Group Accident Certificate of Insurance

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

This certificate applies to insureds in the state of Texas.

POLICYHOLDER:	AHS Management Company, Inc. dba Ardent Health Services
POLICY NUMBER:	76386
POLICY EFFECTIVE DATE:	January 1, 2025
CERTIFICATE EFFECTIVE DATE:	This certificate represents the plan in effect as of January 1, 2025.
	This certificate replaces any and all certificates previously issued to you under the group policy. Please replace any certificate previously issued to you with this new certificate.
ASSOCIATED COMPANIES:	All subsidiaries and affiliates reported to Securian Life by the policyholder for inclusion in the policy.
POLICY SITUS STATE:	The policy was issued and delivered in Tennessee.

THIS CERTIFICATE IS NOT MAJOR MEDICAL INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL INSURANCE. IT DOES NOT QUALIFY AS MINIMUM ESSENTIAL HEALTH COVERAGE UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010.

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

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

THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.

The Company may change the required premiums as a condition of any renewal of the group policy.

Read Your Certificate Carefully

If you meet the eligibility and enrollment requirements herein, you are insured under the group policy shown in the Certificate Specification section. This certificate is not a contract nor does it modify or amend the group policy. This certificate summarizes the principal provisions of the group policy that affect you. The provisions summarized in this certificate are subject in every respect to the group policy. The group policy is the contract between the policyholder and Securian Life. You may examine the group policy at the principal office of the policyholder during regular working hours.

Legal Actions

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

Renée D. Montz
Secretary

President

Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company. If you don't, you may lose your right to appeal.

Securian Life Insurance Company
To get information or file a complaint with your insurance company:
Call: Consumer Complaints, toll free at: 1-855-651-3500
Email: ConsumerComplaints@securian.com
Mail: 400 Robert Street North, St. Paul, MN 55101-2098

The Texas Department of Insurance
To get help with an insurance question or file a complaint with the state:
Call with a question: 1-800-252-3439
File a complaint: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov
Mail: MC 111-1A, P.O. Box 12030, Austin, TX 78711-2030

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros. Si no lo hace, podría perder su derecho para apelar.

Securian Life Insurance Company
Para obtener información o para presentar una queja ante su compañía de seguros:
Llame a: Consumer Complaints, teléfono gratuito al 1-855-651-3500
Correo electrónico: ConsumerComplaints@securian.com
Dirección postal: 400 Robert Street North, St. Paul, MN 55101-2098

El Departamento de Seguros de Texas
Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:
Llame con sus preguntas al: 1-800-252-3439
Presente una queja en: www.tdi.texas.gov
Correo electrónico: ConsumerProtection@tdi.texas.gov
Dirección postal: MC 111-1A, P.O. Box 12030, Austin, TX 78711-2030

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ENTIRE CONTRACT

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

Any statements made in your application (if any) will, in the absence of fraud, be considered representations and not warranties. Also, any statement made will not be used to void your insurance nor defend against a claim unless a copy of the written instrument containing the statement has been provided to you, or in the event of your death or incapacity, to your beneficiary or personal representative.

This certificate is issued in consideration of your application (if any) and the payment of any required premium.

CERTIFICATE SPECIFICATIONS

Group:
The group is composed of all active employees of the policyholder working in the United States in the following class:

Class 1: All eligible active employees

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

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

Minimum hour per week requirement:
The number of hours your employer requires you to be actively at work in order to be eligible for coverage under this certificate. Your minimum hour per week requirement is 20 hours per week.

Employment waiting period:
The period of continuous employment with the employer that you must satisfy prior to becoming eligible for coverage under this certificate. Your employment waiting period is the period commencing with your date of employment and ending with the first day of the month next following or coinciding with your completion of 30 days of continuous employment. You are not eligible to become insured until the first day following the waiting period.

Eligibility:
You are eligible for group accident insurance if you meet all the following requirements:

(1) are an employee of the eligible group and of an eligible class;
(2) work for the employer for at least the number of hours per week shown as the minimum hours per week requirement;
(3) have satisfied the employment waiting period, if any; and
(4) meet the actively at work requirement.

Dependent eligibility:
If you are insured for group accident insurance coverage, your dependents are eligible for insurance.

Enrollment period:
You must enroll in order to be insured for contributory coverage under the group policy. You can enroll for coverage within 31 days of when you first become eligible. After that period you can only enroll for coverage or make changes during your annual open enrollment, or within 31 days of a qualified status change event as defined by the policyholder's plan rules.

You will become insured on the date you meet all eligibility requirements.

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

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

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

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

Double coverage:
If you are eligible as an employee under the policy, or insured under the portability provisions, you are not eligible as a dependent. Only you can insure an eligible dependent child.

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

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

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

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

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

Dependent Non-confinement requirement:
If a dependent is hospitalized or confined because of an illness or injury on the date their insurance would otherwise become effective, their effective date shall be delayed until they are released from such hospitalization or confinement. This does not apply to a newborn child.

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

Continuation during a leave of absence:
Insurance may be continued when you are not actively at work due to illness, injury, leave of absence, or temporary layoff, subject to the employer's practices and procedures, including the employer's limits on the length of continuation allowed for the type of absence. Continuation is contingent upon continued premium payment and is subject to the following maximum time frames:

(1) if you are on a non-medical leave of absence, or temporary layoff, insurance cannot be continued beyond 12 months from the last day you were actively at work.
(2) if you are on a medical leave of absence, insurance cannot be continued beyond the later of 12 months from the last day you were actively at work or attained age 65.

Continuation of insurance must be in accordance with practices and procedures that preclude individual selection.

Coverage during a leave of absence and upon return from a leave of absence shall meet all state and federal requirements. The above limits will be expanded, if necessary, in order to meet such requirements.

Changes in your coverage amount:
Requested increases in the amount of your contributory insurance are effective on the date as shown below in the Annual open enrollment and Qualified status changes sections. Requested decreases in the amount of your contributory insurance are effective on the first day of the month following receipt of your request for a decrease. In addition, elections made during an enrollment period will not become effective prior to the effective date for that enrollment.

Change of insurance carriers
If you are not actively at work due to illness or injury on the date the policyholder changes its insurance carrier to us, and you were covered under the policyholder's prior policy at the time coverage under us became effective, we will provide coverage under our insurance policy.

Coverage provided under our insurance policy is subject to payment of premiums.

Annual open enrollment:
During the policyholder's annual open enrollment, you may elect or change your and your dependents accident insurance benefit plan.

Coverage will be effective on the January 1 following the annual open enrollment, subject to the actively at work requirement for employees and the hospitalization/non-confinement requirement for dependents.

Qualified status changes:
If you experience one of the qualified status changes as defined by your policyholder's plan rules you may elect or change your and your dependents accident insurance benefit plan, provided enrollment is made within 31 days of the status change.

Qualified status change for purposes of the enrollment opportunities described above means marriage or establishment of a legal partnership, birth of a child, filing of a petition to adopt a child, entering into a suit in which you or your spouse are seeking to adopt a child, adoption of a child, placement of a foster child or acquisition of a stepchild.

Coverage will be effective on the date of the election. All increases are subject to the actively at work requirement and the hospitalization/non-confinement requirement for dependents.

PLAN OF INSURANCE

Employee Benefit Schedule

Employee Supplemental Accident Insurance

Eligible Class	Supplemental Accident Insurance Benefit Plan
Class 1	Benefit Plan as elected by you.
Contributory/Non-Contributory:	Supplemental accident insurance is contributory insurance.
Retirement Termination:	All insurance terminates at employee's retirement, except as otherwise outlined in this certificate.

Spouse Benefit Schedule

You must be insured for supplemental accident insurance in order to elect spouse accident insurance.

Spouse Supplemental Accident Insurance

Eligible Class	Supplemental Accident Insurance Benefit Plan
Class 1	Spouse supplemental benefit plan will match your supplemental accident insurance plan.
Contributory/Non-Contributory:	Supplemental accident insurance is contributory insurance.

Retirement Termination: All insurance terminates at employee's retirement, except as otherwise outlined in this certificate.

Child Benefit Schedule

You must be insured for supplemental accident insurance in order to elect child accident insurance.

Child Supplemental Accident Insurance

Eligible Class	Supplemental Accident Insurance Benefit Plan
Class 1	Child supplemental benefit plan will match your supplemental accident insurance plan.

Contributory/Non-Contributory: Supplemental accident insurance is contributory insurance.

Retirement Termination: All insurance terminates at employee's retirement, except as otherwise outlined in this certificate.

Automatic Child Coverage: If you currently have dependent child coverage and you have a newborn child, grandchild, adopted child, or stepchild, then your newborn child, grandchild, adopted child or stepchild will be automatically covered for the amount of child coverage outlined in the Plan of Insurance section from date of live birth, adoption, or the date you acquire a stepchild.

If you currently have dependent child coverage and you have a foster child, child of legal ward, a child of court-appointed guardianship, or a child of court-ordered custody or administrative order placed with you, the child will be automatically covered for the amount of child coverage outlined in the Plan of Insurance section from date the child becomes eligible according to the definition of child outlined within the Definition Section of this certificate.

