

SERFF Tracking Number: ICCI-127879267 State: Arkansas
Filing Company: Madison National Life Insurance Company, Inc. State Tracking Number:
Company Tracking Number: MNL LMB POL 0112
TOI: H14G Group Health - Hospital Indemnity Sub-TOI: H14G.000 Health - Hospital Indemnity
Product Name: MNL LMB POL 0112
Project Name/Number: MNL LMB POL 0112/MNL LMB POL 0112

Filing at a Glance

Company: Madison National Life Insurance Company, Inc.

Product Name: MNL LMB POL 0112 SERFF Tr Num: ICCI-127879267 State: Arkansas

TOI: H14G Group Health - Hospital Indemnity SERFF Status: Closed-Approved-
Closed State Tr Num:

Sub-TOI: H14G.000 Health - Hospital Indemnity Co Tr Num: MNL LMB POL 0112 State Status: Approved-Closed

Filing Type: Form

Author: Brenda Dawson

Reviewer(s): Rosalind Minor

Date Submitted: 07/06/2012

Disposition Date: 07/06/2012

Disposition Status: Approved-

Closed

Implementation Date Requested:

Implementation Date:

State Filing Description:

General Information

Project Name: MNL LMB POL 0112

Status of Filing in Domicile:

Project Number: MNL LMB POL 0112

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Small and Large

Group Market Type: Employer

Overall Rate Impact:

Filing Status Changed: 07/06/2012

State Status Changed: 07/06/2012

Deemer Date:

Created By: Brenda Dawson

Submitted By: Brenda Dawson

Corresponding Filing Tracking Number:

Filing Description:

Enclosed for review and approval of use in your state are the forms attached to the form schedule tab. These forms are new and are not intended to replace any forms previously approved by your state.

Insurance Compliance Consultants, Inc., is making this filing on behalf of Madison National Life Insurance Company, Inc. A filing authorization letter is attached. All correspondence should be addressed to Insurance Compliance Consultants, Inc.

Master Group Limited Indemnity Benefit Health Insurance Policy form MNL LMB POL 0112 will be issued to employers located in your state.

SERFF Tracking Number: ICCI-127879267 State: Arkansas
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Form MNL LMB CERT 0112 is the Group Limited Indemnity Benefit Health Insurance Certificate of Insurance evidencing coverage under the Master Group Policy. Amendatory Endorsement form MNL LMB AEAR 0112 will be attached to all certificates issued in Arkansas.

The Schedule of Benefit MNL LMB SOB 0112 is attached to the Certificate based on the benefit levels selected by the employer.

Form MNL LMB ER APP 0112 is the employer application and form MNL LMB EE APP 0112 is the employee enrollment application used to apply for coverage.

The following Optional benefit rider will also be offered to the Employer:

- [Optional] Accident Expense Benefit Rider – MNL LMB ACC 0112
- [Optional] Accidental Death and Dismemberment Benefit Rider – MNL LMB ADD 0112
- [Optional] Critical Care Indemnity Benefit Rider – MNL LMB CCR 0112
- [Optional] Dental Benefit Rider – MNL LMB DEN 0112
- [Optional] Term Life Insurance Benefit Rider – MNL LMB LIF 0112
- [Optional] Vision Benefit Rider – MNL LMB VIS 0112
- [Optional] Non-Occupational Weekly Disability Income Insurance Benefit Rider – MNL LMB WDI 0112

Amendatory Endorsement form MNL LMB AEHBA 0112 will be attached to the Certificate for employees whose employers have established a program of health benefits using an hour bank accounting system to administer contributions.

We certify that to the best of our knowledge and belief, these forms do not violate any laws or regulations of your state and do not contain any previously disapproved provisions.

These documents were prepared on a personal computer and will ultimately be printed from another data processing system that may cause some print style and/or page spacing changes. However, there will not be any changes to the actual text of the forms other than listed or bracketed variables, or to the general print size.

State Narrative:

Company and Contact

Filing Contact Information

SERFF Tracking Number: ICCI-127879267 State: Arkansas
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Brenda Dawson, Authorized Representative Brendadawson@inscompliance.com
3925 East State Street, Suite 200 815-316-6714 [Phone]
Rockford, IL 61108 815-986-2355 [FAX]

Filing Company Information

(This filing was made by a third party - insurancecomplianceconsultantsinc)

Madison National Life Insurance Company, Inc. CoCode: 65781 State of Domicile: Wisconsin
P. O. Box 5008 Group Code: Company Type:
Madison, WI 53705 Group Name: State ID Number:
(800) 356-9601 ext. [Phone] FEIN Number: 39-0990296

Filing Fees

Fee Required? Yes
Fee Amount: \$700.00
Retaliatory? No
Fee Explanation: \$50 per form
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Madison National Life Insurance Company, Inc.	\$700.00	07/06/2012	60689574

SERFF Tracking Number: ICCL-127879267 State: Arkansas
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	07/06/2012	07/06/2012

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Disposition

Disposition Date: 07/06/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	MNL Authorization Letter 2012	Approved-Closed	Yes
Form	Group Limited Indemnity Benefit Health Insurance Policy	Approved-Closed	Yes
Form	Group Limited Indemnity Benefit Health Insurance Certificate of Insurance	Approved-Closed	Yes
Form	Schedule of Benefits	Approved-Closed	Yes
Form	Employer Application	Approved-Closed	Yes
Form	Employee Enrollment Application	Approved-Closed	Yes
Form	Amendatory Endorsement Hour Bank Accounting	Approved-Closed	Yes
Form	[Optional] Accident Expense Benefit Rider	Approved-Closed	Yes
Form	[Optional] Accidental Death and Dismemberment Insurance Benefit Rider	Approved-Closed	Yes
Form	[Optional] Critical Care Indemnity Benefit Rider	Approved-Closed	Yes
Form	[Optional] Dental Benefit Rider	Approved-Closed	Yes
Form	[Optional] Term Life Insurance Benefit Rider	Approved-Closed	Yes
Form	[Optional] Vision Benefit Rider	Approved-Closed	Yes
Form	[Optional] Non-Occupational Weekly Disability Income Insurance Benefit Rider	Approved-Closed	Yes
Form	Amendatory Endorsement	Approved-Closed	Yes

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Form Schedule

Lead Form Number: MNL LMB POL 0112

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 07/06/2012	MNL LMB POL 0112	Policy/Cont ract/Fratern al Health Insurance Certificate	Group Limited Indemnity Benefit Health Insurance Policy	Initial		0.000	MNL LMB POL 0112 (MasterGroup Policy)ForFiling(022812).pdf
Approved-Closed 07/06/2012	MNL LMB CERT 0112	Certificate	Group Limited Indemnity Benefit Health Insurance Certificate of Insurance	Initial		0.000	MNL LMB CERT 0112 (Certificate)ForFiling(061512).pdf
Approved-Closed 07/06/2012	MNL LMB SOB 0112	Schedule Pages	Schedule of Benefits	Initial		0.000	MNL LMB SOB 0112 (ScheduleOfBenefits)ForFiling(031312).pdf
Approved-Closed 07/06/2012	MNL LMB ER APP 0112	Application/ Enrollment Form	Employer Application	Initial		0.000	MNL LMB ER APP 0112 (EmployerApplication)ForFiling(050812).pdf
Approved-Closed 07/06/2012	MNL LMB EE APP 0112	Application/ Enrollment Form	Employee Enrollment Application	Initial		0.000	MNL LMB EE APP 0112 (Employee Application)ForFiling(061512).pdf
Approved-Closed 07/06/2012	MNL LMB AEHBA 0112	Certificate Amendmen t, Insert	Amendatory Endorsement Hour Bank Accounting	Initial		0.000	MNL LMB AEHBA 0112 (HourBankAc

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<i>Product Name:</i>	<i>MNL LMB POL 0112</i>		
<i>Project Name/Number:</i>	<i>MNL LMB POL 0112/MNL LMB POL 0112</i>		
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<i>Project Name/Number:</i>	<i>MNL LMB POL 0112/MNL LMB POL 0112</i>		
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MADISON NATIONAL LIFE INSURANCE COMPANY, INC.
[P.O. Box 5008, Madison, WI 53705]

**MASTER GROUP LIMITED INDEMNITY BENEFIT HEALTH
INSURANCE POLICY**

Policyholder: [Employer Name]
Policy Number: [10000-1]
Effective Date: [January 1, 2012]
Policy Anniversary Date: [January 1 of each subsequent year, beginning in 2013]
Premium Due Date/Policy Renewal Date: [First day of each month]
State of Issue: [State]

The Policy is issued in the State of Issue in accordance with its laws. These laws and rules govern in resolving any questions about the Policy.

[The Policy replaces any prior one given by the Company to the Policyholder as of the Policy's Effective Date.]

This Master Policy ("Policy") is issued to the Policyholder by the Company on the Effective Date at 12:01 a.m. at the Policyholder's address. Madison National Life Insurance Company, Inc., Madison, Wisconsin agrees to pay the Benefits provided by this Policy in accordance with its terms and conditions. This Policy is a legal contract between the Policyholder and the Company

This Policy is issued in consideration of the application of the Policyholder, a copy of which is attached hereto, and payment of the required premiums when such premiums are due.

The first premium is due on the Effective Date. Subsequent premiums will be due on the dates stated above at the office of the Company or at the office of Our authorized administrator.

All periods of time under this Policy will begin and end at 12:01 A.M. local time at the Policyholder's address.

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.



Larry R. Graber
President



Adam C. Vandervoort
Secretary

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DEFINITIONS

All terms are as defined in the Certificate of Insurance in Section 2 – Definitions. .

CERTIFICATE OF GROUP INSURANCE

The Certificate of Insurance is incorporated into and made a part of this Policy. An Employer that provides a welfare benefit plan for its Employees under this Policy may select some or all of the following insurance benefits which are described in the Certificate of Insurance.

