THE ACTUAL CERTIFICATE PROVISIONS FOR ADDITIONAL LIMITATIONS AND COMPLETE DETAILS.

1. Emergency and Hospitalization Benefits

A. Hospital Inpatient Admission Benefit

Primary Insured	$750/day
Spouse	$750/day
Child	$750/day
Maximum Benefit per Covered Person	1 day/Calendar Year

B. Daily Inpatient Hospital Confinement Benefit

Primary Insured	$150/day
Spouse	$150/day
Child	$150/day
Maximum Benefit per Covered Person	365 days/Calendar Year

C. Intensive Care Unit Admission Benefit

Primary Insured	$1,250/day
Spouse	$1,250/day
Child	$1,250/day
Maximum Benefit per Covered Person	1 day/Calendar Year

D. Intensive Care Unit Confinement Benefit

Primary Insured	$250/day
Spouse	$250/day
Child	$250/day
Maximum Benefit per Covered Person	30 days/Calendar Year

E. Inpatient Rehabilitation Benefit

Primary Insured	$200/day
Spouse	$200/day
Child	$200/day
Maximum Benefit per Covered Person	60 days/Calendar Year

F. Emergency Room Benefit

Primary Insured	$250/day
Spouse	$250/day
Child	$250/day
Maximum Benefit per Covered Person	3 days/Calendar Year

G. Urgent Care Benefit

Primary Insured	$150/day
Spouse	$150/day
Child	$150/day
Maximum Benefit per Covered Person	3 visits/Calendar Year

H. Initial Physician's Office Visit

Primary Insured	$60/day
Spouse	$60/day
Child	$60/day
Maximum Benefit per Covered Person	3 visits/Calendar Year

I. Initial Telemedicine Visit

Primary Insured	$60/day
Spouse	$60/day
Child	$60/day
Maximum Benefit per Covered Person	3 visits/Calendar Year

J. Ambulance Benefit

Ground/Water	$350/day
Air	$1,250/day
Maximum Benefit per Covered Person	1/Calendar Year

K. Major Diagnostic Testing Benefit	$125/day
Maximum Benefit per Covered Person	3/Calendar Year

L. X-Ray Benefit	$300/day
Maximum Benefit per Covered Person	3/Calendar Year

2. Covered Injuries Benefits

A. Burns Benefit

Minor Burns	$200
Moderate Burns	$400
Severe Burns	$5,000
Skin Graft	50% of burn benefit
Maximum Benefit per Covered Person	3/Calendar Year

B. Coma Benefit	$4,000
Maximum Benefit per Covered Person	1/Calendar Year

C. Concussion Benefit	$200

D. Eye Injury Benefit

Removal of Foreign Body	$150
Surgical Repair	$350
Maximum Benefit per Covered Person	3/Calendar Year

E. Dislocation Benefit

Ankle	$1,000
Collarbone (sternoclavicular)	$750
Collarbone (acromioclavicular and separation)	$250
Elbow	$500
Finger	$150
Foot (except toes)	$1,000
Hand (except fingers)	$750
Hip	$3,000
Knee (except patella)	$1,500

Lower jaw	$750
Shoulder blade	$800
Toe	$150
Wrist	$500
Open reduction	200% of benefit otherwise payable
Partial (Incomplete) Dislocation	25% of benefit otherwise payable
Multiple Dislocations Maximum Amount	200% of highest benefit payable

F. Fracture Benefit

Ankle	$1,200
Collarbone (clavicle)	$1,250
Coccyx	$300
Face or nose (other than jawbone)	$800
Finger	$150
Foot (except toes)	$1,200
Forearm (radius and/or ulna)	$1,200
Hand (except fingers)	$1,200
Hip	$3,000
Kneecap (patella)	$1,200
Leg (tibia and/or fibula)	$1,800
Lower Jaw (mandible, other than alveolar process)	$1,000
Pelvis	$2,500
Rib	$400
Skull (depressed)	$2,700
Skull (simple)	$1,000
Shoulder blade	$1,250
Sternum	$1,250
Thigh (femur)	$3,000
Toe	$150
Upper Arm (humerus)	$1,000
Upper Jaw (maxilla, other than alveolar process)	$1,000
Vertebrae (other than vertebral process)	$2,700
Vertebral Processes	$500
Wrist	$1,200
Open reduction	200% of benefit otherwise payable
Chip Fracture	25% of benefit otherwise payable
Multiple Fractures Maximum Amount	200% of highest benefit payable

G. Laceration Benefit

Not requiring stitches/sutures	$50
Less than 2 in. length	$150
2-6 in.	$250
Greater than 6 in.	$500
Maximum Benefit per Covered Person	2/Calendar Year

3. Surgical Benefits

A. Arthroscopic Surgery Benefit	$300
Maximum Benefit per Covered Person	2/Calendar Year
B. Cranial Surgery Benefit	$600
Maximum Benefit per Covered Person	2/Calendar Year

C. Hernia Surgery Benefit	$300
Maximum Benefit per Covered Person	2/Calendar Year
D. Herniated Disc Surgery Benefit	
Surgical Repair	$600
Exploratory	$200
Maximum Benefit per Covered Person	2/Calendar Year
E. Torn Knee Cartilage Surgery Benefit	
Surgical Repair	$600
Exploratory	$200
Maximum Benefit per Covered Person	2/Calendar Year
F. Open Abdominal or Thoracic Surgery Benefit	
Surgical Repair	$1,250
Exploratory	$350
Maximum Benefit per Covered Person	2/Calendar Year
G. Tendon, Ligament, or Rotator Cuff Surgery Benefit	
Surgical Repair of One	$750
Surgical Repair of Two or More	$1,500
Exploratory	$200
Maximum Benefit per Covered Person	2/Calendar Year
H. Miscellaneous Surgery Benefit	
General Anesthesia	$250
Conscious Sedation	$125
Maximum Benefit per Covered Person	2/Calendar Year

4. Treatment and Other Services

A. Accident Follow Up Treatment Benefit (Physician's Office)	$80/day
Maximum Benefit per Covered Person	10 days/Calendar Year
B. Accident Follow Up Treatment Benefit (Urgent Care/Telemedicine)	$80/day
Maximum Benefit per Covered Person	10 days/Calendar Year
C. Emergency Dental Benefit	
Crown	$150/day
Extraction	$60/day
Maximum Benefit per Covered Person	3/Calendar Year
D. Blood, Plasma, Platelets Benefit	$200/day
E. Medical Appliance Benefit	
Wheelchair	$350
Knee Scooter	$350
Body Jacket	$350
Walking Boot	$100
Walker	$100
Crutches	$125
Leg Brace	$100

Cervical Collar	$100
Cane	$100
Ankle Brace	$100
Maximum Benefit per Covered Person	3/Calendar Year
F. Prosthetic Benefit	
One Prosthetic Device	$500
Two or More Prosthetic Devices	$1,000
G. Therapy Services Benefit	$60/day
Maximum Benefit per Covered Person	10 days/Calendar Year
H. Family Member Lodging Benefit	
Daily benefit amount	$125/day
Maximum benefit per Covered Person	30 days/Calendar Year
I. Transportation Benefit	$250/round trip
Maximum benefit per Covered Person	3 trips/Calendar Year

5. Accidental Death and Dismemberment Benefits

A. Accidental Death Benefit	$50,000
B. Accidental Death – Common Carrier Benefit	$100,000
C. Accidental Dismemberment – Catastrophic Loss Benefit	
Loss of Both Hands or Both Feet	$20,000
Loss of Both Arms or Both Legs	$20,000
Loss of Use of Both Arms or Both Legs	$20,000
Loss of One Hand and One Foot	$20,000
Loss of One Arm and One Leg	$20,000
Loss of Use of One Arm and One Leg	$20,000
Total Blindness	$20,000
Loss of Hearing in Both Ears	$20,000
Loss of Speech	$20,000
D. Home or Vehicle Modification Benefit	$2,000

6. Optional Benefits

A. Wellness Benefit	$50/Calendar Year

CONDITIONS OF COVERAGE

Eligibility

Each person that is a member of an Eligible Class is eligible for coverage under the Policy as a Primary Insured, subject to any Eligibility Waiting Period shown on the Certificate Schedule. Coverage may also be extended to include the Primary Insured's Dependent(s) based on the provisions below.

Primary Insured's Effective Date

We have issued this Certificate in consideration of: (1) authorization of the required premium; and (2) the Primary Insured's enrollment form (if required). The Primary Insured's coverage begins on the Primary Insured's Coverage Effective Date at 12:01 A.M. Standard Time at the address where the Policy was delivered.

An eligible person may enroll only within 31 days after becoming eligible or acquiring a new Dependent or during an open enrollment period.

Dependent's Effective Date

Insurance for a Dependent that is eligible on the Primary Insured's Coverage Effective Date is effective on that date, provided the Primary Insured enrolls the Dependent, and the required premium is authorized. Otherwise, a Dependent's insurance becomes effective at 12:01 A.M. Standard Time at the address where the Policy was delivered on the Dependent's Coverage Effective Date, provided the Primary Insured enrolls the Dependent and the required premium has been authorized.

In no case will coverage for eligible Dependents take effect before the Primary Insured's coverage.