If you currently do not have dependent child coverage and you have a newborn child, grandchild, adopted child, or stepchild, then your newborn child, grandchild, adopted child, or stepchild will automatically be covered for the amount of child coverage outlined in the Plan of Insurance section for the first 61 days following the date of live birth, the date of adoption, or the date you acquire a stepchild. The coverage will terminate at the end of the 61 day period unless you apply for dependent child coverage within the 61 days of the live birth, the date of adoption, or the date you acquire a stepchild, and pay the additional premium for coverage.

If you currently do not have dependent child coverage and you have a foster child, child of legal ward, a child of court-appointed guardianship, or a child of court-ordered custody or administrative order placed with you, the child will automatically be covered for the amount of child coverage outlined in the Plan of Insurance section for the first 61days as of the date the child is eligible according to the definition of child outlined within the Definition Section of this certificate. The coverage will terminate at the end of the 61 day period unless you apply for dependent coverage within 61 days of the child becoming eligible according to the definition of child outlined within the Definition Section of this certificate.

NOTE: If you had previously declined to enroll in dependent child coverage for your eligible children, you may still elect child coverage for any newly eligible child according to the enrollment period rules shown within the Certificate Specifications section of this certificate.

PLAN OF INSURANCE – ADDITIONAL BENEFITS

Employee Additional Benefit Schedule

Employee Supplemental Accidental Death and Dismemberment (AD&D) Benefit

Eligible Class	Supplemental AD&D Benefit Plan
Class 1	If Benefit Plan elected for supplemental accident, supplemental AD&D amount = $25,000

Employee Supplemental Designated Facility Benefit

Eligible Class	Supplemental Designated Facility Benefit
Class 1	See the Covered Accident Benefits table under the Designated Facility Benefit described under the Additional Benefits section.

Employee Supplemental Wellness Screening Benefit

Eligible Class	Supplemental Wellness Screening Benefit Plan
Class 1	$50

Employee Portability Benefit

Eligible Class	Portability Benefit
Class 1	The employee's benefit plan in force as of the portability date.

Spouse Additional Benefit Schedule

Spouse Supplemental Accidental Death and Dismemberment (AD&D) Benefit

Eligible Class	Supplemental AD&D Benefit Plan
Class 1	The spouse supplemental AD&D benefit amount is equal to 50% of your supplemental AD&D benefit amount, subject to a maximum of $12,500.

Spouse Supplemental Designated Facility Benefit

Eligible Class	Supplemental Designated Facility Benefit
Class 1	See the Covered Accident Benefits table under the Designated Facility Benefit described under the Additional Benefits section.

Spouse Supplemental Wellness Screening Benefit

Eligible Class	Supplemental Wellness Screening Benefit Plan
Class 1	$50

Spouse Portability Benefit

Eligible Class	Portability Benefit
Class 1	Spouse Benefit plan matches the employee's benefit plan.

Child Additional Benefit Schedule

Child Supplemental Accidental Death and Dismemberment (AD&D) Benefit

Eligible Class	Supplemental AD&D Benefit Plan
Class 1	The child supplemental AD&D benefit amount is equal to 25% of your supplemental AD&D benefit amount, subject to a maximum of $6,250.

Child Supplemental Designated Facility Benefit

Eligible Class	Supplemental Designated Facility Benefit
Class 1	See the Covered Accident Benefits table under the Designated Facility Benefit described under the Additional Benefits section.

Child Supplemental Wellness Screening Benefit

Eligible Class	Supplemental Wellness Screening Benefit Plan
Class 1	$50

Child Portability Benefit

Eligible Class	Portability Benefit
Class 1	Child Benefit plan matches the employee's benefit plan.

COVERED ACCIDENT BENEFITS

INJURY BENEFITS	BENEFIT PLAN
Burn benefit	
2nd degree burns	
Less than 10% of the body	$300
Between 10% and 20% of the body	$750
20% or more of the body	$1,500
3rd degree burns	
Less than 10% of the body	$3,000
Between 10% and 20% of the body	$7,500
20% or more of the body	$15,000
Concussion	$400
Dislocation – Principal Amount (Surgical)	$8,000
Ankle	$3,200
Collarbone	$1,600
Elbow	$1,600
Finger	$800
Foot	$3,200
Hand (excluding fingers)	$1,600
Hip/Thigh	$8,000
Knee	$6,000
Lower jaw	$1,600
Ribs	$1,600
Shoulder	$2,400
Toe	$800
Wrist	$2,400
Non-surgical	50% of surgical benefit

Partial Dislocation	25% of non-surgical benefit
Eye injury – with surgery	$400
Eye injury - removal of foreign object without surgery	$100
Fracture - Principal Amount (Surgical)	$8,000
Ankle	$2,000
Chip fracture	25% of non-surgical benefit
Collarbone	$1,200
Coccyx	$1,200
Facial (excluding lower jaw)	$2,800
Finger	$1,200
Foot	$2,000
Hand (excluding fingers)	$2,400
Hip/Thigh	$8,000
Kneecap	$2,000
Lower jaw	$2,000
Lower leg	$4,000
Nose	$800
Pelvis	$6,000
Ribs	$2,000
Sacrum	$4,000
Shoulder blade	$4,000
Skull – depressed	$12,000
Skull – non depressed	$8,000
Sternum	$6,000
Toe	$800
Upper arm	$2,800
Vertebral body	$4,000
Vertebral processes	$1,600
Wrist or forearm	$2,000
Non-surgical	50% of surgical benefit
Lacerations	
No repair	$100
Repair	$500
Organized sports injury - Total Accident Claim Amount	25% of the total accident claim up to a maximum of $3,000
Paralysis - Principal Amount	$30,000
Quadriplegia	$30,000

Paraplegia	$15,000
Hemiplegia	$15,000
Uniplegia	$7,500
Traumatic brain injury	$800
EMERGENCY CARE	**BENEFIT PLAN**
Ambulance	
Ground or water	$500
Air	$2,000
Blood, plasma, or platelets transfusion	$600
Emergency dental	
Crown	$300
Extraction	$150
Filling	$50
Emergency room visit	$300
Initial physician's office visit	$200
Urgent care facility visit	$250
HOSPITAL CARE	**BENEFIT PLAN**
Coma	$20,000
Diagnostic testing	$300
Hospital stay	
Initial benefit, non-ICU	$1,000
Initial benefit, ICU	$2,000
Daily benefit, non-ICU	$200
Daily benefit, ICU	$400
Spinal injection for pain management	$150
Surgical anesthesia	
General	$200
Regional	$100
X-ray	$150
SURGERY BENEFIT	**BENEFIT PLAN**
Abdominal or pelvic, cranial, or thoracic surgery	$2,000
Inpatient surgery	$1,500
Joint replacement surgery of elbow, hip, knee, or shoulder	$1,500

Knee cartilage surgery	
Open	$1,500
Arthroscopic	$750
Outpatient surgery	
Tier 1	$500
Tier 2	$1,000
Ruptured disc surgery	$1,500
Skin graft	50% of applicable burn benefit
Tendon, ligament, or rotator cuff surgery	
Open	$1,500
Arthroscopic	$750
FOLLOW-UP CARE	**BENEFIT PLAN**
Adaptive home and vehicle benefit	$3,000
Appliances	
Tier 1	$200
Tier 2	$1,000
Follow-up physician's office visit	$150
Post-traumatic stress disorder benefit (PTSD)	$700
Prescription drug benefit	$40
Prosthetics	
One prosthetic	$2,000
Two or more prosthetics	$4,000
Rehabilitative therapy (inpatient) – cognitive behavioral, occupational, physical, respiratory, speech, trauma counseling, vocational	$200
Rehabilitative therapy (outpatient) – acupuncture, chiropractic, cognitive behavioral, massage, occupational, physical, respiratory, speech, trauma counseling, vocational	
Lump Sum Benefit	$600
Transportation	$500
SUPPORT CARE	**BENEFIT PLAN**
Adult companion lodging	$200
Family care	$100
Pet boarding and professional sitting	$50

DEFINITIONS

Any term used in this certificate is given the meaning as defined in this section unless otherwise defined in another provision of this certificate.

accident
An act or event which is:

(1) unintended, unexpected, and unforeseen; and

(2) directly results in bodily injury to the insured.

application
Your application or enrollment for insurance under the group policy.

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

child or child(ren)
Your or your spouse's:

(1) natural child;
(2) adopted child;
(3) stepchild;
(4) foster child;
(5) grandchild;
(6) legal ward;
(7) a child in your or your spouse's court-appointed guardianship;
(8) a child in your or your spouse's court-ordered custody or administrative order; or
(9) a child for whom you have been ordered to provide medical support.

Children are eligible from the moment of live birth (stillborn or unborn children are not eligible) to the attainment of age 26. Children age 26 or older are eligible as a dependent child provided the child is physically or mentally incapable of self-support, was incapable of self-support prior to age 26 and remains physically dependent on you for their support and maintenance. Coverage on a qualified dependent child age 26 or older that continues beyond limiting age shall remain at the child premium rate. If you are a newly eligible employee, you may insure your child who is over the age of 26 provided the child is physically or mentally incapable of self-support, was incapable of self-support prior to age 26 and remains financially dependent on you for their support and maintenance.