[VISION BENEFIT RIDER]
[DENTAL BENEFIT RIDER]
[TERM LIFE INSURANCE BENEFIT RIDER]
[ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT RIDER]
[WEEKLY DISABILITY INCOME INSURANCE BENEFIT RIDER]
[ACCIDENT EXPENSE BENEFIT RIDER]
[FIRST DAY HOSPITAL ADMISSION INDEMNITY BENEFIT]
[HOSPITAL INPATIENT DAILY INDEMNITY BENEFIT]
[DAILY HOSPITAL INTENSIVE CARE UNIT INDEMNITY BENEFIT]
[INPATIENT MENTAL ILLNESS DISORDERS INDEMNITY BENEFIT]
[INPATIENT SUBSTANCE ABUSE INDEMNITY BENEFIT]
[INPATIENT SKILLED NURSING FACILITY INDEMNITY BENEFIT]
[MISCELLANEOUS INPATIENT HOSPITAL SERVICES INDEMNITY BENEFIT]
[EMERGENCY ROOM VISIT INDEMNITY BENEFIT (ILLNESS ONLY)]
[DOCTOR'S INITIAL OFFICE VISIT INDEMNITY BENEFIT]
[DOCTOR'S OFFICE VISITS INDEMNITY BENEFIT]
[PREVENTIVE CARE INDEMNITY BENEFIT]
[OUTPATIENT DIAGNOSTIC LAB TEST AND X-RAY INDEMNITY BENEFIT]
[OUTPATIENT DIAGNOSTIC ADVANCED STUDIES INDEMNITY BENEFIT]
[INPATIENT SURGICAL INDEMNITY BENEFIT]
[OUTPATIENT SURGICAL INDEMNITY BENEFIT]
[OUTPATIENT MINOR SURGICAL INDEMNITY BENEFIT]
[OUTPATIENT SURGERY FACILITY INDEMNITY BENEFIT]
[OUTPATIENT VENIPUNCTURE SURGICAL INDEMNITY BENEFIT]
[DOCTOR VISIT WHILE HOSPITAL CONFINED INDEMNITY BENEFIT]
[ANESTHESIOLOGY INDEMNITY BENEFIT]
[AMBULANCE INDEMNITY BENEFIT]
[OUTPATIENT PRESCRIPTION MEDICATION INDEMNITY BENEFIT]
[MAJOR ORGAN TRANSPLANT INDEMNITY BENEFIT]
[DURABLE MEDICAL EQUIPMENT INDEMNITY BENEFIT]

The insurance Benefits and Coverage for an Employer are as selected and agreed upon between Us and the Employer. All Coverages and actual Benefit amounts in effect with respect to each Eligible Person and their Dependents, if any, will be as described in the Certificate of Insurance issued by Us to or for that Eligible Person which will include his or her personal Schedule of Benefits and any applicable Riders and Endorsements.

We will [issue] [make available] to each Eligible Person a Madison National Life Insurance Company, Inc. identification card, a Certificate of Insurance, including a Schedule of Benefits, and applicable endorsements, if any, which generally describe, without amending, superseding or changing the Policy in any way, the essential features of Coverage to which each Eligible Person is entitled under this Policy. The Employer is solely responsible for the timely delivery of the identification card, Certificate of Insurance including the Schedule of Benefits, and any applicable endorsements, if any, to each of its Eligible Persons. The Employer acts as the agent for, and representative of, its Eligible Persons and their

Dependents, if any, when receiving and/or distributing such documents to each Eligible Person. Madison National Life Insurance Company, Inc. is not liable or responsible in any way whatsoever for any act, omission or statement by the Employer or its agent or representative in connection with this Policy or the delivery of any of these documents.

EMPLOYER AS COVERED PERSON'S REPRESENTATIVE

For any and all purposes regarding the Policy, including each Covered Person's Coverage provided under the Policy, the Employer is neither the agent nor representative of Madison National Life Insurance Company, Inc. The Employer represents only itself and its Covered Persons under this Policy; its employees, agents and representatives do not represent Madison National Life Insurance Company, Inc., employees, agents and representatives.

Madison National Life Insurance Company, Inc., agents and representatives are not liable or responsible in any way whatsoever for any act, omission or statement by the Employer, its Eligible Persons, Employees, [Contract Staff,] [Retirees,] agents or representatives.

PARTICIPATION

Eligibility for Participation: An Employer is eligible to maintain coverage under the Policy for the benefit of its Employees, [Contract Staff] [and] [Retirees] if it:

- operates a viable business for 52 weeks each Calendar Year;
- offers coverage to the Eligible Classes it determines on the Effective Date of Coverage;
- offers coverage to persons eligible for and added to such Eligible Classes after the Effective Date of Coverage;
- [meets or exceeds the minimum participation requirements;] and
- [maintains the required contribution towards premium.]

Eligible Class: The Employer shall determine the Eligible Classes. The Eligible Classes are shown on the Employer's application.

Possible Eligible Classes include: Salaried Employees, Hourly Employees, [Contract Staff] [and Retirees].

An Eligible Person whose Eligible Class is changed after the Effective Date of his coverage shall become eligible under another Eligible Class on the [first day of the month coinciding with or next following] the date of the change.

[Minimum Participation: The Company requires [25%-100%] participation of the Employees of the Employer, and [25%-100%] participation of eligible Dependents.]

Eligible Persons: A Salaried Employee and his or her Dependents are eligible for coverage on the first of the month following [0-180] days of the Employee's employment with the Employer. An Hourly Employee and his or her Dependents are eligible for coverage on the first of the month following [0-180] days of the Employee's employment with the Employer. [Contract Staff [and Retirees] are eligible without a waiting period.]

[Late Enrollee: If an Employee does not apply for coverage on his or her initial eligibility date, coverage may not be applied for until the next Policy Anniversary Date.]

POLICY PREMIUM

Payment: The premium is the amount the Company charges for insurance under this Policy. The premium rates are shown on the premium notice given to the Employer with or prior to delivery of the Policy. Each premium shall be equal to the sum of the premium payable for each Covered Person. Any overpayment or underpayment of premium will be credited or debited to the Employer's account without interest.

Due Date: All premiums are payable by the Employer on the dates shown on the cover page of this Policy. If the Company agrees to change the method of paying premiums, any pro rata adjusted premium required will be paid by the Employer. Each [monthly] payment will pay for the insurance then in force under this Policy for a period of one [month].

[Employer Contribution: The Company requires the Employer to contribute [at least [0%-50%]] [100%] of the cost of Eligible Person coverage [[and [at least [0-50%]] [100%] of the cost of Dependent coverage].]

Change of Premium Rates: The rates may be changed on any [Policy anniversary date] [on any premium due date] subject to [31-60] days advance written notice by the Company or its authorized administrator. When state law requires a notice of rate change to be greater than [31-60] days, Employers residing in such states will be notified accordingly.

Grace Period: After payment of the first premium, We will allow an Employer a Grace Period of [31-45] days following a premium due date to pay subsequent premiums. During this Grace Period, the Policy and Covered Person's Coverage under the Policy will remain in force. If the Employer fails to pay the premium during the Grace Period, the Policy and Covered Person's Coverage under the Policy will automatically end at the end of the period for which the last premium payment has been paid. The Grace Period does not apply if the Policy terminates for reasons other than nonpayment of premium.

Adjustment Due Date: If, between premium due dates, there is a change in the number of Eligible Persons or Dependents, Madison National Life Insurance Company, Inc. will determine if any additional premium is due or if the Employer is entitled to a premium refund. Any additional premium due because of an increase in the number of persons covered will become due on the first premium due date coincident with or next following the month the increase occurred.

Any refund due because of a decrease in the number of persons covered will become due on the first day of the next premium due date.

Returned Check Fee: If a check in payment for any premium is dishonored for insufficient funds, a reasonable service charge shall be debited to the Employer's account. A dishonored check shall be considered a failure to pay premium.

POLICY TERMINATION

Policyholder's Request: The Policyholder may terminate the Policy at any time by providing Madison National Life Insurance Company, Inc. or its authorized administrator with at least a [31]-day advance written notice. The Policy will then terminate on the date stated in the notice or the date [31] calendar days after Madison National Life Insurance Company, Inc. receives the notice, whichever occurs later.

Madison National Life Insurance Company, Inc.'s Request: Madison National Life Insurance Company, Inc. may terminate the Policy at any time by providing the Policyholder with at least [31] days advance written notice. The Policy will then terminate on the date stated in the notice or the date [31] calendar days after the Policyholder receives the notice, whichever occurs later.

Premium Refund: Upon termination of the Policy, any unearned premium will be determined on a pro-rata basis. Madison National Life Insurance Company, Inc. will promptly return any unearned premium paid by the Policyholder.

Premium Due: The Employer is liable for any unpaid premium, which accrues while the Policy remains in force.

No Prejudice to Claims: Termination of the Policy will not prejudice any claims incurred by a Covered Person prior to the effective date of termination.

GENERAL PROVISIONS

Representations Not Warranties: Unless fraudulent, all statements made by, or for, an Eligible Person under this Policy are representations and not warranties. No statement can be used to void an Eligible Person's coverage unless a copy of the statement is signed by the Eligible Person and furnished to the Eligible Person or his or her beneficiary.

Incontestability: After the Policy has been in force two years from its effective date, no statement of the Employer will be used to void the Policy. No statement by any Eligible Person on a written application for insurance will be used to reduce or deny a claim after the Eligible Person's Coverage, with respect to which claim has been made, has been in effect for two years or more.

Policy Renewal: The Policy shall automatically renew monthly.

Clerical Error: If a clerical error is made so that an otherwise Covered Person's Coverage does not become effective, Coverage may be in effect if: (a) the Eligible Person makes a written request for coverage on a form We approve; and (b) any premium not paid because of the error is paid in full from the Effective Date of Coverage. The Company reserves the right to limit retroactive Coverage to two months preceding the date the error was reported.

If a clerical error is made so that the Coverage is in effect for a person who is not eligible, an adjustment will be made to correct the error. Any premium refund will be reduced by any payment made for claims.

If claims paid exceed the premium refund or if Benefits are paid to any person who Madison National Life Insurance Company, Inc. subsequently identifies as not being entitled to Coverage under the Policy on the date a claim for Benefit was incurred, the Employer will be liable for the amount of the Benefits so paid. At Madison National Life Insurance Company, Inc.'s option, it will bill the Employer for these amounts or adjust future premiums.

Non-Participation: This Policy is non-participating. It does not share in the Company's profits or surplus earnings.

Conformity With Laws: If any provision of this Policy is contrary to any law to which it is subject, such provision is hereby amended to conform to the minimum requirements of such law.