A person may not be covered under the Policy as both a Primary Insured and a Spouse. The Primary Insured may not apply for coverage for the Primary Insured's spouse if the spouse is covered under the Policy as a Primary Insured. If the Primary Insured and spouse are both covered under the Policy as Primary Insureds, any Child(ren) may be covered under one of the parent's plans, but not both.

Newborn Child Coverage

A Child of the Primary Insured born while the Primary Insured's coverage under the Policy is in force is covered from the moment of birth until the 31st day of age. If any additional premium is required, a notice of birth, together with the additional premium, must be submitted to Us within 31 days of birth to continue coverage beyond the initial 31 day period.

Adopted Child Coverage

A minor child who comes under the charge, care and control of the Primary Insured while the Primary Insured's coverage under the Policy is in force is covered if the Primary Insured files a petition to adopt. The child's coverage is the same as provided for the Primary Insured's other Dependent(s). The child is covered from the date the petition to adopt is filed if the Primary Insured applies for coverage and pays any required premium within 31 days after filing the petition to adopt. However, coverage starts at the moment of birth if the petition for adoption, application for coverage and payment of premium occur within 31 days after the child's birth. Coverage for the minor child continues, unless the petition for adoption is dismissed or denied.

Foster Child Coverage

A child placed with the Primary Insured as a foster child while the Primary Insured is covered under the Policy is covered from the date of placement. If any additional premium is required, a notice of placement as a foster child together with the additional premium must be submitted to Us within 31 days after the date of such placement to continue coverage beyond the 31-day period.

Medical Support Order

A child who is the subject of a medical support order is covered under the Policy when We receive notice of the medical support order. If any additional premium is required, it must be submitted to Us within 31 days after the date of the notice to continue coverage beyond the 31-day period.

Deferred Effective Date

All Coverage Effective Dates will be deferred if the Primary Insured is not Actively at Work on the day coverage would otherwise begin. If deferred, coverage will become effective on the first day of the month following the day after the date the Primary Insured has completed one full day of Active Work, except that coverage will become effective on the first day of the current month if these requirements are met on that date.

Other Insurance With Us

A Covered Person cannot be covered under more than one of Our Accident policies at a time. If we issue more than one such policy, the Primary Insured must select one of the Covered Person's coverages to cancel. If the cancellation results in a decrease in the required premium payment, We will refund the premiums paid for the cancelled coverage for the time duplicate coverage was in effect. If the Primary Insured does not select one coverage to cancel, we will automatically cancel the Covered Person's coverage purchased most recently.

PREMIUM PROVISIONS

Payment of Premiums

If the Primary Insured is responsible for paying premiums directly to Us, such premiums may be paid to Us at Our Home Office. The first premium is due on or before the Primary Insured's Coverage Effective Date. All subsequent premiums are due on the premium due date. The premium for additional, increased, reduced, or terminated insurance may cause a pro-rata adjustment on the next premium due date.

Premium Changes

After the initial premium rates have been in effect for 24 months from the Policy Effective Date, We may recalculate premium rates. We also have the right to recalculate the initial or any subsequent premium rate when the terms of the Policy or Certificate change.

If the Primary Insured is responsible for paying premiums directly to Us, We will give the Primary Insured 60 days advance written notice of any change in premium rates. We will not change the rates more than once in any period of 12 consecutive months.

Grace Period

A Grace Period of 31 days will be granted for the payment of each premium falling due after the first premium. During the Grace Period, the coverage offered under this Certificate shall continue in force unless the Primary Insured gives Us written notice of termination in advance of the date of termination and in accordance with the terms of this Policy. If the entire premium is not paid by the end of the Grace Period, the coverage provided by this Certificate will terminate.

Reinstatement

If any renewal premium is not paid within the time granted the Primary Insured for payment, a subsequent acceptance of premium by Us or by any agent duly authorized by Us to accept such premium, without requiring an application for reinstatement, shall reinstate the Covered Person's coverage. However, if We or Our agent require an application for reinstatement, the Covered Person's coverage will be reinstated upon the earlier of the approval of the application by Us, or the 45th day following the date the premium was received by Us, unless We have previously notified the Primary Insured in writing of Our disapproval of the application.

The reinstated insurance shall cover only loss occurring after the date of reinstatement. In all other respects, all parties shall have the same rights as under the Policy immediately before the due date of the defaulted premium, subject to the provisions of any Rider which may be attached in connection with the reinstatement.

Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

Return of Premium

In the event of termination of the Primary Insured's coverage, We shall promptly return on a pro-rata basis the unearned premium paid, if any, and the Primary Insured shall promptly pay, on a pro-rata basis, the unpaid earned premium, if any.

TERMINATION OF COVERAGE

Primary Insured's Termination

Coverage for the Primary Insured ends, subject to any continuation, portability, or conversion privileges (if available), on the earliest of:

1. the date the Policy terminates;
2. the last day of the month following the date the Primary Insured is no longer part of an Eligible Class, unless contributions for coverage were made in advance, in which case coverage terminates at the end of the period for which premiums have been paid;
3. any premium due date, if full payment is not made when due, subject to the Grace Period provision;
4. the last day of the month following the date the Primary Insured attains age 70;
5. the date the Primary Insured enters an armed service on full-time active duty. Premium will be returned on a pro-rata basis if the Policyholder notifies Us in writing;
6. the date the Primary Insured requests coverage be terminated; or
7. the date of the Primary Insured's death.

The Policy will remain in force for any period for which the premium is paid when due or during the Grace Period. If the Policy terminates due to nonpayment of premium, it will terminate on the Renewal Date at 12:01 A.M. Standard Time at the address where the Policy was delivered (subject to the Grace Period provision).

Termination of coverage under the Policy will not affect a claim that existed on the date of termination.

Dependent's Termination

Coverage for Dependents ends, subject to any continuation, portability, or conversion privileges (if available), on the earlier of:

1. the Primary Insured's termination date;
2. the date We receive the Primary Insured's written request to terminate coverage under the Policy for such Dependent; or
3. the date the Dependent is no longer eligible, unless contributions for coverage were made in advance, in which case coverage terminates at the end of the period for which premiums have been paid.

In no case will Dependent coverage end later than the Primary Insured's coverage. Termination of coverage under the Policy will not affect a claim that existed on the date of termination.

CONTINUATION PRIVILEGE

Primary Insured Continuation

If the Primary Insured is no longer part of an Eligible Class, coverage may be continued when loss of eligibility is the result of one or more of the following:

1. illness or injury;
2. a temporary leave of absence or furlough, which is approved by the Policyholder in writing;
3. a disability that renders the Primary Insured unable to perform the regular duties of the Primary Insured's occupation and is eligible for disability insurance as a result;
4. is laid off by the Policyholder as a result of downsizing or other strategic business decision unrelated to the Primary Insured's job performance;
5. the Family Medical Leave Act (FMLA).

Coverage continued under this provision will end on the next premium due date following the earliest of:

1. 12 weeks from the date the Primary Insured ceased to be part of an Eligible Class, unless the continuation is triggered by a leave of absence in accordance with the FMLA, in which case coverage will continue for the statutorily prescribed duration;
2. the date the Primary Insured is reinstated as part of an Eligible Class; or
3. the date the Primary Insured begins full-time employment with an employer other than the Policyholder.

If coverage is continued under this provision and premiums are not paid when due, coverage will terminate. Coverage continued under this provision will also end in accordance with the Termination of Coverage provisions. Except as described in this provision, coverage continued under this provision is subject to all other terms and provisions of the Policy.

PORTABILITY PRIVILEGE

The Primary Insured may be eligible for portability coverage when coverage ends under the Policy. The terms, conditions, and premium rates of the portability coverage will be governed by a separate portability policy and may not be the same as those under this Certificate.

Primary Insured Portability

If the Primary Insured is age 64 or younger, the Primary Insured may request portability coverage when:

1. the Primary Insured is no longer part of an Eligible Class and is not eligible for coverage under the Continuation of Coverage provision in this Certificate;
2. the Primary Insured is no longer employed by the Policyholder; or
3. the Policy terminates and the Policyholder does not obtain a replacement Policy with another insurance carrier within 31 days.

Electing Portability

To elect portability coverage, the Primary Insured must send a request to Us. The benefits and premium rates of the portability coverage will be provided along with Our portability request form, which can be obtained by contacting the Policyholder or Us. The initial premium due must be received within 31 days after insurance under the Policy ends.

The continued group insurance portability coverage is available as a result of portability rights that arise solely from the Policy, as arranged for the Primary Insured as an employee welfare benefit, subject to the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

BENEFITS

Subject to the terms, conditions, exclusions, and limitations of the Policy, We will pay the benefits described below for a Covered Person's covered Injury. The benefit amounts and any applicable maximums payable for each benefit are shown in the Benefits Schedule (unless otherwise stated in the benefit itself). If care received is due to more than one covered Injury, benefits will be payable only for the covered Injury with the greatest covered benefits. Hospitalization must begin while this Policy is in force for the Covered Person.