Adopted child includes children that are placed with you, or for whom you or your spouse have filed a petition to adopt, or for whom you or your spouse are a party to a suit in which you are seeking to adopt the child. Children for whom you or your spouse have filed a petition to adopt within 60 days of the adopted child's date of birth, are eligible from the moment of live birth (stillborn or unborn children are not eligible). Coverage for an adopted child is effective from the earliest of adoption, placement for adoption, the date of a suit seeking adoption, or filing of the petition for adoption.

Foster child includes a child from the moment of placement in the foster home.

Grandchild means a grandchild:

(1) who is unmarried;
(2) younger than 25 years of age; and
(3) is dependent on you for federal income tax purposes at the time application for coverage of the grandchild is made.

confined or confinement
The assignment to a bed as a resident inpatient in a hospital (including an intensive care unit of a hospital) or confinement in an observation area within a hospital for a period of no less than 18 continuous hours.

contributory insurance
Insurance for which you are required to make premium contributions.

covered accident
An accident which:

(1) is not excluded under the Exclusions section or any other terms of this certificate;
(2) occurs while the insured's coverage is in force under this certificate;
(3) occurs in the United States or a United States territory; and
(4) occurs during and outside the course and scope of your employment.

dependent
Your spouse or child(ren).

If your spouse is eligible as an employee under the group policy, they are not eligible to be insured as a dependent spouse. If both parents of a child qualify as eligible employees under the group policy, the child shall be considered a

dependent of only one parent for purposes of this certificate. If any child qualifies as an eligible employee under the group policy, they are not eligible to be insured as a dependent child.

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

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

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

An emergency room or a satellite emergency center does not include a hospital, an urgent care facility, or an office maintained by a licensed physician for the practice of medicine or dentistry.

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

employer
The policyholder or any designated associated companies.

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

hospital
A short-term, acute care general facility that:

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

A hospital is not a rehabilitation facility, nursing home, rest home, extended-care facility, convalescent home, hospice care facility, skilled nursing facility, assisted living facility, a substance use facility, or a mental health facility, even if such facilities are affiliated with or adjoined to a hospital.

injury or injuries
A bodily injury which is sustained as a direct result of a covered accident.

inpatient
Medical advice, care, diagnostic measures, or treatment provided while admitted as a resident inpatient to a hospital.

insured
An employee or dependent covered for insurance under this certificate.

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

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

legal partner
The person with whom you have entered into a legally sanctioned domestic partnership or civil union partnership that grants the partners the same rights, responsibilities, and obligations as married couples in accordance with applicable law. Legal partner does not include any person who is eligible as an employee.

non-contributory insurance
Insurance for which you are not required to make premium contributions.

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

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

outpatient
Medical advice, care, diagnostic measures, or treatment provided without being admitted as a resident inpatient to a hospital.

paralysis
Paralysis refers to the total, permanent, and irreversible loss of movement. Paralysis includes quadriplegia, paraplegia, hemiplegia, and uniplegia.

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

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

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

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

physician
A person who is licensed to practice medicine in the United States or United States territory in which treatment is received and who is providing treatment or advice in accordance with the license. Relevant law may require or allow for consideration of professional services of a practitioner other than a medical doctor. If so, such practitioner must be licensed as required by the jurisdiction where care is given and must be operating in the scope of their license. Other than for a dentist providing emergency dental care, we will not recognize you, your family member, a person who ordinarily resides in your household, or a business or professional partner, or any person who has a financial affiliation or business interest with you as a physician for a claim submitted to us.

policyholder
The owner of the group policy.

spouse
Your legally married spouse. For the purposes of this certificate, spouse shall also include legal partner. Spouse does not include any person who is eligible as an employee.

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

urgent care facility
A health care facility:

(1) that maintains all appropriate licensing for a facility that provides urgent or immediate care;
(2) that is supervised by a physician;
(3) that is separate from a hospital or is a separate unit within a hospital; and
(4) the primary purpose of which is the offering and provision of immediate, short-term medical care.

An urgent care facility does not include an emergency room or a satellite emergency center.

telemedicine
The use of telecommunication and information technologies (including, but not limited to, audio or video communications) for the evaluation, diagnosis, or treatment of the insured as would be practiced in person. This does not include requests for prescription refills or medical records.

we, our, us
Securian Life Insurance Company.

year
The benefit year beginning on any month within the calendar year or plan year. The calendar year and/or plan year is determined by the policyholder. In no event will a calendar year and/or plan year be more than 12 months.

you, your, certificate holder
An insured employee.

ACCIDENT INSURANCE BENEFITS

Injury Benefits

Burn benefit
If an insured sustains a second or third degree burn in a covered accident, we will pay the appropriate amount shown in the Covered Accident Benefits section based on the type of burn and the percentage of the body surface burned.

The burn must be treated by a physician within 15 days after the covered accident. If the burn meets more than one of the burn classifications shown in the Covered Accident Benefits section, the amount we pay will be based on the burn classification that pays the highest benefit.

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

Concussion
If an insured is injured in a covered accident and the injury causes a concussion, we will pay the amount shown in the Covered Accident Benefits section.

If an insured is injured in a covered accident and the injury causes a concussion, we will pay the amount shown in the Covered Accident Insurance Benefits. The insured must be treated and diagnosed by a physician within 30 days of the covered accident.

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

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

Dislocation
If a joint is dislocated in a covered accident, and it is diagnosed and treated by a physician within 90 days after the covered accident, we will pay the amount shown in the Covered Accident Benefits section.

The amount varies based on the joint that is dislocated, whether the dislocation is a full or a partial dislocation, and whether surgery is required to treat the dislocation. A full dislocation refers to a completely separated joint due to a covered accident. A partial dislocation means the joint is misaligned but not completely dislocated, as diagnosed by a physician.

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

(1) the total of the benefit amounts shown for each applicable dislocation in the Covered Accident Benefits section; or
(2) Two times the highest dislocation benefit that would otherwise be payable for any one of the dislocations involved.

Surgery required to treat a dislocation is payable only under this benefit and is not covered under the Surgery Benefits section.

Eye injury – with surgery
If an insured is injured in a covered accident and the injury results in an eye injury that requires surgery, we will pay the amount shown in the Covered Accident Benefits section.

The surgery must be performed within 365 days of the covered accident. This benefit is limited to one payment per eye per insured per covered accident.

Surgery required to treat an eye injury is payable only under this benefit and is not covered under the Surgery Benefits section.

Eye injury – removal of foreign object without surgery
If an insured is injured in a covered accident and the injury results in an eye injury that requires removal of a foreign object, but does not require surgery, we will pay the amount shown in the Covered Accident Benefits section.

The removal of the foreign object must be performed at a physician's office, urgent care facility, or a hospital within 365 days of the covered accident. This benefit is limited to one payment per eye per insured per covered accident.

Fracture
If a bone is fractured in a covered accident, and it is diagnosed and treated by a physician within 90 days after the covered accident, we will pay the amount shown in the Covered Accident Benefits section.

The amount varies based on the bone that is fractured, whether or not the fracture is a chip fracture, and whether surgery is required to treat the fracture. Fracture refers to a break in a bone that can be seen by x-ray. A chip fracture is a fracture in which a small fragment of the bone is broken off.

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

(1) the total of the benefit amounts shown for each applicable fracture in the Covered Accident Benefits section; or
(2) 3 times the highest fracture benefit that would otherwise be payable for any one of the bones involved.

We will pay no more than one fracture benefit per bone, per covered accident per insured.

In no event will multiple fracture benefits be paid for the same fracture benefit shown in the Covered Accident Insurance Benefits unless it is a bi-lateral fracture. Bi-lateral fracture means the fracture of the same bone on both the left and right sides of the body.

Surgery required to treat a fracture is payable only under this benefit and is not covered under the Surgery Benefits section.

Lacerations
If an insured is injured in a covered accident and the injury results in a laceration, we will pay the appropriate amount shown in the Covered Accident Benefits section. The benefit will be based on whether the laceration requires a repair or no repair.

The laceration must be treated by a physician within 15 days after the covered accident. For the purposes of the repair benefit, the following are considered repair techniques utilized by a physician:

(1) stitches;
(2) staples;or
(3) surgical glue;or
(4) steristrips

This benefit is limited to one payment per insured per covered accident. In no event will we pay more than one laceration benefit per year.

Organized sports injury benefit
If an insured is injured in a covered accident while participating in an organized sport, we will pay the appropriate amount shown in the Covered Accident Benefits section. An organized sport refers to a sport activity that is governed by an organization and requires formal registration to participate. For the benefit to be payable for an insured child, adult supervision of practice and competition is required. Proof of registration must be submitted with claims. Benefits will be paid according to the Claims section of your certificate.

The organized sports injury benefit is subject to the following conditions:

(1) the insured employee, spouse, or child suffers an injury in a covered accident while participating in an organized sport; and
(2) a benefit is payable for the insured employee, spouse, or child under another provision of the group policy for the same covered accident.

This benefit is limited to two payments per insured per year.