Non-Waiver of Terms: Failure to insist upon compliance with any of the Policy's terms, at any time or under any circumstance, will not operate as a waiver of or as a modification to these terms.

EMPLOYER RESPONSIBILITIES

The Employer agrees:

1. To offer each Eligible Person the opportunity to elect coverage under the Policy as a procedure of employment when he or she attains the status of an Employee as provided for in the Policy.
2. To furnish Madison National Life Insurance Company, Inc., or its authorized administrator on a monthly basis and on Madison National Life Insurance Company, Inc. approved forms, such information as may reasonably be required by Madison National Life Insurance Company, Inc. for the administration of coverage under the Policy, including any change in a Covered Person's eligibility status.
3. To comply with all policies and procedures established by Madison National Life Insurance Company, Inc. in administering and interpreting coverage under the Policy.
4. To furnish all enrollment and termination change notifications to Madison National Life Insurance Company, Inc. or its authorized administrator in a timely manner.
5. If the Employer is subject to the Consolidated Omnibus Budget Reconciliation Act of 1986, as amended (COBRA), the Policy will provide its group health coverage as required by COBRA's laws and regulations.

Madison National Life Insurance Company, Inc. will allow COBRA continuation, however, only if:

- A. A COBRA election form is signed by the qualified beneficiary within the time frames prescribed by COBRA; and
- B. The Employer notifies Madison National Life Insurance Company, Inc. or its authorized administrator, in writing, of the qualified beneficiary's request to continue coverage within 31 days from the date the qualified beneficiary signed the COBRA election form.

Any continued coverage allowed under this provision will provide only the minimum benefits for the minimum length of time as required by COBRA on the date a person covered by the Policy becomes a qualified beneficiary.

Madison National Life Insurance Company, Inc. assumes no liability for any damages resulting from the Employer's non-compliance with any COBRA requirement or regulation. Additionally, the Employer will hold Madison National Life Insurance Company, Inc. harmless and indemnify Madison National Life Insurance Company, Inc. against any and all taxes, fines, penalties, losses, damages, costs, expenses, and legal fees incurred by Madison National Life Insurance Company, Inc., except to the extent prohibited by law, for any failure on the part of the Employer to comply with COBRA requirements or its regulations.

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.
[P.O. Box 5008, Madison, WI 53705]

**GROUP LIMITED INDEMNITY BENEFIT HEALTH INSURANCE
CERTIFICATE OF INSURANCE**
THIS CERTIFICATE PROVIDES LIMITED BENEFITS, PLEASE READ CAREFULLY

VALIDATION OF COVERAGE

Your Certificate is validated by the attachment of this Validation of Coverage showing Your name and plan information.

Policyholder [EMPLOYER NAME]
[Plan [PLAN NO.]
[Employer/Plan Administrator: [EMPLOYER NAME]] **[Employer Location:** [STATE]]
Eligible Person: [ELIGIBLE PERSON'S NAME]
Covered Persons: [ELIGIBLE PERSON] [SPOUSE] [DOMESTIC PARTNER][DOMESTIC SAME SEX PARTNER] [CHILD/CHILDREN][FAMILY]
[Case Number:] [CASE NO.] **[Part Number:]** [PART NO.]
Eligible Person Effective Date: [ELIGIBLE PERSON EFFECTIVE DATE] [NOT COVERED]
[Dependent Effective Date: [DEPENDENT EFFECTIVE DATE]]
[Insurance Identification Number: [ID NO.]
[Minimum Number of Hours of Work Credit] [40, 80, 100, 120, 130, 140, 150, 160, 180]
[Policy Anniversary Date] [SAME DATE AS LISTED ON THE POLICY]

The insurance Coverage, Benefits and the principal provisions that apply to the Covered Persons are summarized in this Validation of Coverage, the Schedule of Benefits and the Certificate of Insurance and are merely evidence of insurance under the Policy. Insurance Coverage is subject to the terms of the Policy, which alone constitutes the contract under which payment is made. The Policy is a contract between the Policyholder and Us. It may be changed or terminated only by those parties. Coverage is provided under Policy number [POLICY NO.].

THIS FACE PAGE SUPERSEDES AND REPLACES ANY AND ALL PREVIOUSLY ISSUED TO THE ELIGIBLE PERSON NAMED ABOVE

[THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKER'S COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER PARTICIPATES IN THE WORKER'S COMPENSATION SYSTEM AND HAS PURCHASED A WORKER'S COMPENSATION INSURANCE POLICY.]

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.



Larry R. Graber
President



Adam C. Vandervoort
Secretary

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SECTION 1 – INTRODUCTION

This Certificate of Insurance is composed of 4 parts:

1. The Validation of Coverage;
2. The Schedule of Benefits;
3. This Certificate; and
4. The Benefit Riders as selected by the Policyholder and reflected in Your Schedule of Benefits.

This Certificate of Insurance describes Your eligibility and enrollment requirements, Your Benefits, and the exclusion and limitations applicable to Your Benefits.

Specific definitions apply to the Policy. When used in this Certificate of Insurance these words are capitalized. Please see the following Definitions section for definitions of specific terms.

SECTION 2 – DEFINITIONS

The capitalized terms used herein shall be defined as follows:

Accidental Bodily Injury/Injury: Bodily Injury resulting directly from an accident and independently of all other causes occurring while a Covered Person's Coverage is in force under the Policy. It does not include an intentional, self-inflicted Injury.

All Injuries sustained in any one accident, including all related conditions and recurrent symptoms of these Injuries, are considered a single Injury.

Actively At Work: An Employee, [except for a Retiree] [or for Contract Staff], must be [a permanent Employee] present and actively performing all of his or her normal duties and paid a salary or wages at the Employer's place of business, for the minimum number of hours required by the Employer.

If an Employee, [except for a Retiree] [or for Contract Staff of Policyholder], were Actively At Work on his or her last regular working day, then he or she will be deemed to be Actively At Work:

1. On each day of a paid vacation; or
2. A regular non-working day.

[[Advanced Study/Studies: Those procedures in the [CPT Code 90000 Series] excluding Preventive Care and limited to: [Angiogram; Arteriogram; Computer Tomography Scan (CT); Electroencephalogram (EEG); Magnetic Resonance Imaging (MRI); Myelogram; Positron Emission Tomography Scan (PET); and Thallium Stress Test].]

[Ambulance: Emergency ground ambulance transportation when Medically Necessary and used locally to or from the nearest facility qualified to render treatment; Emergency air or water ambulance when Medically Necessary to transport a Covered Person to the nearest facility qualified to render treatment in a life-threatening situation; and ambulance transportation necessary for the provision of emergency medical care for a newborn Child when such Child is transported to the nearest Hospital capable of providing the Medically Necessary treatment on a timely basis, and the mode of transportation is the most economically consistent with the well-being of such Child.]

Ambulatory Surgical Center/Outpatient Surgery Center/Same Day Surgery Center: A health care facility designed, equipped and operated primarily for the purpose of performing surgical procedures in an Outpatient setting. The facility must be licensed, if required by law, and staffed with health care professionals as in conventional surgery departments.

Benefit: The dollar amount payable by Us to an Eligible Person [or assignee of an Eligible Person] under the Policy.

[Benefit Period: The beginning and end time for which Coverage is provided under the Policy.]

Benefit Waiting Period: A period following a Covered Person's Effective Date during which no Benefits are payable. If a specific Benefit has a Benefit Waiting Period the time period is set forth in the Schedule of Benefits.

[Calendar Year: The period of time beginning January 1st and ending on December 31st of the same year. The first [Calendar Year] of the Certificate will begin on the date a Covered Person's Coverage becomes effective and end on the first December 31st after a Covered Person's Effective Date of Coverage.]

[Calendar Year Maximum Benefit: The maximum Benefit payable per Covered Person under the Policy in a Calendar Year for certain Benefits as specified in the Schedule of Benefits. When a Covered Person reaches the Calendar Year Maximum Amount no further Benefits will be paid for the remainder of that Calendar Year for the specific Benefit in which the Calendar Year Maximum Amount is reached.]

Certificate: This summary of the Policy which constitutes evidence of Your Coverage under the Policy.

Child:

1. An Eligible Person's natural Child;
2. An Eligible Person's lawfully adopted Child;
3. A Child placed for adoption with an Eligible Person;
4. An Eligible Person's stepchild [including a Child of the Domestic Partner];
5. [An Eligible Person's foster Child;]
6. A Child for whom the Eligible Person has been appointed legal guardian by a court of competent jurisdiction and who resides with and who is dependent upon the Eligible Person in a regular parent-child relationship; or
7. A Child of the Eligible Person for whom the Eligible Person is obligated to provide medical child support pursuant to a Qualified Medical Support Order.

[Contract Staff: A person who contracts to do work or perform a service for the Employer and retains total and free control over the means and methods used in doing the work or performing the service and whose reimbursement for services rendered to the Employer, for any [Calendar] [Policy] Year in which Coverage is in force, is reported by the Employer to the Internal Revenue Service on Form 1099-MISC.]

[Copay/Copayment: The fixed dollar amount specified in the Schedule of Benefits that is payable by a Covered Person to a [pharmacy] [provider] at the time of service in connection with specific Covered Benefits.]

Coverage: The right of the Covered Person to receive Benefits subject to the terms, conditions, limitations and exclusions of the Policy.

Coverage Month: One month immediately following the Coverage effective date and every consecutive one month period thereafter while this Coverage is in force.

Coverage Waiting Period: A period of time that must pass with respect to an Employee before the Employee is eligible for Coverage under the terms of the Policy. The Coverage Waiting Period is determined by the Employer on its application for Coverage under the Policy.

Covered Benefits: Those services or supplies that:

1. Are Medically Necessary;
2. Are received while the Covered Person is insured under the Policy; and
3. Are not excluded under Section 6 – Exclusions and Limitations From Coverage.

Covered Person: A person who has satisfied all of the following requirements:

1. He or she is eligible for Coverage under the Policy, either as an Eligible Person or as a Dependent;
2. He or she has been accepted for Coverage under the Policy or has been automatically added;
3. Premium has been paid for him or her; and
4. His or her Coverage has become effective and has not terminated.

Covered Persons are shown on the [Identification Card] [Schedule of Benefits] [Validation of Coverage].