1. EMERGENCY AND HOSPITALIZATION BENEFITS

A. *Hospital Inpatient Admission Benefit.*
We will pay the amount shown in the Benefits Schedule for the first day of a Covered Person's inpatient Confinement in a Hospital for a covered Injury, subject to the maximum benefit shown in the Benefits Schedule. The Covered Person must be admitted to the Hospital within 180 days of the Accident that caused the Injury. Readmissions to the Hospital for the same covered Injury are not eligible for this benefit unless the Hospital admission occurs more than 180 days after the initial Confinement. This benefit is not payable for Treatment in an Emergency Room or Outpatient Care Facility, or confinement of less than 20 hours in an Observation Unit. If a Covered Person qualifies for a Hospital Inpatient Admission Benefit and an Intensive Care Unit Admission Benefit on the same day, only the highest benefit is payable.

B. *Daily Inpatient Hospital Confinement Benefit.*
We will pay the benefit amount shown in the Benefits Schedule for each day a Covered Person is Confined in a Hospital due to a covered Injury, not to exceed the maximum number of days shown on the Benefits Schedule. The Covered Person must be Confined to a Hospital within 180 days of the date of the Accident that caused the Injury.

This benefit is not payable for Treatment in an Emergency Room, Outpatient Care Facility, or confinement of less than 20 hours in an Observation Unit. If a Covered Person qualifies for a Daily Hospital Confinement Benefit and Intensive Care Unit Confinement Benefit on the same day, only the highest benefit is payable.

C. *Intensive Care Unit Admission Benefit.*
We will pay the amount shown in the Benefits Schedule for the first day of a Covered Person's Confinement in an Intensive Care Unit for a covered Injury subject to the maximum benefit shown in the Benefits Schedule. The Covered Person must be admitted to the Intensive Care Unit within 30 days of the Accident that caused the Injury. Readmissions to the Intensive Care Unit for the same covered Injury are not eligible for this benefit unless the Intensive Care Unit admission occurs more than 180 days after the initial Confinement. This benefit is not payable for Treatment in an Emergency Room, Outpatient Care Facility, Observation Unit, or Step-Down Care Unit. If a Covered Person qualifies for a Hospital Inpatient Admission Benefit and an Intensive Care Unit Admission Benefit on the same day, only the highest benefit is payable.

D. *Intensive Care Unit Confinement Benefit.*
We will pay the benefit amount shown in the Benefits Schedule for each day a Covered Person is Confined in an Intensive Care Unit due to a covered Injury, not to exceed the maximum number of days shown on the Benefits Schedule. The Covered Person must be Confined in the Intensive Care Unit within 30 days of the date of the Accident that caused the Injury.

This benefit is not payable for Treatment in an Emergency Room, Outpatient Care Facility, Observation Unit or Step-Down Care Unit. If a Covered Person qualifies for a Daily Hospital Confinement Benefit and Intensive Care Unit Confinement Benefit on the same day, only the highest benefit is payable.

E. *Inpatient Rehabilitation Benefit.*
We will pay the amount shown in the Benefits Schedule for each day a Covered Person is Confined to a Rehabilitation Unit or Skilled Nursing Facility for a covered Injury. Inpatient Rehabilitation Confinement must follow within 30 days of a covered Confinement in a Hospital.

This benefit is not payable on the same day a Daily Inpatient Hospital Confinement Benefit is payable.

F. *Emergency Room Benefit.*
We will pay the amount shown in the Benefits Schedule for each day a Covered Person receives Treatment in an Emergency Room for a covered Injury. This benefit is payable only once per Covered Person per Accident. In the event of multiple Accidents in a Calendar Year, the total benefits payable will not exceed the maximum shown in the Benefits Schedule. Treatment in the Emergency Room must be received within 72 hours following the Accident that caused the Injury. If the Urgent Care Benefit or Initial Physician's Office Visit Benefit payable on the same day as the Emergency Room Benefit, only the highest benefit will be paid.

G. *Urgent Care Benefit.*
We will pay the amount shown in the Benefits Schedule for each day a Covered Person receives Treatment in an Urgent Care Facility for a covered Injury. This benefit is payable only once per Covered Person per Accident. In the event of multiple Accidents in a Calendar Year, the total benefits payable will not exceed the maximum shown in the Benefits Schedule. The Treatment must be performed within 90 days of the date of the Accident that caused the Injury.

If the Emergency Room Benefit or Initial Physician's Office Visit Benefit are payable on the same day as the Urgent Care Benefit, only the highest benefit is payable.

H. *Initial Physician's Office Visit.*
We will pay the amount shown in the Benefits Schedule for each day a Covered Person receives initial Treatment in a Physician's office or Walk-In Clinic for a covered Injury. This benefit is payable only once per Covered Person per Accident. In the event of multiple Accidents in a Calendar Year, the total benefits payable will not exceed the maximum shown in the Benefits Schedule. The Treatment must be performed within 60 days of the date of the Accident that caused the Injury.

A Covered Person may not receive both the Initial Physician's Office Visit Benefit and the Initial Telemedicine Visit Benefit for the same Injury. If the Covered Person seeks Treatment in a Physician's office or Walk-In Clinic and also seeks Telemedicine Services for the same Injury, the service provided first will be deemed the initial treatment for purposes of determining which benefit is payable.

This benefit will not be paid for Therapy Services or for any day for which any Inpatient Hospital Benefit is payable. If the Emergency Room Benefit or Urgent Care Benefit are payable on the same day as the Physician's Office Visit Benefit, only the highest benefit is payable.

I. *Initial Telemedicine Visit.*
We will pay the amount shown in the Benefits Schedule for each day a Covered Person receives initial Treatment through Telemedicine provided by a Medical Practitioner. This benefit is payable only once per Covered Person per Accident. In the event of multiple Accidents in a Calendar Year, the total benefits payable will not exceed the maximum shown in the Benefits Schedule. The Treatment must be performed within 60 days of the date of the Accident that caused the Injury.

A Covered Person may not receive both the Initial Physician's Office Visit Benefit and the Initial Telemedicine Visit Benefit for the same Injury. If the Covered Person seeks Treatment in a Physician's office or Walk-In Clinic and also seeks Telemedicine Services for the same Injury, the service provided first will be deemed the initial treatment for purposes of determining which benefit is payable.

This benefit will not be paid for Therapy Services or for any day for which any Inpatient Hospital Benefit is payable. If the Emergency Room Benefit or Urgent Care Benefit are payable on the same day as the initial Telemedicine Visit Benefit, only the highest benefit is payable.

J. Ambulance Benefit.

We will pay the amount shown in the Benefits Schedule for each day a Covered Person receives ambulance transportation to or from a Hospital or between medical facilities for the Treatment of a covered Injury. Ambulance transportation must be provided by a licensed professional air, ground, or water ambulance. This benefit is payable only once per Covered Person per Accident. The benefit paid will not exceed the maximum shown in the Benefits Schedule. Air ambulance transportation must occur within 48 hours after the Accident that caused the Injury. Ground or water ambulance transportation must occur within 90 days of the date of the Accident that caused the Injury. If the Covered Person is transported by ambulance multiple times in the same day, only the highest benefit is payable.

K. ***Major Diagnostic Testing Benefit.***

We will pay the amount shown in the Benefits Schedule for each day a Covered Person receives a Major Diagnostic Test for the purpose of diagnosing a covered Injury. The Major Diagnostic Test must occur within 90 days of the date of the Accident that caused the Injury. This benefit is payable only once per Covered Person per Accident. In the event of multiple Accidents in a Calendar Year, the total benefits payable will not exceed the maximum shown in the Benefits Schedule.

L. ***X-Ray Benefit.***

We will pay the amount shown in the Benefits Schedule for each day a Covered Person receives an X-Ray for the purpose of diagnosing a covered Injury. The X-Ray must occur within 60 days of the date of the Accident that caused the Injury. This benefit is payable only once per Covered Person per Accident. In the event of multiple Accidents in a Calendar Year, the total benefits payable will not exceed the maximum shown in the Benefits Schedule.

2. COVERED INJURIES BENEFITS

A. ***Burns Benefit.***

We will pay the amount shown in the Benefits Schedule if a Covered Person sustains covered burns as the result of an Accident. The Covered Person must be treated by a Medical Practitioner within 72 hours after the Accident. If the Covered Person meets more than one of the burn classifications, We will pay only the greater benefit amount as shown in the Benefits Schedule.

We will pay an additional benefit if, due to a burn for which this Burn Benefit is payable, the Covered Person undergoes skin graft Treatment. The amount payable will be equal to the percentage of the applicable Burn Benefit shown in the Benefits Schedule, not to exceed the maximum benefit shown in the Benefits Schedule.

B. ***Coma Benefit.***

We will pay the amount shown in the Benefits Schedule if a Covered Person is in a Coma caused by an Accident. The Coma must be diagnosed by a Medical Practitioner within 90 days of the date of the Accident that caused the Injury and must continue for 15 days. This benefit is payable only once per Covered Person per Accident.

C. ***Concussion Benefit.***

We will pay the amount shown in the Benefits Schedule if a Covered Person suffers a Concussion as the result of an Accident. The Concussion must be diagnosed by a Medical Practitioner within 72 hours after the Accident that caused the Injury. This benefit is payable only once per Covered Person per Accident.

D. *Eye Injury Benefit.*

We will pay the amount shown in the Benefits Schedule if a Covered Person sustains a covered Injury of the eye that requires surgical repair or removal of a foreign body by a Medical Practitioner. The eye Injury must be treated by a Medical Practitioner within 90 days after the Accident that caused the Injury. This benefit is payable only once per Covered Person per Accident. The benefit paid will not exceed the maximum shown in the Benefits Schedule.