Paralysis
If an insured is injured in a covered accident and the injury causes paralysis which lasts more than 30 days we will pay the appropriate amount shown in the Covered Accident Benefits section.

The paralysis must be diagnosed by a physician within 180 days after the accident. The amount payable will be based on the the type of paralysis. We will pay no more than one paralysis benefit per covered accident per insured. In the event that an insured qualifies under multiple types of paralysis, the highest benefit amount will be paid.

Traumatic brain injury
If an insured is injured in a covered accident and the injury results in a traumatic brain injury, we will pay the amount shown in the Covered Accident Benefits section.

Traumatic brain injury means only the following: intracranial hemorrhage, cerebral contusion, or cerebral laceration. The traumatic brain injury must be diagnosed and treated by a physician within 30 days after the accident by computer tomography (CT) scan or magnetic resonance imaging (MRI). Scalp hematomas and scalp lacerations are not covered under this benefit.

This benefit is payable only once per insured per covered accident.

If a benefit is payable under the concussion benefit for the same covered accident, only the higher of the two benefits will be paid.

Emergency Care Benefits

For the purpose of this section, “emergency care” means bona fide emergency services provided after the sudden onset of a medical condition 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 patient’’s health in serious jeopardy;
(2) serious impairment to bodily functions; or
(3) serious dysfunction of any bodily organ or part.

Ambulance
If an insured is injured in a covered accident and requires transportation to a hospital (or between hospitals) we will pay the appropriate ambulance benefit shown in the Covered Accident Benefits section.

Ground or water transportation must be provided by a licensed professional ambulance service within 90 days of the covered accident. Air transportation must be provided by a licensed professional ambulance service within 90 days of the covered accident. This benefit is limited to one payment per insured per covered accident. If an insured requires more than one ambulance transport, the highest benefit amount will be paid.

Ambulance means any publicly or privately owned surface, water, or air vehicle, including a helicopter that is specifically designed and constructed or modified and equipped to be used, maintained, or operated primarily for the transportation of individuals who are sick, injured or wounded.
Ambulance does not include a surface, water or air vehicle that is owned and operated to accommodate an incapacitated or disabled person who does not require medical monitoring, care, or treatment during transport.

Blood, plasma, or platelets transfusion
If an insured is injured in a covered accident and requires a blood, plasma, or platelets transfusion, we will pay the blood/plasma/platelets transfusion benefit shown in the Covered Accident Benefits section.

The transfusion must occur within 90 days of the covered accident. This benefit is limited to one payment per insured per covered accident.

Emergency dental
If an insured has an injury to sound natural teeth as a result of a covered accident, we will pay the appropriate emergency dental benefit shown in the Covered Accident Benefits section.

A benefit is payable for a broken tooth repaired with a filling(s) or crown(s), or a broken tooth requiring extraction. Treatment must occur within 90 days of the covered accident. The maximum number of filling benefits payable per insured per covered accident is two. The maximum number of crown benefits payable per insured per covered accident is two. The maximum number of extraction benefits payable per insured per covered accident is two.

Injuries resulting from biting or chewing are not covered under this benefit.

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

Emergency room visit
If an insured is injured in a covered accident and requires treatment in an emergency room, we will pay the emergency room visit benefit shown in the Covered Accident Benefits section.

The visit must occur within 15 days of the covered accident. This benefit is limited to one payment per insured per covered accident.

If a benefit is payable under the initial physician's office visit benefit or urgent care facility visit benefit for the same covered accident, only the higher of the three benefits will be paid. If the benefit amounts are the same, the insured can choose the benefit to be paid.

Initial physician's office visit
If an insured is injured in a covered accident, we will pay the initial physician's office visit benefit shown in the Covered Accident Benefits section. For purposes of this benefit, care received through telemedicine meets the benefit description of an initial physician's office visit.

Benefits are payable for the initial visit received in a physician's office or via telemedicine visit for injuries resulting from a covered accident. The visit must occur within 15 days of the covered accident. Only one benefit is payable per covered accident.

If a benefit is payable under the emergency room visit benefit or urgent care facility visit benefit for the same covered accident, only the higher of the three benefits will be paid. If the benefit amounts are the same, the insured can choose the benefit to be paid.

Urgent care facility visit
If an insured is injured in a covered accident, we will pay the urgent care facility visit benefit shown in the Covered Accident Benefits section.

Benefits are payable for the initial visit received in an urgent care facility for injuries resulting from a covered accident. The visit must occur within 15 days of the covered accident. Only one benefit is payable per covered accident.

If a benefit is payable under the emergency room visit benefit or initial physician office visit benefit for the same covered accident, only the higher of the three benefits will be paid. If the benefit amounts are the same, the insured can choose the benefit to be paid.

Hospital Care Benefits

Coma
If an insured is injured in a covered accident that results in a coma lasting 7 or more consecutive days, we will pay the coma benefit shown in the Covered Accident Benefits section.

Coma refers to a state of unconsciousness with no reaction to external stimuli or internal needs. The insured must be diagnosed as comatose by a physician.

This benefit is limited to one payment per insured per covered accident. Medically induced comas and comas resulting directly from substance use are not covered under this benefit.

Diagnostic testing
If an insured is injured in a covered accident and requires diagnostic testing for treatment of the injury within 90 days of a covered accident, we will pay the diagnostic testing benefit shown in the Covered Accident Benefits section per visit.

The following diagnostic tests are covered under this benefit:

- computed axial tomography (CAT)
- computed tomography scan (CT)
- electroencephalogram (EEG)
- magnetic resonance (MR)
- magnetic resonance imaging (MRI)
- ultrasound

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

Hospital stay
If an insured is injured in a covered accident and requires treatment in a hospital for the injury within 180 days of a covered accident, we will pay the hospital stay benefit shown in the Covered Accident Benefits section.

Daily hospital stay benefit
We will pay the daily hospital stay benefit shown in the Covered Accident Benefits section for each day the insured is confined in the hospital, including the first day. The daily hospital stay benefit will be limited to a maximum of 365 days per covered accident.

Initial hospital stay benefit
We will pay the initial hospital stay benefit shown in the Covered Accident Benefits section for the insured's first day they are confined in the hospital. This benefit is paid in addition to the daily hospital stay benefit for the first day of the confinement.

Daily intensive care unit (ICU) hospital stay benefit
If the insured requires confinement in an intensive care unit (ICU) of a hospital, we will pay the daily intensive care unit hospital stay benefit shown in the Covered Accident Benefits section. This benefit will be limited to one benefit per day per insured up to a maximum of 60 days per insured per confinement. This benefit is paid in lieu of the daily hospital stay benefit.

Initial intensive care (ICU) unit hospital stay benefit
If an insured requires confinement in an intensive care unit (ICU) of a hospital, we will pay the initial intensive care unit hospital stay benefit shown in the Covered Accident Benefits section for the insured's first day they are confined in an ICU. This benefit is paid in addition to the intensive care unit hospital stay benefit for the first day of the confinement in an ICU. This benefit is paid in lieu of the initial hospital stay benefit.

Only one daily benefit is payable per insured per day. In the event the insured is eligible for both the Daily Hospital Stay Benefit and the Daily Intensive Care Unit Hospital Stay Benefit, the higher benefit will be payable.

Only one initial benefit is payable per insured per covered accident. In the event the insured is eligible for both the Initial Hospital Stay Benefit and the Initial Intensive Care Unit Hospital Stay Benefit, the higher benefit will be payable.
If an insured is released from the hospital and subsequently requires treatment in a hospital for injuries sustained in the same covered accident, the subsequent treatment will be considered a continuation of the same hospital stay for purposes of determining the cumulative maximum initial and daily benefits so long as the treatment occurs within two years of the date of the covered accident.

Spinal injection for pain management
If an insured is injured in a covered accident and undergoes one of the procedures listed below to manage the pain from the injury, we will pay the spinal injection for pain management benefit shown in the Covered Accident Benefits section.

- caudal steroid injections
- cervical epidural injections
- facet blocks
- facet medial branch radiofrequency neurolysis
- lumbar epidural injections
- lumbar transforaminal injections

- lumbar sympathetic blocks
- sacroiliac joint injections
- stellate ganglion blocks

We will not pay a benefit for a procedure administered more than 180 days after the covered accident occurs. We will pay the benefit no more than two times per insured per covered accident.

Surgical anesthesia
If an insured is injured in a covered accident and requires surgery to treat the injury, we will pay the surgical anesthesia benefit shown in the Covered Accident Benefits section.

Anesthesia must be administered by a nurse anesthetist or physician and is not limited to epidural anesthesia. This benefit is only payable if a surgical benefit is payable under the Surgery Benefits section of this certificate. The regional benefit is payable for surgery requiring regional anesthesia. The general benefit is payable for surgery requiring general anesthesia. In the event both benefits are payable for the same surgery, the higher benefit will be paid.

X-ray
If an insured is injured in a covered accident and requires an x-ray for treatment of the injury within 90 days of a covered accident, we will pay the x-ray benefit shown in the Covered Accident Benefits section.