Close Relative: An Eligible Person's Spouse or the parent, brother, sister, Child or grandparent of the Eligible Person or of the Eligible Person's Spouse.

CPT: The Current Procedural Terminology published by the American Medical Association, version in effect on the date the service is provided.

Custodial Care: Any care, regardless of whether it is prescribed by a Doctor, that is provided to a Covered Person who is disabled to support the essential activities of daily living.

Dependent: An Eligible Person's:

1. Spouse;
2. [Unmarried Child who is primarily dependent upon the Eligible Person for support and maintenance and is:
 - a. Less than [19] years of age; or
 - b. Between [19 and 25] years of age; provided however, that the Child is dependent upon the Eligible Person for support and maintenance and a full-time student actively attending an accredited college, vocational or high school. Full-time, as used in this definition, means actively attending at least 12 hours of class a week or, if less, attending the minimum hours of class the school considers as full-time status;]
- [2. [Unmarried] Child who is less than [26] years of age.]

[If both the Employee and Dependent are Employees of the same Employer, each person must apply as an Employee and only one can cover the Dependent Children.] [If both the Employee and Dependent Spouse are Employees of the same Employer, each person must apply as an Employee and each person can also enroll as a Dependent of the Employee. However, Benefits will not be duplicated. If the Covered Person is covered as the Eligible Person and also covered as a Dependent, the Benefits will be paid for the Employee up to the specific Benefit maximums or limitations and [Calendar] [Plan] Year maximum Benefits, as shown in the Schedule of Benefits. After the specific Benefit maximum is reached further Benefits will be paid for the Dependent up to the Benefit maximums or limitations and [Calendar] [Plan] Year maximum Benefits, as shown in the Schedule of Benefits. The same Covered Benefit will not be paid under Employee and under the Dependent Coverage.]

Dependent does not include anyone who:

1. Lives outside the United States;
2. Is in the armed forces of any country; or
3. Has Coverage under the Policy as an Eligible Person or as a Dependent of another person].

Doctor: A person who is:

1. Licensed as a provider of medical services by the state in which he or she practices;
2. Acting within the scope of his or her license; and
3. Not one of the following:
 - a. A person who ordinarily resides in Your household.
 - b. A Close Relative by blood or marriage.
 - c. The Policyholder.

[[Domestic Partners [Domestic Same Sex Partners]: Two [same sex] adults who are in a committed relationship and mutually responsible for one another financially and otherwise. To qualify as a Domestic [Same Sex] Partner, or Dependent under the Policy, the following conditions must all be met:

1. You and the Domestic Partner are over the age of 18 and mentally competent to enter into contracts;
2. You and the Domestic Partner reside in the same household together;
3. You and the Domestic Partner have a committed relationship with each other for no less than 6 months; intend to continue the relationship indefinitely and have no such relationship with any other person;
4. You and the Domestic Partner are not related by blood;
5. You and the Domestic Partner are not married to any third party;
6. [You and the Domestic Partner are of the same sex]; and
7. You and the Domestic Partner are not claiming Dependent status for the primary reason of gaining insurance Coverage under the Policy.]]

Effective Date: The date Coverage becomes effective under the Policy.

Eligible Class: An hourly-paid staff [or salaried staff] [or Contract Staff] [or Retiree] of the Policyholder meeting all eligibility requirements in the Policy.

Eligible Person: An Employee or a person whose employment or whose status with the Employer in an Eligible Class is the basis for eligibility for Coverage under the Policy and who meets the enrollment rules.

Employee:

An Employee of the Employer who is:

1. Actively at Work in the service of the Employer at the Employer's usual place of business;
2. Compensated for such service by a regular periodic wage or salary that is subject to FICA and federal income tax withholding by the Employer; and
3. Hourly-paid staff or salaried staff; and
4. [Not a seasonal or temporary employee and is scheduled to work at least [9] months per year; and]
5. [A seasonal or temporary employee who is scheduled to work at least [120] days per year.]

An Employee is also:

1. A partner or proprietor actively engaged in the business of the Employer on a full-time basis; [and]
2. [A Retiree [or Contract Staff] who is in a class eligible for benefits under the Policy, as designated by the Employer in the Employer application and approved by Us; and]
3. Those new Employees who are added from time to time as they become eligible.

Emergency: The sudden onset of a medical condition manifested by symptoms of such severity that the failure to immediately provide Medically Necessary treatment could reasonably be expected to result in:

1. Placing the Covered Person's health in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Employer: A sole proprietorship, partnership, or corporation that is actively pursuing business interests and has applied for the Policy in connection with its own employee welfare benefit plan. An Employer must complete an Employer application agreeing to all the terms specified by Us, meet Our underwriting requirements, meet and maintain any Policy participation requirements and meet all other requirements of the state in which the Employer application is signed. The Employer is deemed the Plan Administrator for the purposes of compliance with and duties arising under the Employee Retirement Income Security Act ("ERISA"), the Consolidated Omnibus Budget Reconciliation Act ("COBRA") and other applicable federal laws and regulations.

Experimental/Investigational: One or more of the following applies:

1. The medical treatment, surgical procedure, service or supply is under study or in a clinical trial to evaluate its toxicity, safety or efficacy for a particular diagnosis or set of indications. Clinical trials include, but are not limited to Phase I, II and III clinical trials.
2. The prevailing opinion within the appropriate specialty of the United States medical profession is that the medical treatment, surgical procedure, service or supply needs further evaluation for the particular diagnosis or set of indications before it is used outside clinical trials or other research settings based on:
 - a. published reports in authoritative medical literature; and
 - b. regulations, reports, publications and evaluations issued by government agencies or professional organizations such as the National Cancer Institute, the Agency for Health Care Policy and Research, the National Institute of Health and the FDA.
3. The provider's institutional review board acknowledges that the use of the medical treatment, surgical procedures, services or supply is Experimental or Investigational and subject to that board's approval.
4. Research protocols indicate that the medical treatment, surgical procedure, service or supply is Experimental or Investigational. This item applies for protocols used by the Covered Person's provider as well as for protocols used by other providers studying substantially the same medical treatment, surgical procedure, service or supply.

Hospital: An institution that:

1. Operates pursuant to law;
2. Has 24 hour nursing services by registered nurses;
3. Has a staff of one or more Doctors;
4. Provides inpatient therapeutic and diagnostic services for Illness or Injury;
5. Provides facilities for major surgery or has a formal arrangement with another institution for surgical facilities; and
6. Is approved by the Joint Commission on the Accreditation of Health Care Facilities as a Hospital (JCAHO); the American Hospital Association (AHA); the American Osteopathic Healthcare Association (AOHA); the

American Osteopathic Association accreditation (AOA); or the Commission on Accreditation of Rehabilitation Facilities (CARF) accreditation.

Hospital does not include any of the following:

1. A rest or nursing home, home for the aged or convalescent home;
2. A Skilled Nursing Facility; an extended care facility; or
3. A hospice, a place for Custodial Care, or a birthing center.

Illness:

1. A disorder or disease of the mind or body; or
2. A Pregnancy.

[Initial Enrollment Period: The period of time during which an Employee or Dependent is first eligible to enroll under the Policy.]

Inpatient and Outpatient: The terms "Inpatient" and "Outpatient" refer either to the setting in which medical care is given or to a Covered Person who is receiving care in that setting.

When the terms describe the setting in which medical care is given:

1. "Inpatient" means therapeutic services which are available on a 24-hour basis to a Covered Person while confined in a Hospital or other treatment facility, as a registered bed patient;
2. "Outpatient" means therapeutic services are furnished to a Covered Person while not confined.

When the terms refers to a Covered Person who is receiving medical care:

1. "Inpatient" means a Covered Person who is confined in a Hospital as a registered bed patient for a period of 23 consecutive hours or longer upon the advice of a Doctor for the purpose of other than Custodial Care;
2. "Outpatient" means a Covered Person who is not so confined.

Lab Test: A test that is done in the laboratory where the appropriate equipment, supplies and certified expertise are available [including those procedures in the [CPT Code Range [70000]]; but excluding Preventive Care and those procedures in the [CPT Code Range [36400-36416] (Venipuncture)].

[Late Enrollee: An Employee or Dependent who does not submit an Enrollment Application during the Initial Enrollment Period and who does not qualify for a Special Enrollment Period when the Application is submitted.]

Lifetime Maximum Benefit While Insured: The maximum Benefit payable under the Policy for certain Benefits as specified in the Schedule of Benefits for each Covered Person while covered under the Policy. When a Covered Person reaches the Lifetime Maximum Benefit, no further Benefits will be paid after such date for the specific Benefit in which the Lifetime Maximum Benefit is reached.

Medically Necessary: Treatment, services or supplies provided for an Illness or Injury which:

1. Have been established as safe and effective;
2. Are furnished in accordance with generally accepted professional standards to treat an Illness or Injury;
3. Are determined by Us to be:
 - a. Rendered for the treatment or diagnosis of an Illness or Injury;
 - b. Appropriate for the symptoms, consistent with the diagnosis;
 - c. Are otherwise in accordance with generally accepted medical practice and professionally recognized standards;
 - d. Not mainly for the convenience of the Covered Person, his or her Doctor or other providers;
 - e. Not in excess (in scope, duration or intensity) of that level of care which is needed to provide safe, adequate and appropriate diagnosis or treatment;
 - f. Not Experimental or Investigational;
 - g. Services and supplies that are necessary for the therapeutic treatment of an Illness or Injury; and
4. When applied to confinement in a Hospital, the Covered Person:
 - a. Must be confined as an Inpatient due to the nature of treatment, services or supplies rendered or due to his or her condition; and
 - b. Cannot receive safe and adequate care through Outpatient treatment.

Treatment, services or supplies are not automatically deemed Medically Necessary based solely on the fact that they were prescribed, ordered or recommended by a Doctor or any other provider.

[Medicare National Fee Schedule – The schedule used by the federal government to calculate Medicare allowances. Benefits for Surgical procedures as shown on the Schedule of Benefits are payable based on the Medicare National Fee Schedule in effect on the date on which the Surgery was performed.]