E. *Dislocation Benefit.*

We will pay the amount shown in the Benefits Schedule if a Covered Person's joint is Dislocated as the result of an Accident. The Dislocation must be diagnosed by a Medical Practitioner within 90 days after the Accident that caused the Injury. The amount paid will be based on the affected joint and will be adjusted as shown in the Benefits Schedule if the repair requires an open reduction or if the Covered Person sustains a Partial Dislocation. If a Covered Person sustains more than one Dislocation in a single Accident, we will pay the applicable amount shown in the Benefits Schedule for each Dislocation, not to exceed the Multiple Dislocations Maximum Amount of the highest single Dislocation benefit amount.

F. *Fracture Benefit.*

We will pay the amount shown in the Benefits Schedule if a Covered Person's bone is Fractured as the result of an Accident. The Fracture must be diagnosed by a Medical Practitioner within 90 days after the Accident that caused the Injury. The amount paid will be based on the affected bone and will be adjusted as shown in the Benefits Schedule if the repair requires an open reduction or if the Covered Person sustains a Chip Fracture. If a Covered Person sustains more than one Fracture in a single Accident, we will pay the applicable amount shown in the Benefits Schedule for each Fracture, not to exceed the Multiple Fractures Maximum Amount of the highest single Fracture benefit amount.

G. *Laceration Benefit.*

We will pay the amount shown in the Benefits Schedule if, as the result of an Accident, a Covered Person sustains a Laceration that must be repaired by a Medical Practitioner with stitches (sutures). The Covered Person must be treated by a Medical Practitioner within 72 hours after the Accident. The amount paid will be based on the total length of all Lacerations as shown in the Benefit Schedule. If a Covered Person is treated for a Laceration that does not require stitches by a Medical Practitioner, We will pay the applicable amount shown in the Benefit Schedule.

3. SURGICAL BENEFITS

A. *Arthroscopic Surgery Benefit.*

We will pay the amount shown in the Benefit Schedule if a Covered Person undergoes exploratory arthroscopic Surgery, with no repair, as the result of a covered Injury. Arthroscopic Surgery with surgical repair may be paid under another Surgical Benefit. The arthroscopic Surgery must be performed within 180 days after the Accident occurs. The total benefits payable in a Calendar Year will not exceed the maximum shown in the Benefits Schedule. If a Covered Person has multiple surgeries on the same day, We will pay only the largest Surgical Benefit for which the Covered Person is eligible.

B. *Cranial Surgery Benefit.*

We will pay the amount shown in the Benefit Schedule if a Covered Person undergoes cranial Surgery as the result of a covered Injury. The cranial Surgery must be performed within 180 days after the Accident occurs. The total benefits payable in a Calendar Year will not exceed the maximum shown in the Benefits Schedule. If a Covered Person has multiple surgeries on the same day, We will pay only the largest Surgical Benefit for which the Covered Person is eligible.

C. *Hernia Surgery Benefit.*
We will pay the amount shown in the Benefit Schedule if a Covered Person undergoes hernia Surgery as the result of a covered Injury. The hernia Surgery must be performed within 180 days after the Accident occurs. The total benefits payable in a Calendar Year will not exceed the maximum shown in the Benefits Schedule. If a Covered Person has multiple surgeries on the same day, We will pay only the largest Surgical Benefit for which the Covered Person is eligible.

D. *Herniated Disc Surgery Benefit.*
We will pay the amount shown in the Benefit Schedule if a Covered Person undergoes Surgery for a herniated or ruptured disc as the result of a covered Injury. This Surgery must be performed within 180 days after the Accident occurs. The total benefits payable in a Calendar Year will not exceed the maximum shown in the Benefits Schedule. If a Covered Person has multiple surgeries on the same day, We will pay only the largest Surgical Benefit for which the Covered Person is eligible.

E. *Torn Knee Cartilage Surgery Benefit.*
We will pay the amount shown in the Benefit Schedule if a Covered Person undergoes Surgery for repair of torn knee cartilage as the result of a covered Injury. This Surgery must be performed within 180 days after the Accident occurs. The total benefits payable in a Calendar Year will not exceed the maximum shown in the Benefits Schedule. If a Covered Person has multiple surgeries on the same day, We will pay only the largest Surgical Benefit for which the Covered Person is eligible.

F. *Open Abdominal or Thoracic Surgery Benefit.*
We will pay the amount shown in the Benefit Schedule if a Covered Person undergoes open abdominal or thoracic Surgery as the result of a covered Injury. This Surgery must be performed within 180 days after the Accident occurs. Two or more surgical procedures through the same incision or entry point are considered a single Surgery. The total benefits payable in a Calendar Year will not exceed the maximum shown in the Benefits Schedule. Surgery related to hernia is not included in this benefit. If a Covered Person has multiple surgeries on the same day, We will pay only the largest Surgical Benefit for which the Covered Person is eligible.

G. *Tendon, Ligament, or Rotator Cuff Surgery Benefit.*
We will pay the amount shown in the Benefit Schedule if a Covered Person undergoes Surgery for repair of a tendon, ligament, or rotator cuff as the result of a covered Injury. This Surgery must be performed within 180 days after the Accident occurs. The total benefits payable in a Calendar Year will not exceed the maximum shown in the Benefits Schedule. If a Covered Person has multiple surgeries on the same day, We will pay only the largest Surgical Benefit for which the Covered Person is eligible.

H. *Miscellaneous Surgery Benefit.*
We will pay the amount shown in the Benefit Schedule if a Covered Person undergoes a Surgery not covered by any other named surgical benefit as the result of a covered Injury. This Surgery must be performed within days after the Accident occurs. The total benefits payable in a Calendar Year will not exceed the maximum shown in the Benefits Schedule. If a Covered Person has multiple surgeries on the same day, We will pay only the largest Surgical Benefit for which the Covered Person is eligible.

4. TREATMENT AND OTHER SERVICES

A. *Accident Follow-Up Treatment Benefit (Physician's Office).*
We will pay the amount shown in the Benefit Schedule for each day a Covered Person receives follow-up Treatment of a covered Injury in a Physician's office. Such Treatment must be recommended or advised by a Physician, follow initial treatment for the same Injury, and must be provided within 90 days after the Accident occurs. This benefit is not payable for routine examinations or preventative testing. The benefit paid will not exceed the maximum number of days shown in the Benefits Schedule. If Accident Follow-Up Treatment in more than one facility is provided in the same day, only the highest benefit is payable.

B. *Accident Follow-Up Treatment Benefit (Urgent Care/Telemedicine).*
We will pay the amount shown in the Benefit Schedule for each day a Covered Person receives follow-up Treatment of a covered Injury in an Urgent Care Facility or through Telemedicine performed by a Medical Practitioner. Such Treatment must be recommended or advised by a Medical Practitioner, follow initial treatment for the same Injury, and must be provided within 90 days after the Accident occurs. This benefit is not payable for routine examinations or preventative testing. The benefit paid will not exceed the maximum number of days shown in the Benefits Schedule. If Accident Follow-Up Treatment in more than one facility is provided in the same day, only the highest benefit is payable.

C. *Emergency Dental Benefit.*
We will pay the amount shown in the Benefits Schedule for each day a Covered Person requires the following dental work as a result of a covered Injury:

1. repair of a broken sound, natural tooth with a crown; or
2. extraction of a broken sound, natural tooth.

This benefit is payable only once per Covered Person per Accident, regardless of the number of teeth involved. The benefit paid will not exceed the maximum shown in the Benefits Schedule.

D. *Blood, Plasma, Platelets Benefit.*
We will pay the amount shown in the Benefits Schedule for each day a Covered Person receives a transfusion of blood, plasma, or platelets during a Surgery for a covered Injury. The transfusion must be received within 90 days of the date of the Accident that caused the Injury. This benefit is payable only once per Covered Person per Accident.

E. *Medical Appliance Benefit.*
We will pay the amount shown in the Benefits Schedule if a Covered Person is prescribed a Medical Appliance to aid the Covered Person due to a covered Injury. The Medical Appliance must be prescribed within 90 days of the date of the Accident that caused the Injury. The benefit paid will not exceed the maximum shown in the Benefits Schedule.

F. *Prosthetic Benefit.*
We will pay the amount shown in the Benefits Schedule if a Covered Person loses a hand, foot, arm, leg, or eye due to a covered Injury and requires a prosthetic device, artificial limb, or artificial eye, as prescribed by a Medical Practitioner. The Medical Appliance must be received within 365 days of the date of the Accident that caused the Injury. This benefit is payable only once per Covered Person per Accident.

G. *Therapy Services Benefit.*
We will pay the amount shown in the Benefits Schedule for each day a Covered Person receives Therapy Services on an outpatient basis for a covered Injury. The benefit paid will not exceed the maximum number of days shown in the Benefits Schedule. Must be prescribed and begun within 60 days of the date of the Accident that caused the Injury.

If the Emergency Room Benefit, Urgent Care Benefit or Initial Physician's Office Visit Benefit are payable on the same day as the Therapy Services Benefit, only the highest benefit is payable.