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

Surgery Benefits

Abdominal or pelvic, cranial, or thoracic surgery
If an insured is injured in a covered accident and requires abdominal or pelvic, cranial, or thoracic surgery to treat the injuries, we will pay the abdominal or pelvic, cranial, or thoracic surgery benefit shown in the Covered Accident Benefits section.

The surgery must be performed within 365 days of the covered accident. This benefit is limited to one abdominal or pelvic, one cranial, or one thoracic payment per insured per covered accident.

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

Inpatient surgery
If an insured is injured in a covered accident and requires inpatient surgery, we will pay an inpatient surgery benefit subject to the following:

(1) the inpatient surgery is ordered and performed by a physician; and
(2) the inpatient surgery is performed while the insured is confined to a hospital as an inpatient.

We will pay the inpatient surgery benefit shown in the Covered Accident Benefits section for each day the insured undergoes inpatient surgery.

The surgery must be performed within 365 days of the covered accident. This benefit is limited to one benefit per insured per day and two benefits per insured per accident.

If any other inpatient surgery benefits are payable for the same covered accident, we will pay the higher of that benefit amount or the Inpatient Surgery benefit.

Joint replacement surgery of elbow, hip, knee, or shoulder
If an insured is injured in a covered accident and requires joint replacement surgery of the elbow, hip, knee, or shoulder to treat the injury, we will pay the joint replacement surgery benefit shown in the Covered Accident Benefits section.

The surgery must be performed within 365 days of the covered accident. This benefit is limited to one payment per insured per covered accident.

Knee cartilage surgery
If an insured is injured in a covered accident and requires knee cartilage surgery to treat the injury, we will pay the knee cartilage surgery benefit shown in the Covered Accident Benefits section.

The surgery must be performed within 365 days of the covered accident. This benefit is limited to two payment per insured per covered accident. If both open and arthroscopic surgeries are required for the same injury, only the open benefit will be paid.

Outpatient surgery
If an insured undergoes outpatient surgery as a result of a covered accident, we will pay an outpatient surgery benefit shown in the Covered Accident Benefits section:

(1) the outpatient surgery is ordered and performed by a physician; and
(2) the outpatient surgery is performed in a physician's office, or hospital outpatient department, or ambulatory surgical center, or emergency room.

We will pay the outpatient surgery benefit shown in the Covered Accident Benefits section for each day the insured undergoes outpatient surgery.

Tier 1
Performed in a physician's office or emergency room.

Tier 2
Performed in a hospital outpatient department or ambulatory surgical center.

The surgery must be performed within 365 days of the covered accident. This benefit is limited to one benefit per insured per day and two benefits per insured per covered accident.

This benefit will not be payable if the sole reason for the outpatient surgery is wound repair with sutures or staples.

If any other outpatient surgery benefit is payable for the same covered accident, we will pay the higher of that benefit amount or the outpatient surgery benefit.

Ruptured disc surgery
If an insured is injured in a covered accident and requires surgery for one or more ruptured discs to treat the injury, we will pay the ruptured disc surgery benefit shown in the Covered Accident Benefits section.

The surgery must be performed within 365 days of the covered accident. This benefit is limited to one payment per insured per covered accident.

Skin graft
The skin graft benefit is subject to the following conditions:

(1) a benefit is payable under the burn benefit of the Injury Benefits section of the certificate; and
(2) the skin graft is performed within 365 days of the covered accident.

We will pay the skin graft benefit shown in the Covered Accident Benefits section. This benefit is limited to one payment per insured per covered accident.

Tendon, ligament, or rotator cuff surgery
If an insured is injured in a covered accident and requires tendon, ligament, or rotator cuff surgery to treat the injuries, we will pay the tendon, ligament, or rotator cuff surgery benefit shown in the Covered Accident Benefits section.

The surgery must be performed within 365 days of the covered accident. This benefit is limited to two payments per insured per covered accident. If both open and arthroscopic surgeries are required, only the open benefit will be paid.

Follow-Up Care Benefits

Adaptive home and vehicle benefit
If an insured is injured in a covered accident and requires adaptive modifications to their primary residence or private vehicle to be made drivable or rideable, we will pay the adaptive home and vehicle benefit shown in the Covered Accident Benefits section subject to the following conditions:

(1) the covered accident results in paralysis of the insured or a benefit is payable under the dismemberment benefit of the Accidental Death and Dismemberment Benefit;
(2) the modification must take place within two years of the covered accident;
(3) such home alterations are made by a person or persons with experience in such alterations and recommended by a recognized organization associated with the injury; and
(4) such vehicle modifications are carried out by a person or persons with experience in such matters and approved by the Motor Vehicle Department.

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

Appliances
If an insured is injured in a covered accident and a medical appliance is prescribed by a physician for mobility, we will pay the appliance benefit shown in the Covered Accident Benefits section.

Covered appliances means only the following: Bedside commode, body jacket, braces, canes, cervical collar, crutches, hospital bed, medical aid cushion, walkers, walking boot, scooters, wheelchairs, or other medical devices to aid movement.

We will pay an appliance benefit shown in the Covered Accident Benefits section based on the medical appliance prescribed and the length of time the medical appliance is required for use.

Tier 1
Bedside commode, body jacket, braces, canes, cervical collar, crutches, hospital bed, medical aid cushion, walkers, walking boot, scooters, wheelchairs, or other medical devices to aid movement. For scooters and wheelchairs, the expected use of less than one year.

Tier 2
Hospital bed, scooters, and wheelchairs. For scooters and wheelchairs, the expected use of one year or longer.

The order for the appliance must be placed within 180 days of the covered accident. This benefit is limited to payment for two covered appliances per insured per covered accident. This benefit does not cover replacement appliances.

Follow-up physician's office visit
If an insured is injured in a covered accident and follow-up care for the injury is ordered by the treating physician, we will pay the follow-up physician's office visit benefit shown in the Covered Accident Benefits section. For purposes of this benefit, care received through telemedicine meets the benefit description of a follow-up physician's office visit.

The follow-up visit(s) must occur within 180 days of the covered accident. This benefit is limited to six payments per insured per covered accident. Follow-up at an urgent care facility is not covered under this benefit.

Post-traumatic stress disorder benefit (PTSD)
If an insured is diagnosed with Post-traumatic stress disorder (PTSD) resulting from a covered accident, we will pay the post-traumatic stress disorder benefit amount shown in the Covered Accident Benefits section.

An insured must be diagnosed by a physician and must meet the diagnostic criteria for PTSD as described in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). The diagnosis must take place within one year after the covered accident for a benefit to be payable.

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

Prescription drug benefit
If an insured is injured in a covered accident and receives a prescription, we will pay the prescription drug benefit shown in the Covered Accident Benefits section.

The prescription must be ordered by a physician, filled by a licensed pharmacist, and medically necessary as determined by the physician for the care and treatment of the insured. The prescription must be ordered and filled within 180 days of the covered accident.

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

Prosthetics
If an insured is injured in a covered accident and sustains the loss of a limb, hand, foot, or sight in an eye, we will pay the prosthetic benefit shown in the Covered Accident Benefits section, subject to the following:

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

Prosthetic device refers to an artificial device (including orthotic devices) that replaces a missing limb, hand, foot, or an eye. For purposes of this benefit, the term prosthetic device does not include corrective lenses or other cosmetic prostheses. In addition, this benefit does not provide coverage for damaged prosthetics; more than one prosthetic device for the same limb, hand, foot or eye; the replacement of a prosthetic device; or a joint replacement.

Rehabilitative therapy (inpatient) – cognitive behavioral therapy, occupational therapy, physical therapy, respiratory therapy, speech therapy, trauma counseling, vocational therapy
If an insured is injured in a covered accident and is receiving rehabilitative therapy ordered by a physician to treat the injury on an inpatient basis, we will pay one rehabilitative therapy benefit per day shown in the Covered Accident Benefits section for each day the insured is confined as an inpatient in a hospital or rehabilitative facility.
The following rehabilitative therapies are covered under this benefit:

- cognitive behavioral therapy
- occupational therapy
- physical therapy
- respiratory therapy
- speech therapy
- trauma counseling
- vocational therapy

The benefit is limited to 30 benefits payments per insured per covered accident. Inpatient rehabilitative therapy must be received within two years from the date of the covered accident. If rehabilitative therapy is provided in a hospital and the sole purpose of the insured's hospital stay is for rehabilitative services, then only the inpatient rehabilitative therapy benefit is payable and not the hospital stay benefit.

This benefit does not include inpatient rehabilitative therapy received in a nursing home, rest home, extended-care facility, convalescent home, skilled nursing facility, hospice care facility, substance use facility, mental health facility, or assisted living facility.

Rehabilitative therapy (outpatient) – acupuncture therapy, chiropractic therapy, cognitive behavioral therapy, massage therapy, occupational therapy, physical therapy, respiratory therapy, speech therapy, trauma counseling, vocational therapy
If an insured is injured in a covered accident and is receiving rehabilitative therapy ordered by a physician to treat the injury on an outpatient basis, we will pay the rehabilitative therapy benefit if the insured receives one or more of the following outpatient rehabilitative therapies:

- acupuncture therapy
- chiropractic therapy
- cognitive behavioral therapy
- massage therapy
- occupational therapy
- physical therapy
- respiratory therapy
- speech therapy
- trauma counseling
- vocational therapy

For purposes of this benefit, care received through telemedicine meets the benefit description of a follow-up physician's office visit. The lump sum rehabilitative therapy benefit shown in the Covered Accident Insurance Benefits is payable as a one-time payment if the insured receives one or more of the covered outpatient rehabilitative therapies.
The benefit is limited to one benefit payment per insured per covered accident.