Mental Illness Disorder: Any nervous, emotional and mental disease, illness, syndrome, or dysfunction, other than a behavior or conduct disorders, classified in the most recent edition of the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders including, but not limited to neurosis, psychoneurosis, psychopathy, psychosis, and eating or panic disorder except for mental retardation. It also includes any emotional or nervous disorder that may be a manifestation of an organic condition, disease, illness, or syndrome, including organic mental syndrome associated with psychoactive substances (e.g., alcohol, cocaine, opiate, and others).

[Open Enrollment Period: An annual period during which an Eligible Person and Dependents are eligible to enroll for coverage or change benefit plan options. Eligible Persons and Dependents can change benefit plans only during an Open Enrollment Period, except as set for herein.]

[Outpatient Minor Surgical Procedure: Surgery [as follows] on an Outpatient basis: [Those procedures in the following CPT Code ranges: [incision and drainage (10040-11010)], [small lesions (11055-11311)], [excision of benign lesions (11400-11442)], [nails (11719-11755)], [surgical injections (20500-20612)], [application of casts and strapping (29035-29750)], [catheterizations (36400-36680)], [lesions of the mouth (40800-40840 & 41000-41116)], [gum lesions (41800-42107)], [nerve blocks (64402-64553)] [lesions of the eye (67700-67850)] and [lesions of the ear (69400-69424).]]

Plan Administrator: The Employer.

[Plan Year: Benefits begin immediately on Your Effective Date and renew 12 months following the initial Effective Date. For Dependents applying on other than Your initial Effective Date, Benefit maximums will be adjusted or prorated according to the amount of time remaining in the Plan Year with full 12-month benefits becoming effective on Your anniversary date of the next Plan Year.]

[Plan Year Maximum Benefit: The maximum Benefit payable per Covered Person under the Policy in a Plan Year for certain Benefits as specified in the Schedule of Benefits. When a Covered Person reaches the Plan Year Maximum Amount no further Benefits will be paid for the remainder of that Plan Year for the specific Benefit in which the Plan Year Maximum Amount is reached.]

Policy: The contract providing the benefits described herein issued to the Policyholder.

Policyholder: The entity, in whose name the Policy is issued, as specified on the Validation of Coverage.

Pregnancy: The period following the receipt by a Covered Person of a diagnosis of Pregnancy until the discharge of the Covered Person from the Hospital or other facility following the delivery of the newborn Child.

Prescription Medication: Any medical substance, remedy, vaccine, biological product, drug, pharmaceutical or chemical compound which can only be dispensed pursuant to a prescription and which is required to bear the following statement on the label: "Caution: Federal law prohibits dispensing without a prescription."

Preventive/Preventive Care: Includes, but is not limited to, the following:

1. Periodic health evaluations, including tests and diagnostic procedures ordered in connection with a routine examination, such as annual physicals.
2. Routine prenatal and well-child care.
3. Child and adult immunizations.
4. Cancer screening services.
5. Hearing and vision screening services.

However, Preventive Care does not include any service intended to treat an existing Illness or Injury.

[Retiree: Any former Employee of the Policyholder who is covered under a non-discriminatory, written retirement plan that provides for benefits on the same terms and conditions as an Employee.]

Skilled Nursing Facility: A free-standing facility or part of a Hospital that is certified by Medicare to accept patients in need of rehabilitative and skilled care.

Sound Natural Teeth: Teeth which are intact with a root, pulp and have two surfaces restored and/or decayed, and no missing tooth structure due to fracture.

[Special Enrollment Period: An enrollment period, other than Your Initial Enrollment Period, established when You meet the criteria in Section 3 – Eligibility for Insurance and Effective Date of Coverage, during which You will not be considered a Late Enrollee.]

Spouse: The Eligible Person's lawful Spouse, common law Spouse, [Domestic Partner] [or] [Domestic Same Sex Partner].

Substance Abuse: The pathological use or abuse of alcohol or other drugs in a manner and to a degree that produces impairment in personal, social or occupational functioning and which may, but need not, include a pattern of tolerance and withdrawal.

Surgery/Surgical: A medical procedure or operation involving an incision with instruments, performed to repair damage, arrest disease in a living body or find out if disease is present.

Totally Disabled/Total Disability: The complete inability to engage in any occupation for pay or profit if employed immediately prior to the onset of the Disability, or the complete inability to perform the normal activities of a person of like age and sex in good health if not so employed. Total Disability must be certified by, and require the regular care of a Doctor.

Venipuncture: The puncture of a vein with a needle for the purpose of obtaining a blood specimen [limited to those procedures in the [CPT Code Range 36400-36416]].

We, Our, Us, The Company: Madison National Life Insurance Company, Inc.

X-ray: A type or irradiation used for imaging purposes with the image captured on photographic film [including those procedures in the [CPT Code Range 80000 and those procedures in the CPT Code Range 90000]] other than Advanced Studies; but excluding Preventive Care.

You, Your: An Eligible Person in an Eligible Class who is covered under the Policy.

SECTION 3 – ELIGIBILITY FOR INSURANCE AND EFFECTIVE DATE OF COVERAGE

ELIGIBILITY

To be eligible for Coverage under the Policy, an individual must either meet the definition of Employee or meet the definition of Dependent.

You: You are eligible for Coverage upon [completion of an Enrollment Application or completion of the enrollment process and] payment of any required premium on the later of:

1. The Policyholder's Effective Date; or
2. [The date You complete the Coverage Waiting Period, if any; or]
3. [The date You complete and submit an Enrollment Application or complete the enrollment process, during a Special Enrollment Period; or]
4. [The date You complete and submit an Enrollment Application or complete the enrollment process, during an Open Enrollment Period.]

Dependent: A Dependent is eligible for Coverage on the later of:

1. The date You become eligible for Coverage; or
2. The date You first acquire the Dependent after Your Effective Date of Coverage.

[If You or Your Dependents do not enroll when first eligible, You or Your Dependents may only apply for coverage during an annual Open Enrollment Period, except as stated in "Special Enrollment Provisions" herein. The Effective Date of coverage for an Application made during an Open Enrollment Period is the Policy Anniversary Date next following that Open Enrollment Period.]

EFFECTIVE DATE

You: Your Coverage begins at 12:01 a.m. at Your residence, on Your Effective Date. Your Effective Date is shown in the [Identification Card] [Schedule of Benefits] [Validation of Coverage]. For Eligible Persons, [other than Retirees], [and] [other than Contract Staff], Your Effective Date will be delayed if You are not Actively At Work until You return to an Actively At Work status.

Dependent: Coverage for Your Dependents, if You are applying for Dependent Coverage when first eligible, will take effect, subject to receipt of an Enrollment Application or completion of the enrollment process and payment of required premium, if any, on Your Effective Date.

Dependents Acquired After Effective Date

Newborn Children: Your newborn Child is automatically covered from the moment of birth until such Child is 31 days old. Coverage for newborns shall be the same as for all other Dependents. You must notify Us in writing or in accordance with the enrollment process within 31 days of such birth, and pay the required additional premium, if any, in order to have Coverage for the newborn Child continue beyond such 31 day period. If an Application is not completed within thirty-one (31) days of birth, the Child may not enroll until the next Open Enrollment Period, unless the Child qualifies under "Special Enrollment Provisions."

Adopted Child: Coverage for an adopted Child is effective upon the earlier of the date of placement for the purpose of adoption, or the date of the entry of an order granting the adoptive parent custody of the Child for purposes of adoption. Coverage for such Child will be the same as for all other Dependents. Coverage will continue unless the placement is disrupted prior to legal adoption and the Child is removed from placement. However, You must notify Us in writing or in accordance with the enrollment process within 31 days of such placement for adoption or entry of an order and pay the required additional premium, if any, in order to have Coverage for the adopted Child continue beyond such 31 day period.

Dependent Spouse: The Effective Date for a new Spouse [or Domestic Partner] will be the date of marriage [or effective date of the Domestic Partnership], as long as the Eligible Person completes an Enrollment Application within thirty-one (31) days of that date; otherwise, the Spouse [or Domestic Partner] may not enroll until the next Open Enrollment Period, unless he or she qualifies under "Special Enrollment Provisions."

Dependent Child Acquired After Marriage: The Effective Date for a Dependent Child who is not a newborn Child, adopted Child or a Child placed for adoption shall be the date the Child becomes an eligible Dependent, as long as the Eligible Person completes an Enrollment Application to add the Child within thirty-one (31) days of that date. If an Application is not completed within thirty-one (31) days, the Child may not enroll until the next Open Enrollment Period, unless the Child qualifies under "Special Enrollment Provisions."

[Late Enrollee: If You do not apply for Coverage when first eligible, Coverage may not be applied for until the Open Enrollment Period and Coverage will be effective on the Policy Anniversary Date next following the Open Enrollment Period, subject to Our receipt of the Enrollment Application and required premium.]

Special Enrollment Provisions

If an Employee or Dependent does not enroll when first eligible, the Employee or Dependent may enroll for coverage under the Policy other than at Open Enrollment if he or she meets the following criteria:

1. At the time of the Initial Enrollment Period, the Employee or Dependent: (i) was covered under another health insurance policy, (ii) lost coverage under the other policy for one or more of the reasons listed below and (iii) requests coverage under the Policy by completing an Enrollment Application within 31 days of the loss of other coverage:
 - a. Dependent termination of employment;
 - b. Employee or Dependent termination of eligibility;
 - c. Employee or Dependent's change from full time to part time employee status;
 - d. Termination of the other policy's coverage;
 - e. The death of a Spouse;
 - f. Legal separation or divorce;
 - g. Exhaustion of COBRA;
 - h. Termination of the Employer's contribution toward the coverage; or
2. We receive an Enrollment Application within 31 days of the person becoming a Dependent of an Employee or an Employee's Spouse through marriage, birth, adoption or placement for adoption.

SECTION 4 – PREMIUM PAYMENT

Payment of Premium

Premiums are payable to Us or Our authorized administrator. No insurance agent, insurance broker or insurance consultant is authorized to accept any premium payment on Our behalf. The Policyholder must timely pay the premium in order to maintain the Eligible Person's Coverage under the Policy. The payment of any premium will not keep the Policy in force beyond the due date of the next premium, except as provided in the Grace Period. If any premium is not received by Us before or at the end of the Grace Period, the Policy will automatically end at the end of the period for which the last premium payment has been paid.