H. *Family Member Lodging Benefit.*
We will pay the daily benefit amount shown in the Benefits Schedule if a Covered Person's family member, who is over the age of 18, incurs charges for qualifying lodging in a motel or hotel room. The purpose of the qualifying lodging must be to accompany or visit a Covered Person who is Confined in a Hospital for Treatment of a covered Injury that is: (1) received on an inpatient basis; (2) prescribed by the Covered Person's Medical Practitioner; (3) received at a Hospital more than 100 miles from the (patient) Covered Person's Primary Residence; and (4) occur not more than 24 hours before or 48 hours after the Covered Person's Treatment. Benefits will not exceed the maximum number of days shown in the Benefits Schedule.

I. *Transportation Benefit.*
We will pay the benefit amount shown in the Benefits Schedule, per round trip, if a Covered Person or any family member of the Covered Person incurs travel charges for Treatment of a covered Injury. Benefits will not exceed the benefit amount shown in the Benefits Schedule.

Where a family member is traveling without the company of the Covered Person, the benefit is payable only for a family member over the age of 18. The family member's travel must be: (1) to accompany or visit a Covered Person who is receiving Treatment of a covered Injury; and (2) to and from a Hospital or Outpatient Care Facility more than 100 miles from the family member's Primary Residence. The travel must be solely for the purpose of accompanying or visiting a Covered Person who is receiving Treatment of a covered Injury. Where a family member is traveling without the company of the Covered Person, the benefit is payable for the mileage from the family member's Primary Residence.

This benefit may not exceed the maximum number of trips shown in the Benefits Schedule, regardless of the number of Covered Persons or family members traveling on each round trip.

5. ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

A. *Accidental Death Benefit.*
We will pay the amount shown in the Benefits Schedule if a Covered Person dies within 90 days of an Accident as a direct result of Injuries sustained in the Accident. If We pay this benefit for a Covered Person, we will not pay the Accidental Death Common Carrier Benefit for the same Covered Person. If the Accidental Death Benefit is payable due to the Primary Insured's death, benefits are payable to the beneficiary named by the Primary Insured in writing to Us. If a Covered Person other than the Primary Insured dies, benefits are payable to the Primary Insured.

B. *Accidental Death – Common Carrier Benefit.*
We will pay the amount shown in the Benefits Schedule if a Covered Person dies within 90 days of an Accident as a direct result of Injuries sustained in the Accident which occurs while the Covered Person is a fare paying passenger on a Common Carrier. If We pay this benefit for a Covered Person, we will not pay the Accidental Death Benefit for the same Covered Person. If the Accidental Death Benefit is payable due to the Primary Insured's death, benefits are payable to the beneficiary named by the Primary Insured in writing to Us. If a Covered Person other than the Primary Insured dies, benefits are payable to the Primary Insured.

C. *Accidental Dismemberment – Catastrophic Loss Benefit.*
We will pay the amount shown in the Benefits Schedule if a Covered Person sustains a Catastrophic Loss as the direct result of an Accident. The Catastrophic Loss must occur within 365 days of the date of the Accident that caused the Injury.

D. *Home or Vehicle Modification Benefit.*

We will pay the amount shown in the Benefits Schedule if, as the result of a covered Injury, a Covered Person requires alterations to the Covered Person's principal residence and/or private automobile to make the residence accessible and/or the automobile drivable or rideable. The residence and/or vehicle modification must occur within 365 days after the Accident occurs. This benefit is payable once per Accident per Covered Person and is payable no more than once per Calendar Year per Covered Person.

6. OPTIONAL BENEFITS

A. *Wellness Benefit.*

We will pay the benefit amount shown in the Benefits Schedule if a Covered Person undergoes or receives documented services for any individual or combination of the following screening exams: abdominal aortic aneurysm ultrasonography, blood test for lipids including total cholesterol, LDL, HDL, and triglycerides, bone marrow testing, bone density screening, breast ultrasound or mammography, CA15-3 blood test for breast cancer, CA 125 blood test for ovarian cancer, carotid doppler, CEA blood test for colon cancer, chest x-ray, colonoscopy, electrocardiogram, double contrast barium enema, fasting blood glucose test, flexible sigmoidoscopy, hemoccult stool analysis, mammogram, pap smear, (including ThinPrep), PSA, serum cholesterol test to determine level of HDL and LDL, serum protein electrophoresis (blood test for myeloma), stress test, thermography, CT angiography, Testicular Ultrasound, Smoking Cessation Program, Cancer Genetic Mutation Test (BRCA), Skin Cancer Screening, Biopsies for Cancer, immunizations, and Lymphocyte Genome Sensitivity Test (LGS) (universal blood test for cancer).

Screening tests must be rendered by a Medical Practitioner while the Covered Person is covered under the Policy. This benefit is payable only once per Calendar Year for each Covered Person.

CLAIM PROVISIONS

Notice of Claim

Notice of claim must be given to Us within 30 days after the occurrence or commencement of any loss covered by the Policy and evidenced by this Certificate, or as soon thereafter as reasonably possible. Notice given by or on behalf of a Covered Person to Us, or to Our authorized agent, at Our Home Office with information sufficient to identify the Covered Person, shall be deemed notice to Us.

Failure to give notice within this time frame will not invalidate nor reduce any claim.

Claim Forms

Upon receipt of a Notice of Claim, We will furnish to the claimant such forms as are usually furnished by Us for filing proof of loss. If forms are not furnished within 15 days after the giving of notice, the claimant shall be deemed to have complied with the requirements of this Certificate as to proof of loss upon submission of, within the time fixed in the Certificate for filing proof of loss, written proof covering the occurrence, the character, and the extent of the loss for which claim is made.

Proof of Loss

Written proof of loss must be furnished to Us, or to Our authorized agent, at Our Home Office within 90 days after the date of the loss. Failure to furnish proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give 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, later than one year from the time proof is otherwise required.

Time of Payment of Claims

Benefits payable under this Certificate, except for benefits that provide periodic payment, will be paid immediately upon Our receipt of due proof of loss. A benefit that is payable by periodic payments, subject to due written proof of loss, will be paid monthly. Any balance remaining unpaid upon termination of liability will be paid immediately upon receipt of due written proof.

Payment of Claims

All benefits are payable to the Primary Insured. Any benefits unpaid at the time of the Covered Person's death will be paid to the Covered Person's designated beneficiary(ies) or if none, then to the Covered Person's estate.

Beneficiary Designation

The Primary Insured can designate one or more beneficiaries to receive any benefits under this Certificate that are unpaid at the time of a Covered Person's death. Beneficiary records will be kept by the Policyholder or the office/system where beneficiary records for the Policy are kept.

Change of Beneficiary

Unless the Primary Insured makes an irrevocable designation of beneficiary, the Primary Insured reserves the right to change the designated beneficiary. The consent of the beneficiary or beneficiaries shall not be required to surrender or assign the Policy, to change beneficiary or beneficiaries, or to any other changes in the Policy.

GENERAL PROVISIONS

Entire Contract

The Policy, including any endorsements, amendments and Riders, the Policyholder application which is attached to the Policy when issued, any Covered Person enrollment forms and the Certificate(s) issued comprise the entire contract between the parties.

Time Limit on Certain Defenses

No statement made by any Covered Person, unless fraudulent, shall be used to contest the validity of the insurance after the insurance has been in force for two years prior to the contest. We may not contest any statement unless the statement is in writing and signed by the Covered Person. This provision shall not preclude Us from asserting at any time a defense based upon the Covered Person's ineligibility for coverage under this Certificate or upon any other provision in the Policy or Certificate.

Statements

All statements made by the Policyholder or any Covered Person shall be deemed representations and not warranties, and no such statements shall be used in the defense of a claim unless a copy of the instrument containing the statement is or has been furnished to the Covered Person or, in the event of the death or incapacity of the Covered Person, to the individual's beneficiary or personal representative.

Physical Examinations and Autopsy

We, at Our own expense, shall have the right and opportunity to examine the Covered Person when and as often as We may reasonably require during the pendency of a claim and to make an autopsy in case of death where it is not forbidden by law.

Overpayments

We have the right to recover any overpayments due to fraud and any error We make in processing a claim. The Primary Insured must reimburse Us in full. We will determine the method by which the repayment is to be made.

Unpaid Premium

Any unpaid premium due for a Covered Person's coverage under this Certificate may be recovered by Us by offsetting against amounts otherwise payable under this Certificate.

Legal Actions

No legal action may be brought to recover on the Policy within 60 days after written proof of loss has been given as required by the Policy. No such action may be brought after the expiration of 3 years after the time written proof of loss is required to be given.

Workers' Compensation

The Policy is not a Workers' Compensation policy. It does not replace nor satisfy any requirement for coverage by Workers' Compensation insurance.

Misstatement of Age

If the age of a Covered Person has been misstated, We may adjust premiums or benefit amounts to reflect the coverage that would have been provided for the correct age.

Conformity With State Statutes

Any provision of this Certificate which, on the Primary Insured's Coverage Effective Date, is in conflict with the statutes of the state in which the Covered Person resides on such date, is hereby amended to conform to the minimum requirements of such state.