Outpatient rehabilitative therapy must be received within two years from the date of the covered accident.

This benefit does not include outpatient rehabilitative therapy received in a nursing home, rest home, extended-care facility, convalescent home, skilled nursing facility, hospice care facility, substance use facility, mental health facility, or assisted living facility.

Transportation
A transportation benefit as shown in the Covered Accident Benefits section may be payable if an insured receives follow-up treatment in a hospital or treatment facility for a covered accident and is required to travel more than 50 miles (one way) from the insured's primary residence to a hospital or treatment facility, subject to the following:

(1) a benefit is payable under this certificate for the same injury;
(2) the follow-up treatment is ordered by a physician and is not available within 50 miles (one way) of the insured's primary residence; and
(3) the ambulance benefit is not payable for the same trip.

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

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

Support Care Benefits

Adult companion lodging
An adult companion lodging benefit as shown in the Covered Accident Benefits section may be payable for each day the insured receives a hospital stay benefit or rehabilitative therapy (inpatient) benefit. Adult companion lodging benefits are payable subject to the following conditions:

(1) a companion who accompanies the insured stays in lodging for which a charge is made;
(2) proof the insured received a hospital stay benefit or rehabilitative therapy (inpatient) benefit on the days the companion lodging expenses were incurred; and
(3) the companion is age 18 or older.

If an adult companion lodging benefit is payable, an additional adult companion lodging benefit may also be payable for the 24-hours following the last day for which an insured receives a hospital stay benefit or rehabilitative therapy (inpatient) benefit.

This benefit is limited to 30 days per covered accident.

Lodging refers to an establishment that provides sleeping accommodations to the general public in exchange for a fee and is located at least 50 miles from the insured's primary residence , such as a motel, hotel, or other short term rental property.

Family care
A family care benefit as shown in the Covered Accident Benefits section may be payable for each day the insured receives a hospital stay benefit or rehabilitative therapy (inpatient) benefit for the injury and the insured's child is provided child care subject to the following:

(1) either the hospital stay benefit or rehabilitative therapy (inpatient) benefit is payable for the same day the child care is payable; and
(2) the child is under age 13. Children age 13 or older are eligible if mentally or physically disabled.

The child for which child care is provided does not need to be insured under this certificate.

Child care refers to professional care by a licensed provider who charges a fee for the care of children. The term does not include child care provided by a family member.

This benefit is limited to one benefit per child per day for up to 30 days per covered stay. This is subject to a combined maximum of 75 benefits for all children per covered stay. If both you and your spouse are insured under this certificate, only one family care benefit claim will be paid per child. Proof must be provided that child care expenses were incurred for each day the benefit is payable.

Pet boarding and professional sitting
A pet boarding and professional sitting benefit as shown in the Covered Accident Benefits section may be payable for each day the insured receives a hospital stay benefit or inpatient rehabilitative therapy benefit and insured's pet requires boarding or sitting. Pet boarding and professional sitting benefits are payable subject to the following:

(1) a charge is incurred for the boarding or professional sitting service; and
(2) the hospital stay benefit or inpatient rehabilitative therapy benefit is payable for the same day the pet boarding and professional sitting benefit is payable.

Pet refers to any breed of feline, canine, or other domesticated animal. Boarding or professional sitting means that the pet is boarded outside of the insured's primary residence or obtains in-home professional sitting services at the insured's primary residence.

This benefit is limited to one benefit per day, regardless of the number of pets, up to a maximum of 30 days per covered accident. If both you and your spouse are insured under this certificate, only one pet boarding and professional sitting benefit claim will be paid per day. The pet is not considered an insured under this certificate.

EXCLUSIONS

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

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

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

CERTIFICATE TERMINATION

Your coverage ends at 11:59 PM on the earliest of the following:

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

Your insured dependent's coverage ends on the earliest of the following:

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

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

Extension of Benefits
If coverage under this policy ends for an injury resulting in total disability, we will continue to pay benefits after the date coverage under the policy ends if you meet the following requirements:

(1) the injury must be continuous after the date of termination; and
(2) coverage must not have ended as a result of your voluntary termination of coverage.

This Extension of Benefits terminates upon the earliest of the following:

(1) the date you recover so that you are no longer totally disabled;
(2) the date you receive the maximum benefit for the injury; or
(3) 90 days after the date coverage would otherwise terminate.

ADDITIONAL BENEFITS

If you are insured under the provisions applicable to accident insurance coverage under this certificate you are eligible for insurance under the following Additional Benefits below. In addition, your spouse or your dependent children are eligible if they are insured under this certificate. Insurance under these Additional Benefits become effective on the date you, your spouse, or your dependent child becomes insured under this certificate as outlined in the Certificate Specification section. Coverage under these Additional Benefits are subject to all terms, conditions, exclusions, limitations, and provisions of this certificate unless otherwise expressly provided for herein.

Accidental Death and Dismemberment (AD&D) Benefit

The AD&D Benefit provides accidental death and dismemberment coverage. The payable amount of the AD&D Benefit is shown in the Plan of Insurance – Additional Benefits section of the certificate. We will pay the benefit upon receipt at our home office of written proof satisfactory to us as to both substance and form that an insured died or suffered a dismemberment as a result of a covered accident. Benefits will be paid according to the Claims section of the certificate.

Benefits
The amount of the benefit shall be a percentage of the amount of AD&D insurance shown in the Plan of Insurance section of the certificate. The percentage is determined by the type of loss as shown in the following table:

TYPE OF LOSS/ DISMEMBERMENT	PERCENT OF AMOUNT OF INSURANCE
Death:	
Life	100%
Dismemberment:	
Both Hands or Both Feet	100%
Sight of Both Eyes	100%
Speech and Hearing in Both Ears	100%
One Hand and One Foot	100%
One Foot and Sight of One Eye	100%
One Hand and Sight of One Eye	100%
Sight of One Eye	50%
Speech or Hearing in Both Ears	50%
One Hand or One Foot	50%
Thumb and Index Finger of One Hand	25%

Loss of hands or feet means complete severance at or above the wrist or ankle joints. Loss of sight, speech, or hearing means the entire and irrecoverable loss of sight, speech, or hearing which cannot be corrected by medical or surgical treatment or by artificial means. Loss of thumb or finger means complete severance at or above the metacarpophalangeal joints (the joints closest to the palm of the hand).

A benefit is not payable for both loss of one hand and the loss of thumb and index finger of one hand for injury to the same hand as a result of any one accident (the largest benefit of these overlapping losses only will be paid). Under no circumstance will more than one payment be made for the loss of the same limb, eye, finger, thumb, hand, foot, sight, speech, or hearing if one payment has already been made for that loss.

Benefits may be paid for more than one covered loss but the total amount of AD&D insurance payable for any one accident, not including any amount paid according to the terms of the Additional Accidental Death and Dismemberment Benefits listed below, will never exceed the full amount of an insured's AD&D insurance.

Additional Accidental Death and Dismemberment Benefits
Additional benefits are paid in addition to any AD&D benefits described above.

Public transportation benefit
If an insured dies or suffers a covered dismemberment as a result of a covered accident which occurs while the insured is a fare-paying passenger on a public transportation vehicle, we will pay an additional benefit equal to 100% of the insured's amount of AD&D insurance.

If a dismemberment benefit is payable for the same covered accident, the public transportation benefit is reduced by the amount of the dismemberment benefit.

Public transportation vehicle means any air, land or water vehicle operated by a government regulated entity. Public transportation vehicle does not include taxi, limousine, ride shares, or privately chartered vehicles.

Limitations
In order for a benefit to be payable all of the following conditions must be met:

(1) the insured's injury, loss, death or dismemberment must be a result of a covered accident;
(2) the insured's loss must occur within 365 days of the date of the accident;
(3) the injury must be the sole cause of the insured's loss; and
(4) the loss must occur while the insured's coverage is in force.

Termination
Insurance under this benefit will terminate on the earliest of the following:

(1) the date requested by the policyholder to cancel the Accidental Death and Dismemberment coverage for its plan; or
(2) the terminating events outlined in the Certificate Termination section.

Designated Facility Benefit

This additional benefit will increase the amount payable for the covered accident benefits when the insured utilizes an eligible client designated facility specified by the policyholder. We will pay the benefit upon receipt at our home office of written proof satisfactory to us as to both substance and form. Listed below are the increased amounts for a covered benefit. Benefits will be paid according to the Claims section of the certificate.

Eligible facilities
Client designated facilities as reported to us by the policyholder**.**

Eligibility
The insured is eligible to receive a Designated Facility Benefit if the following conditions are fully met:

(1) the same benefit is payable according to the provisions of the Certificate to which this benefit is attached;
(2) the benefit is listed as a covered accident benefit; and
(3) the insured utilized a eligible client designated facility.