Grace Period

After payment of the first premium, We will allow the Policyholder a Grace Period of [31-45] days following a premium due date to pay subsequent premiums. During this Grace Period, the Policy and Covered Person's Coverage under the Policy will remain in force. If the Policyholder fails to pay the premium during the Grace Period, the Policy and Covered Person's Coverage under the Policy will automatically end at the end of the period for which the last premium payment has been paid. The Grace Period does not apply if the Policy terminates for reasons other than nonpayment of premium.

Premium Changes

We reserve the right to change premiums under the Policy [on each Policy Anniversary Date] [on any premium due date] by giving the Policyholder at least 31 days prior written notice. [Where state law or regulation requires a notice of rate change to be greater than 31 days, Policyholders residing in such states will be notified accordingly.]

SECTION 5 – BENEFITS

All Covered Benefits must be as a result of a non-occupational Illness or Injury while covered under the Policy. In addition, all Covered Benefits must be Medically Necessary due to Illness or Injury [except Benefits under Preventive Care Indemnity Benefit if this Benefit is included on the Schedule of Benefits]. Subject to the terms and conditions of the Policy, the following Benefits may be subject to specific Benefit maximums or limitations, as shown in the Schedule of Benefits. It is important that the Covered Person reviews the Schedule of Benefits for the Benefit's maximums or limitations.

[First Day Hospital Admission Indemnity Benefit

[This Benefit provision only applies if it is shown as included in the Schedule of Benefits.]

The First Day Benefit, as shown in the Schedule of Benefits, will be paid for the first day of each Hospital Inpatient admission.

The First Day Hospital Admission Indemnity Benefit - will be paid only if:

1. The Covered Person is confined in a Hospital as an Inpatient;
2. A charge is made for room and board; [and]
3. The Hospital confinement is recommended and approved by a Doctor; [and]
4. [The Covered Person is not admitted as a newborn Child.]

The Benefit provided is only payable once for the first day and only once per admission for a covered Illness or Injury. If a Covered Person is readmitted to a Hospital because of the same or related Illness or Injury, We will not pay this Benefit again.]

Hospital Inpatient [and Inpatient Skilled Nursing Facility] Daily Indemnity Benefit

[This Benefit provision only applies if it is shown as included in the Schedule of Benefits.]

A Daily Benefit, as shown in the Schedule of Benefits, will be paid for each day of such Hospital [or Skilled Nursing Facility] confinement.

Hospital Inpatient [and Inpatient Skilled Nursing Facility] Daily Indemnity Benefits will be paid only if:

1. A Covered Person is confined in a Hospital [or Skilled Nursing Facility] as an Inpatient;
2. A charge is made for room and board; and
3. The entire duration of such Hospital [or Skilled Nursing Facility] confinement is recommended and approved by a Doctor.

[A confinement in a Skilled Nursing Facility is covered only if it follows a covered Inpatient Hospital admission of at least 3 consecutive days.]

[Daily Hospital Intensive Care Unit Indemnity Benefit

[This Benefit provision only applies if it is shown as included in the Schedule of Benefits.]

The Daily Hospital Intensive Care Unit Indemnity Benefit, as shown in the Schedule of Benefits, will be paid when a Covered Person has been admitted as an Inpatient in a Hospital Intensive Care Unit [or] [Cardiac Care Unit] [Burn Unit] [or] [Other Specialized Care Unit]. [This Benefit is paid in [addition to] [in lieu of] the Hospital Inpatient Daily Indemnity Benefit.]

[Inpatient Mental Illness Disorder Indemnity Benefit:

[This Benefit provision only applies if it is shown as included in the Schedule of Benefits.]

The Inpatient Mental Illness Disorder Indemnity Benefit, as shown in the Schedule of Benefits, will be paid when a Covered Person has been admitted as an Inpatient in a Hospital or licensed institution that provides treatment for Mental Illness Disorders.]]

[Inpatient Substance Abuse Indemnity Benefit:

[This Benefit provision only applies if it is shown as included in the Schedule of Benefits.]

The Inpatient Substance Abuse Indemnity Benefit, as shown in the Schedule of Benefits, will be paid when a Covered Person receives services as an Inpatient provided in facilities which are accredited by the joint commission on accreditation of Hospitals as alcoholism, Substance Abuse or chemical dependency treatment programs for the treatment of Substance Abuse. This Benefit includes Inpatient detoxification services as a consequence of Substance Abuse.]

[Miscellaneous Inpatient Hospital Services Indemnity Benefit

[This Benefit provision only applies if it is shown as included in the Schedule of Benefits. [The Policy must also include [the Hospital Inpatient Daily Indemnity Benefit] [and Inpatient Skilled Nursing Facility Indemnity Benefit] in order for this Benefit to be included]

The Miscellaneous Inpatient Hospital Services Indemnity Benefit, as shown in the Schedule of Benefits, will be paid when a Covered Person has miscellaneous Hospital services such as Lab work, blood tests, X-rays, diagnostic studies, Prescription Medication, crutches, bandages and other supplies received while confined in a Hospital [or a Skilled Nursing Facility]. [The Benefit does not include Doctor visits [or miscellaneous services or supplies received if the Covered Person is confined for [Mental Illness Disorders] [or Substance Abuse].]]

[This Benefit is paid in [addition to] [in lieu of] the [Hospital Inpatient Daily Indemnity Benefit] [Skilled Nursing Facility Confinement Indemnity Benefit] [Inpatient Mental Illness Disorders Indemnity Benefit] [Inpatient Substance Abuse Indemnity Benefit] [and] [Anesthesiology Indemnity Benefit.]]]

[Emergency Room Visit Indemnity Benefit (Illness only)

[This Benefit provision only applies if it is shown as included in the Schedule of Benefits.]

The Emergency Room Visit Indemnity Benefit, as shown on the Schedule of Benefits, will be paid when a Covered Person has an Emergency Room Visit as a result of a non-occupational Illness, for services that are provided on an Emergency basis and do not result in an Inpatient confinement.

The Emergency Room Visit must occur within [24-72] hours from the time the symptoms for such Illness were first manifested.]

[Doctor's Initial Office Visit Indemnity Benefit

[This Benefit provision only applies if it is shown as included in the Schedule of Benefits.]

The Doctor's Initial Office Visit Indemnity Benefit, as shown on the Schedule of Benefits, will be paid when a Covered Person has an initial Doctor's Office Visit for each covered Illness or Injury. The Benefit is payable once for the initial Doctor's Office Visit for each separate covered Illness or Injury. [Benefits paid under this Doctor's Initial Office Visit Indemnity Benefit are not payable under [any other Benefit in the Policy] [the Doctor's Office Visits Indemnity Benefit].]]

[Doctor's Office Visits Indemnity Benefit

[This Benefit provision only applies if it is shown as included in the Schedule of Benefits.]

The Doctor's Office Visits Indemnity Benefit, as shown on the Schedule of Benefits, will be paid for a Covered Person for each Doctor's Office Visit. [Visits for routine exams, Preventive Care and immunizations are not covered under this Benefit.] [Benefits paid under this Doctor's Office Visit Indemnity Benefit are not payable under [any other Benefit in the Policy] [the Doctor's Initial Office Visit Indemnity Benefit].]]

[Preventive Care Indemnity Benefit

[This Benefit provision only applies if it is shown as included in the Schedule of Benefits.]

The Preventive Care Indemnity Benefit, as shown in the Schedule of Benefits, will be paid for a Covered Person for the following Preventive Care services provided by a Doctor:

1. Well baby and Child care for a Covered Person age [18] and under:
 - a. Routine examinations and medical history, including development assessment and anticipatory guidance;

- b. Routine immunizations;
 - c. One hearing screening from birth to age one; and
 - d. One vision screening per [Calendar Year] [Plan Year].
2. Well adult care for a Covered Person age [19] and over:
- a. One routine physical examination per [Calendar Year] [Plan Year];
 - b. Routine gynecological care, including one cytologic screening per [Calendar Year] [Plan Year];
 - c. One prostate specific antigen test and one rectal exam per [Calendar Year] [Plan Year], for a male Covered Person age 50 and older;
 - d. One routine Chest X-ray per [Calendar Year] [Plan Year] and routine laboratory services; and
 - e. One screening mammography per [Calendar Year] [Plan Year] for a Covered Person age 35 or older.

However, such Benefits will not exceed the [Calendar Year] [Plan Year] Maximum Amount as shown in the Schedule of Benefits.

[Benefits paid under this Preventive Care Indemnity Benefit are not payable under any other Benefit in the Policy.]

[Outpatient Diagnostic Lab Test and X-ray Indemnity Benefit

[This Benefit provision only applies if it is shown as included in the Schedule of Benefits.]

The Outpatient Diagnostic Lab Test and X-ray Indemnity Benefit, as shown on the Schedule of Benefits, will be paid when a Covered Person has Outpatient Lab Tests and X-rays. This Benefit includes the reading of the Lab Test and X-ray. Routine and Preventive Lab Tests and X-rays are not covered under this Benefit.

Benefits will be paid only if:

- 1. A Covered Person is not confined in a Hospital [or Skilled Nursing Facility]; and
- 2. Lab Tests or X-rays are ordered or performed by a Doctor.]

[Outpatient Diagnostic Advanced Studies Indemnity Benefit

[This Benefit provision only applies if it is shown as included in the Schedule of Benefits.]

The Outpatient Diagnostic Advanced Studies Indemnity Benefit, as shown on the Schedule of Benefits, will be paid for each Outpatient Advanced Study received by the Covered Person. This Benefit includes the reading of the Advanced Study. Routine and Preventive Advanced Studies are not covered under this Benefit.

Benefits will be paid only if:

- 1. A Covered Person is not confined in a Hospital [or Skilled Nursing Facility]; and
- 2. Advanced Studies are ordered or performed by a Doctor.]

[Inpatient Surgical Indemnity Benefit

[This Benefit provision only applies if it is shown as included in the Schedule of Benefits.]

The Inpatient Surgical Indemnity Benefit, as shown in the Schedule of Benefits, will be paid when a Covered Person has Inpatient Surgery.

[If two or more Surgical procedures are performed at the same time and in the same Surgical session, the total Benefit shall not exceed the amount shown in the Schedule of Benefits.]