EXCLUSIONS AND LIMITATIONS

We will not pay benefits for loss due to an Injury that occurs when the Covered Person's insurance under this Certificate is not in force. In addition, no benefit is payable for:

1. A loss caused or contributed to by:
    a. declared or undeclared war or act of war;
    b. committing or attempting to commit a felony or illegal occupation;
    c. the Covered Person's active participation in a riot or insurrection;
    d. suicide, attempted suicide, or intentionally self-inflicted injury;
    e. full-time active duty as a member of the armed forces of any country or international authority;
    f. the Covered Person's intoxication or being under the influence of drugs or any narcotic, unless prescribed by or administered by a Medical Practitioner;
    g. the Covered Person's engagement in: parachuting, hang-gliding, mountaineering, bungee jumping, sky diving, cave exploration, cave diving, cliff diving, scuba diving, mountain or rock climbing, BASE jumping, free skiing, heli-skiing, motocross, participation in a rodeo, participation in or practice for a competitive athletic contest of any time where compensation or monetary awards are received, the use of any motor driven vehicle in a race, stunt show, or speed test.
    h. alcoholism or drug addiction;
2. Treatment provided by a Family Member;
3. Cosmetic surgery, except that "cosmetic surgery" does not include reconstructive surgery when the surgery is incidental to or follows surgery resulting from trauma, infection, or other diseases of the involved part. "Cosmetic surgery" also does not include reconstructive surgery for congenital disease or anomaly resulting in functional defect; or
4. Diagnosis or treatment received outside of the United States and its possessions, or Canada.

Eligibility Waiting Period

A person that is part of an Eligible Class must satisfy the Eligibility Waiting Period shown in the Certificate Schedule before becoming eligible for coverage under the Policy.

Credit toward the Eligibility Waiting Period will be given for any period of time a Primary Insured was in an Eligible Class under a Prior Policy.

DEFINITIONS

This section provides the meaning of special or capitalized terms used in this Policy.

Accident means a sudden, unforeseen, and unexpected event which occurs without the Covered Person's intent. Accident must occur while the Covered Person's insurance under the Policy is in force.

Actively at Work *or* ***Active Work*** means that a Primary Insured is:

1. performing all the regular duties of the Primary Insured's occupation for the Policyholder in the usual way for 30 or more hours each week; and
2. receiving compensation from the Policyholder for work performed.

A person is considered Actively at Work any day that is not that person's regular scheduled workday (e.g., vacation, holiday, or sick day) as long as the person was Actively at Work on the person's last preceding regular scheduled workday.

Calendar Year begins on the Primary Insured's Coverage Effective Date and continues through December 31 of that year; thereafter, January 1 through December 31.

Catastrophic Loss means an Injury that results in total and irrecoverable:

1. loss of both hands or both feet;
2. loss of both arms or both legs;
3. loss of use of both arms or both legs;
4. loss of one hand and one foot;
5. loss of one arm and one leg;
6. loss of use of one arm and one leg;
7. total blindness;
8. loss of the hearing of both ears; or
9. loss of the ability to speak.

The loss of use of an arm means the loss of function of the entire arm from the shoulder to the fingers.

The loss of use of the leg means the loss of function of the entire leg from the hip to the toes.

Total blindness means the loss of sight in both eyes, meaning no light perception, and sight cannot be restored.

The loss of hearing means deafness in both ears, meaning best corrected hearing threshold of 90 dB or greater in the better ear, and such that it cannot be corrected to any functional degree by any procedure, aid or device.

The loss of the ability to speak means loss of audible communication, such that it cannot be corrected to any functional degree by any procedure, aid or device.

Certificate means this document, which explains the insurance benefits provided, to whom and how benefits are payable, and limitations and exclusions that apply to coverage.

Child or Children means:

1. the Primary Insured's children by birth;
2. the Primary Insured's adopted children;
3. the Primary Insured's stepchildren at the time of the application for coverage of the stepchildren; and
4. children for whom the Primary Insured is legally obligated to provide medical support.

Additionally, a Child meeting the criteria of any of the categories listed above must also be:

1. unmarried; and
2. either under age 27 or legally incapacitated and unable to be self-supporting because of a medically ascertainable mental or physical handicap.

Proof of incapacity must be given at the time of enrollment if the Child is then incapacitated and older than age 26. If the incapacity occurs after the enrollment is completed, proof of incapacity must also be provided if the incapacity persists after the Child's 27th birthday. We reserve the right to require additional proof that the Child is still incapacitated and dependent on the Primary Insured. After 2 years of continuous incapacity, we will not require such proof more often than once each year.

Chip Fracture means an Injury where small fragments of bone are chipped from the bones main structure. Also referred to as avulsion fractures.

Coma means a state of profound unconsciousness from which a Covered Person cannot be aroused to consciousness by external or internal stimulation, as determined by a Medical Practitioner.

Common Carrier any air, land or water motorized conveyance operated under a license for the transportation of fare-paying passengers, including ridesharing programs. Common Carrier does not include courtesy transportation for which a charge is not made or cruise ships at sea more than 12 consecutive hours or any conveyance, regardless of whether the conveyance is licensed that is hired or used for a sport, gamesmanship, contest, or recreational activity. These conveyances can include, but are not limited to, race cars, bobsleds, hunting vehicles, sightseeing vehicles, helicopters, fishing boats, parasails, paragliders, and boat cruises operating beyond 12 hours.

Concussion means a disruption of brain function resulting from a traumatic blow to the head that causes immediate and transient alteration in brain function, including alteration of mental status and level of consciousness.

Confined or Confinement means a stay in a Hospital or other covered medical facility that is expressly billed:

1. as an inpatient confinement; or
2. on an hourly basis for twenty four or more continuous hours.

The requirement that the Covered Person be billed is not applicable in government Hospitals or other government medical facilities where there is no charge for services. In such an instance, documentation from the Hospital or other medical facility is required confirming either parts 1 or 2 shown above.

Coverage Effective Date for a Covered Person means the later of: (1) the first day of the month following the date the Primary Insured becomes eligible and satisfies all of the requirements found in the "Conditions of Coverage" section except that the Coverage Effective Date will be the first day of the current month if the requirements of coverage are satisfied on that date. (2) the first day of the month following the date we approve any additional Covered Persons under the "Conditions of Coverage" section; or (3) the first day of the month following the date we approve a reinstatement as to a Covered Person, except that the Coverage Effective Date will be the first day of the current month if reinstatement is approved on that date.

Covered Person means the Primary Insured and any Dependent(s) who are currently covered under the Policy and this Certificate.

Dependent(s) means a Primary Insured's Spouse and Child(ren).

Dislocation means a completely separated joint. Open reduction of a Dislocation means surgical repair. Closed reduction of a Dislocation means non-surgical repair.

Eligibility Waiting Period means the continuous period of time an individual must be a member in an Eligible Class before becoming eligible for coverage under the Policy. The Eligibility Waiting Period begins on the date the individual becomes a member of an Eligible Class.

Emergency Room means a specified area that is part of a Hospital designed for the Emergency Care of sickness or Injury. It must:

1. be staffed and equipped to handle trauma;
2. be supervised and provide Treatment by Physicians; and
3. provide care seven days per week, 24 hours per day.

The term Emergency Room does not include an Urgent Care Facility.

Emergency Care means bona fide medical diagnosis Treatment provided after the sudden onset of a sickness or Injury, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

1. placing the Covered Person's health in serious jeopardy;
2. serious impairment to bodily functions;
3. serious dysfunction of any bodily organ or part;
4. serious disfigurement; or
5. jeopardy to an unborn fetus being carried by a Covered Person.

Family Member means a Covered Person's spouse, parents, stepparents, in-laws, brothers, sisters, stepbrothers, stepsisters, children or grandchildren.

Fracture means a broken bone which can be seen by X-Ray. Open reduction of a Fracture means surgical repair. Closed reduction of a Fracture means a non-surgical repair.

Grace Period means the 31-day period after the Renewal Date. Please refer to the *Grace Period* provision.

Home Office means the primary corporate office of Madison National Life Insurance Company, Inc. at PO Box 5008, Madison, Wisconsin 53705 or such other location designated by us in writing to the Policyholder.

Hospital means an institution legally licensed that:

1. provides diagnostic, medical, and surgical Treatment to sick or injured persons on an inpatient basis (or has such surgical facilities available on a prearranged contractual basis);
2. provides 24-hour nursing care by or under the supervision of a nurse; and
3. is under the supervision of at least one licensed Physician practicing within the scope of such Physician's license.

Hospital does not include a: Hospice; Rehabilitation Unit; convalescent, nursing or rest home; home for the aged; facility for the care or Treatment of drug addiction or alcoholism; hotel units, residential annexes or nurse administered units in or associated with a hospital; or special ward, floor, or other accommodation for: (1) convalescent, nursing, rehabilitation, ambulatory, or extended care, or (2) the care or Treatment of drug addiction or alcoholism.

Injury means a bodily injury sustained by the Covered Person, which is the direct result of Accident independent of disease or bodily or mental illness or infirmity, or Treatment thereof. To be covered under the Policy, Injury must not be excluded under the terms of the Policy and must occur while the insurance is in force.

All Injuries sustained in any one event and all complications, including pyrogenic infections, arising the Injury or recurrences of complications shall be deemed to be a single Injury.