Benefits
Benefits are limited to the covered accident benefits expressly listed below and replaces the covered accident benefit amounts listed earlier under the Covered Accident Benefits section.

INJURY BENEFITS	BENEFIT PLAN
Burn benefit	
2nd degree burns	
Less than 10% of the body	$375
Between 10% and 20% of the body	$938
20% or more of the body	$1,875
3rd degree burns	
Less than 10% of the body	$3,750
Between 10% and 20% of the body	$9,375
20% or more of the body	$18,750
Concussion	$500
Dislocation – Principal Amount (Surgical)	$10,000
Ankle	$4,000
Collarbone	$2,000
Elbow	$2,000
Finger	$1,000
Foot	$4,000
Hand (excluding fingers)	$2,000
Hip/Thigh	$10,000
Knee	$7,500
Lower jaw	$2,000
Ribs	$2,000
Shoulder	$3,000
Toe	$1,000
Wrist	$3,000
Non-surgical	50% of surgical benefit
Partial Dislocation	25% of non-surgical benefit
Eye injury – with surgery	$500
Eye injury – removal of foreign object without surgery	$125
Fracture – Principal Amount (Surgical)	$10,000
Ankle	$2,500
Chip fracture	25% of non-surgical benefit
Collarbone	$1,500
Coccyx	$1,500
Facial excluding lower jaw	$3,500
Finger	$1,500
Foot	$2,500
Hand (except fingers)	$3,000

Hip/Thigh	$10,000
Kneecap	$2,500
Lower jaw	$2,500
Lower leg	$5,000
Nose	$1,000
Pelvis	$7,500
Ribs	$2,500
Sacrum	$5,000
Shoulder blade	$5,000
Skull – depressed	$15,000
Skull – non depressed	$10,000
Sternum	$7,500
Toe	$1,000
Upper arm	$3,500
Vertebral body	$5,000
Vertebral processes	$2,000
Wrist or forearm	$2,500
Non-surgical	50% of surgical benefit
Lacerations	
No repair	$100
Repair	$500
Organized sports injury	25% of the total accident claim up to a maximum of $3,000
Paralysis – Principal Amount	$37,500
Quadriplegia	$37,500
Paraplegia	$18,750
Hemiplegia	$18.750
Uniplegia	$9,375
Traumatic brain injury	$1,000
EMERGENCY CARE	**BENEFIT PLAN**
Ambulance	
Ground or water	$625
Air	$2,500
Blood, plasma, or platelets transfusion	$750
Emergency dental	
Crown	$375
Extraction	$188
Filling	$63
Emergency room visit	$375

Initial physician's office visit	$250
Urgent care facility visit	$313
HOSPITAL CARE	**BENEFIT PLAN**
Coma	$25,000
Diagnostic testing	$375
Hospital stay	
Initial benefit, non-ICU	$1,250
Initial benefit, ICU	$2,500
Daily benefit, non-ICU	$250
Daily benefit, ICU	$500
Spinal injection for pain management	$188
Surgical anesthesia	
General	$250
Regional	$125
X-ray	$188
SURGERY BENEFITS	**BENEFIT PLAN**
Abdominal or pelvic, cranial, or thoracic surgery	$2,500
Inpatient surgery	$1,875
Joint replacement surgery of elbow, hip, knee, or shoulder	$1,875
Knee cartilage surgery	
Open	$1,875
Arthroscopic	$938
Outpatient surgery	
Tier 1	$625
Tier 2	$1,250
Ruptured disc surgery	$1,875
Skin graft	50% of applicable burn benefit
Tendon, ligament, or rotator cuff surgery	
Open	$1,875
Arthroscopic	$938
FOLLOW-UP CARE	**BENEFIT PLAN**
Adaptive home and vehicle benefit	$3,750
Appliances	
Tier 1	$250
Tier 2	$1,250
Follow-up physician's office visit	$188

Post-traumatic stress disorder benefit (PTSD)	$875
Prescription drug benefit	$50
Prosthetics	
One prosthetic	$2,500
Two or more prosthetics	$5,000
Rehabilitative therapy (inpatient) – cognitive behavioral, occupational, physical, respiratory, speech, trauma counseling, vocational	$250
Rehabilitative therapy (outpatient) – acupuncture, chiropractic, cognitive behavioral, massage, occupational, physical, respiratory, speech, trauma counseling, vocational	
Lump Sum Benefit	$750
Transportation	$625
SUPPORT CARE	**BENEFIT PLAN**
Adult companion lodging	$250
Family care	$125
Pet boarding and professional sitting	$63

Termination
Insurance under this benefit will terminate on the earliest of the following:

(1) the date requested by the policyholder to cancel the designated facility coverage for its plan; or
(2) the terminating events outlined in the Certificate Termination section.

Wellness Screening Benefit

This benefit provides for an additional benefit to be paid to you if you, your covered spouse, or your covered child undergo one of the wellness screenings listed below while not in a hospital on an inpatient basis. The payable amount of the Wellness Screening Benefit is shown in the Plan of Insurance – Additional Benefits section of the certificate. We will pay the benefit after receipt at our home office of proof satisfactory to us that you, your covered spouse, or your covered child have undergone one of the covered screenings or preventive cares listed in this benefit. The benefit will be paid in a single sum. Benefits will be paid according to the Claims section of the certificate.

Wellness screenings or Preventive care

- annual physical exam;
- mental health screening recommended and performed by a physician;
- biopsies for cancer;
- blood chemistry panel;
- blood test to determine total cholesterol;
- blood test to determine triglycerides;
- bone marrow testing;
- BRCA1/BRCA2 genetic testing;
- breast MRI;
- breast ultrasound;
- breast sonogram;
- CA 15-3 breast cancer test;
- CA 125 ovarian cancer test;
- carotid Doppler;
- CEA colon cancer test;
- chest x-ray;
- clinical testicular exam;
- colonoscopy;
- dental exam;
- digital rectal exam (DRE);
- DNA stool analysis;
- doppler screening for cancer;
- doppler screening for peripheral vascular disease;
- fasting plasma glucose test;
- flexible sigmoidoscopy;
- hearing exam;
- hemoccult stool specimen;
- hemoglobin A1C;
- herpes simplex virus (HSV) test;
- human papillomavirus (HPV) test;
- lipid panel;
- lung cancer CT;
- mammogram;
- non-diagnostic vascular screening;
- nucleic acid test (NAT);
- oral cancer screening;
- pandemic testing (excluding at home testing);
- pap smears or thin prep pap test;
- pharmacologic stress testing;
- prostate-specific antigen (PSA) test;
- serum cholesterol test to determine LDL and HDL levels;
- serum protein electrophoresis;
- skin cancer biopsy;
- skin exam;
- stress test on bicycle or treadmill;
- successful completion of smoking cessation program;
- tests for sexually transmitted infections (STI's);

- double-contrast barium enema;
- echocardiogram;
- electrocardiogram (EKG);
- electroencephalogram (EEG);
- endoscopy;
- eye exam;
- fasting blood glucose test;
- thermography;
- two-hour post-load plasma glucose test;
- ultrasounds;
- urinalysis;
- vaccinations approved by the FDA; or
- virtual colonoscopy.

Employer sponsored wellness screening or preventive care benefits conducted at the employer's place of business are not eligible for payment.

Benefit limitations
You, your spouse, and each child can receive one supplemental Health and Wellness Benefit per year**.**

Termination
Insurance under this benefit will terminate on the earliest of the following:

(1) the date requested by the policyholder to cancel the wellness screening coverage for its plan; or
(2) the terminating events outlined in the Certificate Termination section.

Portability Benefit

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

To continue insurance under this benefit, an insured must make a written request and make the first premium payment within 31 days after insurance provided by the group policy would otherwise terminate. Coverage will remain in effect during the 31 day election period but not beyond this unless all continuation requirements are met. Upon satisfactory completion of all portability election requirements, coverage provided by this benefit will then be deemed effective retroactive to the beginning of the 31 day period. This date is considered to be the insured's portability date and the insured then is considered to have portability status.

If you elect to continue your own coverage according to the provision of this benefit, you may elect to continue insurance for any other individual insured under your certificate. If your former spouse continues their own coverage they may elect to continue insurance on any insured children, provided you are not otherwise insuring the children. Benefits will be paid according to the Claims section of the certificate.

Eligibility
You are eligible to continue group accident insurance under the terms of this benefit if you no longer meet the eligibility requirements due to any of the following:

(1) your termination of employment, including retirement;
(2) your number of working hours are reduced;
(3) you are no longer in a class eligible for insurance or on a leave or layoff; or
(4) a class or group of employees insured under the policy are no longer considered eligible and there is no successor plan for that class or group. Successor plan means an insurance policy or policies provided by us or another insurer that replaces insurance provided under the policy.

Your dependents are eligible to continue group accident insurance under this benefit if they no longer meet the eligibility requirements due to any of the following:

(1) your termination of employment, including retirement;
(2) your number of working hours are reduced;
(3) you are no longer in a class eligible for insurance or on a leave or layoff;
(4) a class or group of employees insured under the policy are no longer considered eligible and there is no successor plan for that class or group. Successor plan means an insurance policy or policies provided by us or another insurer that replaces insurance provided under the policy;
(5) divorce;
(6) the dependent ceases to be an eligible dependent; or
(7) your death.