[No Benefit will be paid for dentistry or oral surgery except:

- 1. Excision of impacted third molars;
- 2. Closed or open reduction of fractures or dislocation of the jaw.]]]

[Outpatient Surgical Indemnity Benefit

[This Benefit provision only applies if it is shown as included in the Schedule of Benefits.]

The Outpatient Surgical Indemnity Benefit, as shown in the Schedule of Benefits, will be paid when a Covered Person has Outpatient Surgery.

[If two or more Surgical procedures are performed at the same time and in the same Surgical session, the total Benefit shall not exceed the amount shown in the Schedule of Benefits.]

[No Benefit will be paid for dentistry or oral surgery except:

1. Excision of impacted third molars;
2. Closed or open reduction of fractures or dislocation of the jaw.]

[This Benefit is not paid if Benefits are paid under the Outpatient Minor Surgical Indemnity Benefit [or the Outpatient Venipuncture Indemnity Benefit.]]]

[Outpatient Minor Surgical Indemnity Benefit

[This Benefit provision only applies if it is shown as included in the Schedule of Benefits.]

The Outpatient Minor Surgical Indemnity Benefit, as shown in the Schedule of Benefits, will be paid when a Covered Person has Outpatient Minor Surgery.

[If two or more Surgical procedures are performed at the same time and in the same Surgical session, the total Benefit shall not exceed the amount shown in the Schedule of Benefits.]

[No Benefit will be paid for dentistry or oral surgery except:

1. Excision of impacted third molars;
2. Closed or open reduction of fractures or dislocation of the jaw.]

[(This Benefit is not paid if Benefits are paid under the Outpatient Surgical Indemnity Benefit [or the Outpatient Venipuncture Indemnity Benefit])]]]

[Outpatient Surgery Facility Indemnity Benefit

[This Benefit provision only applies if it is shown as included in the Schedule of Benefits.] [The Policy must also include the [Outpatient Surgical Indemnity Benefit] [and Outpatient Minor Surgical Indemnity Benefit] [and Anesthesiology Indemnity Benefit] in order for this Benefit to be included.]

The Outpatient Surgery Facility Indemnity Benefit, as shown in the Schedule of Benefits, will be paid when a Covered Person has Outpatient Surgery in an Ambulatory Surgical Center. [This Benefit does not include Outpatient Surgery performed in a Doctor's office.]

[Benefits paid under this Outpatient Surgery Facility Indemnity Benefit are not payable under any other Benefit in the Policy, except this Benefit is paid in addition to the [Outpatient Surgical Indemnity Benefit] [and Outpatient Minor Surgical Indemnity Benefit] [and Anesthesiology Indemnity Benefit.] [This Benefit is not paid if the Covered Person is admitted as an Inpatient immediately following the Outpatient Surgery if Benefits are paid under the [Hospital Inpatient Daily Indemnity Benefit] [or the Daily Hospital Intensive Care Unit Indemnity Benefit].]

[Outpatient Venipuncture Indemnity Benefit

[This Benefit provision only applies if it is shown as included in the Schedule of Benefits.]

The Outpatient Venipuncture Indemnity Benefit, as shown in the Schedule of Benefits, will be paid when a Covered Person has Outpatient Venipuncture performed.]

[Doctor Visit While Hospital Confined Indemnity Benefit

[This Benefit provision only applies if it is shown as included in the Schedule of Benefits.]

The Doctor Visit While Hospital Confined Indemnity Benefit, as shown in the Schedule of Benefits, will be paid when a Covered Person is Hospital confined as an Inpatient and is visited by a Doctor [other than a Surgeon].]

[Anesthesiology Indemnity Benefit

[This Benefit provision only applies if it is shown as included in the Schedule of Benefits.]

The Anesthesiology Indemnity Benefit, as shown on the Schedule of Benefits, will be paid when a Covered Person receives anesthesia when Surgery is performed and Coverage is provided under the Inpatient Surgical Indemnity Benefit, [or Outpatient Surgical Indemnity Benefit] [or, Outpatient Minor Surgical Indemnity Benefit] [or Outpatient Venipuncture Indemnity Benefit].

[The Policy must include the [Inpatient Surgical Indemnity Benefit], [Outpatient Surgical Indemnity Benefit,] [Outpatient Surgery Facility Indemnity Benefit] [Outpatient Minor Surgical Indemnity Benefit] [and/or] the [Outpatient Venipuncture Indemnity Benefit] in order for this Benefit to be included.]]

[Ambulance Indemnity Benefit

[This Benefit provision only applies if it is shown as included in the Schedule of Benefits.]

The Ambulance Indemnity Benefit, as shown on the Schedule of Benefits, will be paid when a Covered Person has a conveyance in an Ambulance that is provided on an Emergency basis.]

[Outpatient Prescription Medication Indemnity Benefit

[This Benefit provision only applies if it is shown as included in the Schedule of Benefits.]

The Outpatient Prescription Medication Indemnity Benefit, as shown on the Schedule of Benefits, will be paid when the Covered Person receives Outpatient Prescription Medication [and after the Covered Person pays the Copayment, if applicable and as shown on the Schedule of Benefits]. [If the Copayment is greater than the cost of the Prescription Medication there is no Benefit payable.]

Outpatient Prescription Medications are separated into two categories:

- **Generic Medication.** These are Prescription Medications that are chemically and therapeutically equivalent to brand name Prescription Medications in the same class but are not protected by a patent. The FDA approves generic Prescription Medication as bioequivalent- meaning they perform in Your body the same as a formulary brand Prescription Medication. These Prescription Medications are generally less costly than their brand-name counterparts.
- **Brand Medication.** These brand-name Prescription Medications have a more cost-effective therapeutic alternative.

Refer to Your Schedule of Benefits for the benefit level of each category.

Excluded Prescription Medications

The following Outpatient Prescription Medications will not be covered under this Benefit:

1. Over-the-Counter medications, supplies or products; or
2. Medications or other agents to increase or enhance fertility or the likelihood of conception; or
3. Medications for the treatment of erectile dysfunction or to assist in or enhance sexual performance; or
4. Vitamins; provided however, pre-natal vitamins will be covered; or
5. Medications to eliminate or reduce a dependency or an addiction to tobacco including, but no limited to, the cessation or termination of cigarette, cigar, or tobacco smoking or the use of smokeless tobacco, including nicotine products, gums and transdermal patches; or
6. Medications for the treatment of hair loss or for the purpose of regrowing lost hair, such as Rogaine, Minoxidil; or
7. Immunization agents, biological sera, blood or blood plasma; or
8. Experimental or Investigational Medication; or
9. Medications covered under Workers' Compensation; or
10. Medications for the treatment or obesity or diet control; or
11. Medications taken, prescribed or administered while an Inpatient at a Hospital, Rest Home, Sanitarium, Skilled Nursing Facility, Convalescent Hospital, Nursing Home or similar institution which operates a facility for dispensing drugs; or
12. Therapeutic devices or appliances, support garments and other non-medicinal substances regardless of intended use; or
13. Homeopathic medications; or
14. Any medication purchased outside the United States of America.]

[Major Organ Transplant Indemnity Benefit

[This Benefit provision only applies if it is shown as applicable in the Schedule of Benefits.]

The Major Organ Transplant Indemnity Benefit, as shown in the Schedule of Benefits, will be paid when a Covered Person receives a Major Organ Transplant. [Benefits paid under this Major Organ Transplant Indemnity Benefit are not payable under any other Benefit in the Policy.] [This Benefit is not paid if Benefits are paid under the Critical Care Indemnity Benefit Rider.]

For the purposes of this Benefit the following definitions apply:

Major Organ Transplant: means a surgery in which a Covered Person receives, as a result of a Surgical transplant, one or more of the following transplant services:

1. Allogenic bone marrow transplant or peripheral stem cell support;
2. Autologous bone marrow transplants;
3. Cornea transplants;
4. Heart transplants;
5. Heart-lung transplants;
6. Kidney transplants;
7. Living related segmental simultaneous pancreas kidney transplant;;
8. Lung transplants;
9. Pancreas transplants;
10. Liver transplants;
11. Pancreas-kidney transplants; and
12. Small bowel transplants.

It does not include transplants involving mechanical or nonhuman organs.]

[Durable Medical Equipment Indemnity Benefit

[This Benefit provision only applies if it is shown as included in the Schedule of Benefits.]

The Durable Medical Equipment Indemnity Benefit, as shown in the Schedule of Benefits, will be paid when a Covered Person rents or purchases Durable Medical Equipment to treat a covered Illness or Injury.

This Benefit will only be paid if the Durable Medical Equipment meets all of the following criteria:

1. It is ordered or provided by a Doctor for Outpatient use;
2. It is used for Medically Necessary purposes;
3. It is not consumable or disposable (except if covered under diabetic supplies and equipment); and
4. It is not useful to a person in the absence of an Illness or Injury.

For the purposes of the Benefit the following definition applies:

Durable Medical Equipment: Equipment that is able to withstand repeated use. Examples of Durable Medical Equipment include:

- Equipment to assist mobility, such as a standard wheelchair;
- A standard Hospital-type bed;
- Oxygen and the rental of equipment to administer oxygen (including tubing connectors and masks);
- Delivery pumps for tube feedings (including tubing and connectors);
- Braces, including necessary adjustment to shoes to accommodate braces; braces that stabilize an injured body part, and braces to treat curvature of the spine are considered Durable Medical Equipment. Durable Medical Equipment does not include orthodontic dental braces and orthotic devices such as braces that straighten or change the shape of a body part;
- Medical equipment necessary for the treatment of chronic or acute respiratory failure (except air conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items);
- The following equipment, supplies and related services for the treatment of Type I, Type II, and gestational diabetes, when Medically Necessary and when recommended or prescribed by a Doctor or other licensed health care provider legally authorized:

- A. Blood glucose monitors;
- B. Blood glucose monitors to the legally blind;
- C. Test strips for glucose monitors;
- D. Visual reading and urine testing strips;
- E. Insulin;
- F. Injection aids;
- G. Cartridges for the legally blind;
- H. Syringes;
- I. Insulin pumps for the appurtenances thereto;
- J. Insulin infusion devices;
- K. Oral agents for controlling blood sugar; and
- L. Podiatric appliances for prevention of complications associated with diabetes.]