Intensive Care Unit means a place which:

1. is a specially designated area of the Hospital called an intensive care unit or neonatal intensive care unit that provides the highest level of medical care and is restricted to patients who are critically ill or injured and who require intensive comprehensive observation and care;
2. is separate and apart from the surgical recovery room and from rooms, beds, and wards customarily used for patient confinement;
3. is permanently equipped with special lifesaving equipment for the care of the critically ill or injured;
4. is under constant and continuous observation by a specially trained nursing staff assigned exclusively to the intensive care unit on a 24-hour basis; and
5. has a Physician assigned to the intensive care unit on a full-time basis.

An Intensive Care Unit is not a progressive care unit, an intermediate care unit, sub-acute intensive care unit, an Observation Unit or any facility not meeting the definition of an Intensive Care Unit as defined above.

Laceration means a cut. Laceration does not include a puncture wound.

Major Burn means second degree burns covering greater than 18% of the body's surface area or third degree burns covering 9%-18% of the body's surface area.

Major Diagnostic Test means any of the following tests: Computerized Tomography (CT), Magnetic Resonance Imaging (MRI), electroencephalogram (EEG), Positron Emission Tomography (PET), or ultrasound.

Medical Appliance means a walking boot that extends above the ankle, brace for the neck, knee or leg, body jacket/back brace, cane, crutches, walker or wheelchair.

Medical Practitioner means a medical professional who is:

1. duly licensed by the state in which such professional practices medicine; and
2. acting within the scope of such professional's medical license.

Medical Practitioner does not include a Covered Person or a Covered Person's spouse, parents, stepparents, in-laws, brothers, sisters, stepbrothers, stepsisters, children or grandchildren.

Minor Burn means second degree burns covering 9%-18% of the body's surface area or third degree burns covering less than 9% of the body's surface area.

Observation Unit means a specified area within a hospital, explicitly billed as observation, apart from the emergency room, where a patient can be monitored by a Physician; and which:

1. is under the direct supervision of a Physician or registered nurse;
2. is staffed by nurses assigned specifically to that unit; and
3. provides care seven days per week, 24 hours per day.

Outpatient Care Facility means any facility licensed by a state, where medical care and Treatment is provided by a Medical Practitioner on an outpatient basis. Such facility must be:

1. an outpatient department of a Hospital;
2. a Physician's office or clinic; or
3. an ambulatory surgical center the primary purpose of which is to perform outpatient surgical procedures and that has a staff of at least one Medical Practitioner on call at all times.

Outpatient Care Facility does not include any facility that provides services or accommodations for patients to stay overnight.

Partial Dislocation means a Dislocation in which the joint is not completely separated.

Physician means an individual who is licensed as a medical doctor (M.D. or D.O.) to practice medicine or perform Surgery for the Treatment of the condition in the state in which Treatment is received. Physician does not include a Covered Person or a Covered Person's spouse, parents, stepparents, in-laws, brothers, sisters, stepbrothers, stepsisters, children or grandchildren.

Policy means the insurance contract issued to the Policyholder under the Policy Number shown in the Certificate Schedule. The Policy includes the Certificate and any amendments, Riders, endorsements or other papers attached.

Policyholder means the entity to which the Policy is issued.

Primary Insured means an individual who is:

1. part of an Eligible Class; and
2. currently covered under the Policy and this Certificate.

The Primary Insured has the right to make all changes to the Certificate and receive benefits under the Certificate.

Prior Policy means group hospital indemnity insurance issued to the Policyholder or an employer acquired by the Policyholder on the day before the Policy Effective Date, which is replaced by the Policy.

Primary Residence means the dwelling a person lives in for more than 50% of a given Calendar Year.

Rehabilitation Care means the use of therapeutic services intended to restore a Covered Person to such person's highest possible physical or mental functional ability. Rehabilitation Care must be prescribed by a Physician.

Rehabilitation Unit means an appropriately licensed facility that provides Rehabilitation Care services on an inpatient basis. Services are provided by or under the supervision of an organized staff of Physicians. The Rehabilitation Unit may be part of a Hospital or a freestanding facility.

A Rehabilitation Unit is not:

1. a skilled nursing facility, assisted living facility, or nursing home (unless Confined to a rehabilitative wing of such an establishment);
2. a hospice care facility; or
3. mainly a place for rest, custodial care, care for the aged, care for persons with substance abuse disorders or mental health disorders, or a hotel or similar establishment.

Renewal Date means the date to which premiums are paid and the date on which the next premium is due to continue this Certificate in force.

Rider means an additional agreement attached to this Certificate for additional coverage.

Severe Burn means third degree burns covering greater than 18% of the body's surface area.

Skilled Nursing Facility means an appropriately licensed healthcare facility, or a distinct unit within a Hospital or other institution, which:

1. provides skilled nursing care and related services 24 hours per day, 7 days per week;
2. is under the direct supervision of a Physician and has a Physician or Medical Practitioner available at all times;
3. has a planned program of policies and procedures developed with and periodically reviewed by one or more Physicians; and
4. is not mainly a place for rest, custodial care, care for the aged, care for persons with substance abuse or mental health disorders, or a hotel or similar establishment.

Confinement in a Skilled Nursing Facility must be at the direction of a Physician. This definition does not include a hospice facility, nursing home, Rehabilitation Unit or swing bed hospital authorized to provide, and be paid for, extended care services.

Spouse means an individual who is named as the Spouse on the Enrollment Form, and under state law, is recognized as the spouse of a Primary Insured. Where a state legally recognizes civil unions, a Spouse may include a Primary Insured's partner in that recognized civil union. Where state law provides for registered domestic partnerships, a Spouse may include a Primary Insured's registered domestic partner. We reserve the right to request proof of the legally recognized status of a marriage, civil union, or domestic partnership. Any reference in the Policy to divorce shall also include the legal dissolution of a civil union or domestic partnership.

Step-Down Care Unit means a special unit of the Hospital designated to provide care for patients who are stable enough to be discharged from the Hospital Intensive Care Unit, but are not yet ready to be cared for in a medical-surgical unit.

Surgery means a medical procedure intended to be curative, palliative or exploratory, performed by a Physician requiring an incision or manipulation (typically with instruments) performed on a Covered Person's body to repair damage or arrest disease.

Telemedicine means the remote diagnosis and/or Treatment of an Covered Person's covered Injury by means of telecommunications technology.

Therapist means a person who is appropriately licensed to practice and provide occupational therapy, physical therapy, or speech therapy, or chiropractic services, and must be acting within the scope of such license. Therapist does not include a Covered Person or a Covered Person's spouse, parents, stepparents, in-laws, brothers, sisters, stepbrothers, stepsisters, children or grandchildren.

Therapy Services mean occupational therapy, physical therapy, speech therapy, or chiropractic services performed by a Therapist.

Total Disability or Totally Disabled means the Primary Insured is unable to perform all of the substantial and material duties of the Primary Insured's regular occupation as required by the Primary Insured's employer (if any). Total Disability must be certified by the Primary Insured's Medical Practitioner. The Primary Insured is deemed Totally Disabled during any covered Confinement.

Treatment means medical advice, Diagnosis, care or services (including diagnostic measures), provided by a Physician or other Medical Practitioner, and received by a Covered Person.

Urgent Care Facility means a licensed, freestanding healthcare facility providing immediate, short-term medical care without an appointment. The facility must:

1. maintain all appropriate licensing for a facility that provides urgent or immediate care;
2. be under the direct supervision of a Physician; and
3. provide Treatment by Physicians and/or Medical Practitioners.

The term Urgent Care Facility does not include a Hospital (including any outpatient department of a Hospital), Emergency Room, or Physician's office.

Walk-in Clinic means a medical facility, staffed by Medical Practitioners, that offers general health care services on a walk-in basis without an appointment.

The term Walk-in Clinic does not include an Emergency Room, Hospital, outpatient surgery facility, Urgent Care Facility or Physician's office.

We, us, our (whether or not capitalized) means Madison National Life Insurance Company, Inc.

X-Ray means a form of electromagnetic radiation that passes through structures within the body and results in images of the structures. This definition does not include a Major Diagnostic Exam.

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.

1241 John Q. Hammons Drive, Madison, WI 53717● PO Box 5008, Madison, WI 53705
(800) 356-9601 ● www.madisonlife.com

Accident Insurance Policy

THIS POLICY IS A LEGAL CONTRACT BETWEEN THE POLICYHOLDER AND US.

THIS POLICY IS GOVERNED BY THE LAWS OF THE ISSUE STATE AND, TO THE EXTENT APPLICABLE, THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA) AND ANY OF ITS AMENDMENTS.

NOTICE OF 30-DAY RIGHT TO EXAMINE POLICY. If the Policyholder is not satisfied with the Policy for any reason, the Policyholder may return it to us within 30 days after it is received. Once returned, we will refund the premiums paid, and the Policy will be voided from the Policy Effective Date.

This Policy is signed for us by:

President and Chief Executive Officer

Executive Vice President and Corporate Secretary

THIS IS AN ACCIDENT ONLY POLICY, AND IT DOES NOT PROVIDE BENEFITS FOR SICKNESS. IT PROVIDES LIMITED BENEFITS. BENEFITS ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES. PLEASE READ THIS POLICY CAREFULLY.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. IF A COVERED PERSON IS ELIGIBLE FOR MEDICARE, THE COVERED PERSON SHOULD REVIEW A GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE AVAILABLE FROM US.