Regardless of whether an insured is otherwise eligible under this benefit to continue, an insured will not be eligible to request coverage under this benefit if they:

(1) have attained age 120;
(2) are an employee and were not actively at work due to sickness or injury on the date immediately preceding the portability date;
(3) lose eligibility due to a class or group of employees no longer being eligible under the policy and there is a successor plan for that class or group of employees;
(4) lose eligibility due to termination of the group policy; or
(5) do not reside in the United States or United States Territory.

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

Benefit amounts
The benefit amounts that can be continued under this additional benefit shall be the amounts shown on the Plan of Insurance section applicable to the insured based on the benefit plan selected by you.

An insured employee and a dependent who ports coverage on their own as provided under the terms of this Additional Benefit may change the benefit plan to one that provides a lower benefit amount but may not change the benefit plan to one that provides a higher benefit amount.

Additional Benefits
Coverage under the Accidental Death & Dismemberment Benefit and the Health and Wellness Benefit will be continued with ported coverage. All other Additional Benefits will terminate upon porting.

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

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

Termination
No individual may elect coverage under this benefit on or after the date of termination of the group policy.

An insured's insurance being continued under this benefit will remain in force until terminated on the earliest of the following:

(1) the insureds 120th birthday;
(2) the date the insured again meets the eligibility requirements of the certificate, not including the terms of this benefit;
(3) in the case of a dependent spouse or child the date your coverage is no longer being continued under this benefit or the date the spouse or child ceases to be eligible as defined under the terms of your plan, unless the spouse or child has ported coverage on their own as provided for under the terms of this benefit;
(4) the date the group policy is terminated;
(5) 31 days after the due date of any premium contribution which is not made;
(6) 31 days after we give written notice of our intent to terminate ported coverage for a group or class of individuals; or
(7) the date the insured requests to terminate their coverage being continued under this benefit.

PREMIUMS

Premium due date
Unless the policyholder and we have agreed to some other premium payment procedure, any premium contributions you are required to make for contributory insurance are to be paid by you to the policyholder on a periodic basis.

Premium determination
The premium will be the applicable premium rate in force on the date premiums are due. The premium may also be computed by any other method on which the policyholder and we agree.
Premium rates are subject to change according to the provisions of the group policy.

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

Reinstatement
If coverage terminates due to non-payment of premium, it may be reinstated.

Reinstatement must occur while the insured is living and within 6 months from the date of coverage termination. To reinstate, all back due premiums must be paid. After all back due premiums are paid, your coverage will be reinstated as if there were no lapse in coverage. Any loss that occurred during the lapse period will be covered.

CLAIMS

We are providing notice that Securian Life Insurance Company is subject to economic and trade sanctions, laws, and regulations. These laws and regulations, including the laws and regulations administered and enforced by the United States Department of the Treasury's Office of Foreign Assets Control (OFAC), prevent Securian Life Insurance Company from providing coverage to, and from paying benefits to, entities and individuals where prohibited by applicable law. In addition, these laws and regulations prohibit certain activities with respect to certain countries.

Notice of claim
Written notice of claim must be given to us within 365 days of the date of a loss resulting from a covered accident. Failure to give notice within the time prescribed does not invalidate or reduce any claim if it is shown that it was not reasonably possible to give the notice within that time and notice was given as soon as was reasonably possible. Notice given by or on the insured's behalf to us at our home office or to any authorized agent of ours, with information to identify the insured, shall be deemed notice to us.

We will acknowledge receipt of the claim, commence any investigation of the claim and request all items, statements and forms that we reasonably believe, at that time, will be required from you, not later than the 15th day after the date we receive notice of claim.

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

Proof of loss
Written proof of a loss resulting from a covered accident satisfactory to us must be provided to us within 180 days of the date of the loss, or as soon as reasonably possible. Failure to provide proof of the loss within this time will not invalidate or reduce a claim if it was not reasonably possible to provide proof within this 180 day period. However, proof must be provided within 15 months of the date proof of loss is required, except in the absence of legal capacity.

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

We, at our own expense, may reasonably require during the pendency of a claim an autopsy in case of death, where it is not forbidden by law.

Payment of claims
We will pay a benefit for a loss resulting from a covered accident within 60 days after receipt at our home office of written proof of the loss which meets all policy requirements and is satisfactory to us. All benefits including dependent's benefits will be paid to you, if you are living, or to your assignee. The benefit will be paid in a single sum or by any other method agreeable to us and the beneficiary. You are responsible for all costs associated with claim form(s) completion, records, and the submission of your claim.

We may pay benefits for a dependent child to a person other than you if an order providing for the appointment of a possessory or managing conservator of the dependent child has been issued by a court. The person must provide us with written notice that he or she is a possessory or managing conservator of the dependent child on whose behalf the claim is made and a certified copy of the court order designating that individual as the possessory or managing conservator of the dependent child, or any other evidence that the person is eligible to receive benefits for the dependent child.

Recovery of overpayment
We have the right to recover from you or the recipient of benefits, any benefit amount paid that we determine to be an overpayment under this certificate. You or the recipient of benefits has the obligation to refund to us any amount of overpayment.
If benefits are overpaid on any claim, you or the recipient of benefits must refund us within 90 days. If the refund is not made in a timely manner, we have the right to offset future benefits payable under this certificate by an amount equal to the overpayment.

Beneficiary
If you die before the claim is paid, benefits will be paid to your assignee, or in the absence of an assignee your estate.

Payment to Texas Health and Human Services Commission
We will pay benefits to the Texas Health and Human Services Commission on behalf of an insured child upon written notice to us if:

(1) you are required to pay child support by a court order issued in Texas or are not entitled to possession or access to the insured child and are required by court order to pay child support;
(2) the Texas Health and Human Services Commission is paying benefits on behalf of the insured child on behalf of the insured child under Chapter 31 and 32 of the Texas Human Resources Code; and
(3) notification is given to us in writing with a submitted claim that such benefits should be paid directly to the Texas Health and Human Services Commission.

ADDITIONAL INFORMATION

Changes to policy or certificate
We retain the right to amend this certificate at any time without your consent. Any amendment will be without prejudice to any claim incurred for benefits prior to the date of the amendment.

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

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

Clerical or administrative errors
If a clerical or administrative error is made in keeping records on or administering the insurance under this certificate, it will not affect otherwise valid insurance.

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

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

Conformity of state law

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

How you're protected if your life or health insurance company fails

The Texas Life and Health Insurance Guaranty Association protects you by paying your covered claims if your life or health insurance company is insolvent (can't pay its debts). **This notice summarizes your protections.**

The Association will pay your claims, with some exceptions required by law, if your company is licensed in Texas and a court has declared it insolvent. You must live in Texas when your company fails. If you don't live in Texas, you may still have some protections.

For each insolvent company, the Association will pay a person's claims only up to these dollar limits set by law:

- **Accident, accident and health, or health insurance (including HMOs):**
  - Up to $500,000 for health benefit plans, with some exceptions.
  - Up to $300,000 for disability income benefits.
  - Up to $300,000 for long-term care insurance benefits.
  - Up to $200,000 for all other types of health insurance.
- **Life insurance**
  - Up to $100,000 in net cash surrender or withdrawal value.
  - Up to $300,000 in death benefits.
- **Individual annuities:** Up to $250,000 in the present value of benefits, including cash surrender and net cash withdrawal values.
- **Other policy types:** Limits for group policies, retirement plans and structured settlement annuities are in Chapter 463 of the Texas Insurance Code.
- **Individual aggregate limit:** Up to $300,000 per person, regardless of the number of policies or contracts. A limit of $500,000 may apply for people with health benefit plans.
- **Parts of some policies might not be protected:** For example, there is no protection for parts of a policy or contract that the insurance company doesn't guarantee, such as some additions to the value of variable life or annuity policies.

To learn more about the Association and your protections, contact:

Texas Life and Health Insurance Guaranty Association
1717 West 6th Street, Suite 230
Austin, Texas 78703-4776
1-800-982-6362 or www.txlifega.org

For questions about insurance, contact:

Texas Department of Insurance
PO Box 12030
Austin, Texas 78711
1-800-252-3439 or www.tdi.texas.gov

Note: You're receiving this notice because Texas law requires your insurance company to send you a summary of your protections under the Texas Life and Health Insurance Guaranty Association Act (Insurance Code, Chapter 463). These protections apply to insolvencies that occur on or after September 1, 2019. **There may be other exceptions that aren't included in this notice.** When choosing an insurance company, you should not rely on the Association's coverage. Texas law prohibits companies and agents from using the Association as an inducement to buy insurance or HMO coverage.

Chapter 463 controls if there are differences between the law and this summary.

Securian Life Insurance Company • A Stock Company

400 Robert Street North • St. Paul, Minnesota 55101-2098

GROUP ACCIDENT CERTIFICATE OF INSURANCE • NONPARTICIPATING