POLICY INDEX GUIDE

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Madison National Life
a Horace Mann company

POLICY SCHEDULE PAGE

POLICY NUMBER:	013781GA
POLICYHOLDER:	West Des Moines CSD
POLICY EFFECTIVE DATE:	July 1, 2026
ISSUE STATE:	Iowa
PREMIUM DUE DATE:	First of each month

PREMIUMS

Premium Mode: Monthly

Class 1: All full-time employees that are Actively at Work for the Policyholder.

Primary Insured Only	$11.51
Primary Insured and Spouse	$18.83
Primary Insured and Child(ren)	$27.54
Primary Insured and Family	$41.76

INCORPORATION PROVISION

The following forms are incorporated into and made a part of this Policy:

1. the group application;
2. all Primary Insured enrollment forms and evidence of insurability forms, if any;
3. the Certificate(s) of coverage; and
4. any amendments, Riders, or endorsements to this Policy or the Certificate(s).

If there is any conflict between the terms and conditions of this Policy and any incorporated form, this Policy shall be controlling. However, in no case will any Covered Person's rights and benefits under this Policy be less than those stated in the Certificate.

PREMIUM PROVISIONS

Payment of Premiums

Unless otherwise agreed to by the Policyholder and Us, the Policyholder must pay premiums to Us at Our Home Office. The first premium is due on the Policy Effective Date. All subsequent premiums are due on the Premium Due Date. The premium for additional, increased, reduced, or terminated insurance may cause a pro-rata adjustment on the next Premium Due Date.

Premium Rates

The premium rates to be charged for the Primary Insured and Dependents, if applicable, are shown on the Policy Schedule Page. The Policyholder will periodically be given the opportunity to modify the group that was originally insured and add new classes of eligible persons.

Premium Changes

After the initial premium rates have been in effect for 24 months from the Policy Effective Date, We may recalculate premium rates. We also have the right to recalculate the initial or any subsequent premium rate when:

1. the terms of this Policy change;
2. the description of an Eligible Class(es) changes;
3. one or more Eligible Class(es) are added to or deleted from this Policy.

For any change in premium rates, We will give the Policyholder 60 days advance written notice. We will not change the rates more than once in any period of 12 consecutive months.

Grace Period

A Grace Period of 31 days will be granted for the payment of each premium falling due after the first premium. During the Grace Period, this Policy shall continue in force unless the Policyholder gives Us written notice of termination in advance of the date of termination and in accordance with the terms of this Policy. If the entire premium is not paid by the end of the Grace Period, this Policy will terminate.

Reinstatement

If any renewal premium is not paid within the time granted the Policyholder for payment, a subsequent acceptance of premium by Us or by any agent duly authorized by Us to accept such premium, without requiring an application for reinstatement, shall reinstate this Policy. However, if We or Our agent require an application for reinstatement and issue a conditional receipt for the premium tendered, this Policy will be reinstated upon the earlier of the approval of the application by Us, or the 45th day following the date of the conditional receipt unless We have previously notified the Policyholder in writing of Our disapproval of the application.

The reinstated insurance shall cover only loss due to Injury occurring after the date of reinstatement. In all other respects, all parties shall have the same rights as under this Policy immediately before the due date of the defaulted premium, subject to the provisions of any rider which may be attached in connection with the reinstatement.

Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

Return of Premium

In the event of termination of this Policy, We shall promptly return on a pro-rata basis the unearned premium paid, if any, and the Policyholder shall promptly pay, on a pro-rata basis, the unpaid earned premium.

TERMINATION

After this Policy has been in force for 12 months, We may terminate this Policy at any time by giving the Policyholder at least 45 days advance written notice. The Policyholder may also terminate this Policy by giving Us at least 45 days advance written notice. This Policy will automatically terminate if the required premium is not paid by the Policyholder as provided in the Grace Period provision.

We may terminate this Policy upon not less than 45 days advance written notice if the Policyholder fails to comply with a material plan provision relating to the Policyholder's group participation rules, which requires enrollment of at least 10 Primary Insureds or 15% of eligible individuals, whichever is greater.

It is the Policyholder's responsibility to notify each Primary Insured upon termination of the Policy, unless state law requires Us to provide such notification.

GENERAL PROVISIONS

Entire Contract

This Policy, including any endorsements, amendments and Riders, the Policyholder application which is attached to this Policy when issued, any Covered Person enrollment forms and the Certificate(s) issued comprise the entire contract between the parties.

Incontestability

The validity of this Policy shall not be contested except for nonpayment of premiums after it has been in force for 2 years from the Policy Effective Date.

Statements

All statements made by the Policyholder or any Covered Person shall be deemed representations and not warranties, and no such statements shall be used in the defense of a claim unless a copy of the instrument containing the statement is or has been furnished to the Covered Person or, in the event of the death or incapacity of the Covered Person, to the individual's beneficiary or personal representative.

Certificates

We will give Certificates to the Policyholder, in electronic or paper form, for delivery to persons covered under this Policy, or We will deliver Certificates directly to persons covered under this Policy if agreed to by Us and the Policyholder. The Certificates will include conditions of eligibility, what benefits are payable and to whom and those provisions of this Policy relative to the procedure to be followed in filing a claim.

Changes to This Policy

We may change the provisions of this Policy upon not less than 45 days advance written notice, unless the Policyholder accepts an amendment during that period. This Policy may also be amended at any time by mutual agreement between the Policyholder and Us without the consent of any Covered Person, but without prejudice to any loss incurred prior to the effective date of the amendment. A change must be approved by one of Our executive officers, and shall not be valid unless and until such change is endorsed in this Policy or attached hereto. No agent can change this Policy or waive any of its provisions. Payment of the applicable premium following any change of this Policy in accordance with this section shall constitute acceptance of that change.

Data To Be Furnished

The Policyholder shall give Us all the information We need that pertains to this insurance. At any reasonable time while this Policy is in force and for one year after that, We may inspect any of the Policyholder's documents, books, or records which may affect the insurance or premiums of this Policy. If the Policyholder gives Us any incorrect information, the relevant facts will be reviewed to establish if insurance is in effect and in what amount. No person shall be deprived of insurance to which such person is otherwise entitled or have insurance to which such person is not entitled, because of any misstatements of fact by the Policyholder or Covered Person. Any required adjustment may be made in coverage, premiums or benefits. However, payment of premium by or on behalf of an ineligible person will not entitle that person to coverage.

Right To Audit

We reserve the right to audit the Policyholder's billing records and premium accounting practices. If We discover an underpayment of premium, the Policyholder will be obligated to remit, in a timely manner, the underpayment amount. In the event of an overpayment of premium, We will return any overpayment amount in a timely manner.

Conformity with State and Federal Laws

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

Adjustments in the Event of Clerical Error

Clerical error, whether by the Policyholder or Us, will not void, alter, extend, increase, decrease, or otherwise affect any coverage provided under the Policy. The terms of the Policy will be adjusted as necessary to correct any clerical errors.

Time Periods

Unless otherwise specifically stated, all time periods begin and end at 12:01 A.M., Standard Time at the place where this Policy is delivered.

MADISON NATIONAL
LIFE INSURANCE COMPANY, INC.

ACCIDENT INSURANCE POLICY

THIS IS AN ACCIDENT ONLY POLICY, AND IT DOES NOT PROVIDE BENEFITS FOR SICKNESS. IT PROVIDES LIMITED BENEFITS. BENEFITS ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES. PLEASE READ THIS POLICY CAREFULLY.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. IF A COVERED PERSON IS ELIGIBLE FOR MEDICARE, THE COVERED PERSON SHOULD REVIEW A GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE AVAILABLE FROM US.

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.

1241 John Q. Hammons Drive, Madison, WI 53717● PO Box 5008, Madison, WI 53705
(800) 356-9601 ● www.madisonlife.com

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 Act (the "Association") and the protection it provides for policyholders. This safety net was created under Iowa law, located at Iowa Code Chapter 508C, 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, health insurance company or health maintenance organization 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 net cash surrender and withdrawal values

Health Insurance:

• $500,000 for health benefit plans (see definition below)

• $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, including net cash surrender and withdrawal values

Annuities:

• $250,000 in the present value of annuity benefits, including net 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 health benefit plans.

“Health benefit plan” is defined in the applicable Iowa law and generally includes hospital or medical expense policies, contracts or certificates, or HMO subscriber contracts that provide comprehensive forms of coverage for hospitalization or medical services, but excludes policies that provide coverages for limited benefits (such as dental-only or vision-only insurance), Medicare Supplement insurance, disability income insurance and long-term care insurance.

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.

Benefits provided by a long-term care rider to a life insurance policy or annuity contract shall be considered the same type of benefits as the base life insurance policy or annuity contract to which the long-term rider relates.

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.ialifega.org*, or contact:

Iowa Life and Health Insurance
Guaranty Association
700 Walnut, Street, Suite 1300
Des Moines, IA 50309
(515) 248-5712

Iowa Insurance Division
1963 Bell Ave, Suite 100
Des Moines, IA 50315
(515) 654-6600

Information about the financial condition of insurers is available from a variety of sources, including financial rating agencies such as AM Best Company, Fitch Ratings Inc., Moody's Investors Service, and S&P Global Ratings.

The Association is subject to the supervision of 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 or HMO coverage. 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.