[[INPATIENT] [AND] [OUTPATIENT] SURGICAL INDEMNITY BENEFITS

[This Benefit provision only applies if it is shown as included in the Schedule of Benefits.]

SCHEDULE OF SURGICAL INDEMNITY BENEFITS

[Benefit is based on the Payment Factor shown below times the Surgical Procedure Units, as shown in the Schedule of Benefits]

Procedure	Payment Factor
[1. ABDOMINAL SURGERY	
[Abdomen, paracentesis	[10-20]]
[Herniotomy, single, inguinal, femoral or umbilical	[45-90]]
[Herniotomy, hiatus or diaphragmatic	[120-240]]
[Herniotomy, ventral or incisional	[65-130]]
[Esophageal diverticulum	[90-180]]
[Gastrotomy or gastrostomy	[100-200]]
[Gastrectomy, total	[150-300]]
[Gastro-enterostomy	[135-270]]
[Peptic ulcer, perforated, closure	[75-150]]
[Peptic ulcer, subtotal gastrectomy	[125-250]]
[Pyloric stenosis (Ramstedt's in infant)	[55-110]]
[Intestines anastomosis	[80-160]]
[Intestines (small) resection	[95-190]]
[Laparotomy	[80-160]]
[Colon, resection	[140-280]]
[Colonoscopy	[40-80]]
[Colostomy	[95-190]]
[Appendectomy	[60-120]]
[Diverticulum intestinal (Meckel's)	[70-140]]
[Common duct with or without Cholecystectomy	[105-210]]
[Appendiceal, abcess, drainage	[60-120]]
[Subdiaphragmatic abcess	[70-140]]
[Cholecystectomy	[75-150]]
[Cholecystoduodenostomy	[110-220]]
[Pancreas Drainage	[95-190]]
[Splenectomy	[85-170]]
[2. OPHTHALMOLOGY	
[Foreign body removal within anterior or posterior chamber	[90-180]]
[Cornea, paracentesis	[15-30]]
[Conjunctival suture	[30-60]]
[Conjunctival flap for corneal ulcer, etc.	[60-120]]
[Chalazion (excision) Simple	[10-20]]
[Chalazion (excision) Multiple	[15-30]]

[Lacrimal sac, plastic	[50-100]]
[Entropion or ectropion or ectropion, Zeigler's puncture	[50-100]]
[Entropion or ectropion, plastic operation	[30-60]]
[Entropion or ectropion, plastic operation graphs of flaps	[45-90]]
[Symblepharon, release	[25-50]]
[Pterygium	[40-80]]
[Corneal ulcer cauterization	[35-70]]
[Tarsorrhaphy, orbicularis paralysis	[55-110]]
[Ptosis (single)	[55-110]]
[Strabismus, one or more muscles	[55-110]]
[Cataract, needling	[40-80]]
[Cataract, removal	[95-190]]
[Iridectomy	[75-150]]
[Removal foreign body of cornea	[5-10]]
[Glaucoma, filtration operation	[75-150]]
[Enucleation or evisceration	[65-130]]
[Enucleation with implant	[65-130]]
[Tumor, exenteration of orbit	[120-240]]
[Dacryosystorhinostomy	[70-140]]
[Detached retina	[120-240]]

[3. ORTHOPEDIC

[Spinal fusion	[145-290]]
[Cartilage of condyle of femur removal	[110-220]]
[Bone plate removal	[40-80]]
[Talipes metatarsus vargus, calcaneus valgus, eqinovarus	[5-10]]
[Semilunar cartilage removal from joint	[70-140]]
[Tenotomy simple open	[75-150]]
[Tenotomy simple Closed	[45-90]]
[Claw foot, except bone surgery (see foot stabilization)	[45-90]]
[Coccyx, excision	[55-110]]
[Arthrotomy, any major joint	[80-160]]
[Hallux valgus radical operation	[70-140]]
[Exostosectomy	[45-90]]
[Osteomyelitis, sequestrum removal	[85-170]]
[Foot stabilization	[25-50]]
[Hammer toe, operation	[45-90]]
[Arthrodisis of knee, hip, shoulder, or elbow	[135-270]]
[Torticollis, operation	[65-130]]
[Arthorplasty, any major joint	[140-280]]
[Hip joint, resection	[130-260]]
[Any major joint resection	[100-200]]
[Any joint resection of fingers or toes	[40-80]]

[4. AMPUTATIONS

[Upper Arm	[85-170]]
[Forearm	[90-180]]
[Hand	[75-150]]
[Finger, single	[80-160]]
[Hip	[150-300]]
[Thigh	[100-200]]
[Knee	[90-180]]
[Leg	[95-190]]
[Toe	[55-110]]
[Foot	[70-140]]
[Scapulothoracic amputation	[145-290]]

5. [DISLOCATIONS

[Carpal bone, one	[50-100]]
[Clavicle	[65-130]]
[Elbow	[35-70]]
[Finger, one	[25-50]]
[Hip	[105-110]]
[Knee	[85-170]]
[Mandible	[80-160]]
[Metacarpal bone, one	[65-130]]
[Metatarsal bone, one	[45-90]]
[Patella	[95-190]]
[Shoulder	[40-80]]
[Tarsal bone, one	[35-70]]
[Thumb	[55-110]]
[Toe, one	[30-60]]
[Vertebra, one or more	[75-150]]

[6. SIMPLE FRACTURES

[Lower jaw	[70-140]]
[Carpal bone, one	[40-80]]
[Clavicle	[30-60]]
[Coccyx	[15-30]]
[Femur	[135-270]]
[Tibia or fibula or both	[60-120]]
[Pott's or Cotton's fracture	[45-90]]
[Finger, one simple	[50-100]]
[Finger, Extension with traction	[25-50]]
[Humerus	[85-170]]
[Metacarpal bone, one	[50-100]]
[Metatarsal bone, one	[35-70]]
[Patella, closed	[25-50]]
[Nasal bone or bones, reduced	[15-30]]
[Pelvis	[115-230]]
[Radius of ulna, or bone	[65-130]]
[Rib, one or more	[10-20]]
[Sacrum	[35-70]]
[Skull	[75-150]]
[Sternum	[75-150]]
[Tarsal bone, one (exclude os calsis and astragalus)	[30-60]]
[Toe, one	[25-50]]
[Vertebra, one or more	[135-270]]
[Oscalsis or astragalus, or both	[60-120]]

[7. COMPOUND FRACTURES

[Two-three] times Simple Fracture
Payment Factor, not to Exceed [150-
300]]

[8. SKULL

[Simple fracture (non-operable) with brain Injury	[5-10]]
[Depressed	[75-150]]
[Compound	[115-230]]
[Brain Tumors	[150-300]]

9. [INFECTIONS AND TRAUMATA

[Abscess incision and drainage	[5-10]]
[Carbuncle	[5-10]]
[Ulcer, surface, excision	[85-170]]
[Tendon, repair, one	[85-170]]
[Tendon, repair, each additional	[85-170]]
[Septic finger, hand (tendon sheath involvement)	[60-120]]
[Lacerations, extensive	[25-50]]
[Lacerations, minor	[10-20]]]

10. [CYSTS

[Removal of ganglion cyst	[35-70]]
[Pilonidal cyst or sinus	[20-40]]
[Thyroglossal cyst, removal	[50-100]]
[Branchial cyst, removal	[30-60]]]

11. [TUMORS

[Tumors, benign external removal	[20-40]]
[Tumors, benign removal	[40-80]]
[Parotid tumor, removal	[100-200]]
[Epithelioma of face, surgical removal	[50-100]]
[Cancer of tongue (resection or removal)	[85-170]]
[Cancer of lip (local operation)	[65-130]]
[Cancer of lip same with neck dissection	[150-300]]]

[12. [BIOPSY

[Biopsy, superficial	[5-10]]
[Biopsy, bone, or bone marrow	[30-60]]]

13. [GLANDS

[Glands, superficial, removal	[20-40]]
[Dissection glands	[125-150]]
[Radical axilla or groin	[70-140]]]

14. [THYROID

[Thyroidectomy	[75-150]]
[Thyroidectomy, two-stage, subtotal (with or without ligation) complete procedure	[100-200]]
[Parathyroidectomy	[110-220]]]

15. [OBSTETRICS

[Pregnancy, delivery (does not include prenatal and postnatal care)	[90-180]]
[Miscarriage (curetage)	[25-50]]
[Caesarean section, vaginal, abdominal	[105-110]]
[Pregnancy, ectopic	[80-160]]]

16. [PROCTOLOGY

[Hemorrhoids, injections, each	[10-20]]
[Hemorrhoids, external, single, thrombosis, incision	[10-20]]
[Complete Hemorrhoidectomy	[30-60]]]

[Fistulectomy, single, excision of tract	[45-90]]
[Fissurectomy, office, Hospital	[25-50]]
[Abscess, ischio-rectal or peri-rectal drainage	[35-70]]
[Carcinoma of rectum resection	[85-170]]
[Propapsed rectum, repair or injection	[45-90]]]

[17. UROLOGY

[Circumcision, infant not requiring anesthesia	[15-30]]
[Circumcision, other	[15-30]]
[Ureterotomy	[105-210]]
[Prostatic abscess	[55-110]]
[Prostatectomy, perineal	[115-230]]
[Prostatectomy, Radical	[150-300]]
[Prostatectomy suprapubic including vasectomy	[100-200]]
[Prostatectomy, transurethral	[60-120]]
[Punch operation with suprapubic drainage	[10-20]]
[Perineoplasty with urethral repair	[30-60]]
[Hydrocele, radical operation	[40-80]]
[Litholapaxy	[40-80]]
[Epididymectomy	[45-90]]
[Vasectomy (when no preliminary to prostatectomy)	[25-50]]]

18. [GYNECOLOGY

[Bartholin's gland, incision	[10-20]]
[Bartholin's gland, excision	[25-50]]
[Fistula recto-vaginal	[90-180]]
[Fistula vesico-vaginal	[90-180]]
[Cul-de-sac, drainage	[20-40]]
[Cauterization, electric	[15-40]]
[Dilation and curettage with or without cauterization	[25-50]]
[Uterine polyp removal with dilation and curettage	[30-60]]
[Cervical polyp removal	[5-10]]
[Trachelorrhaphy	[30-60]]
[Cervix amputation	[35-70]]
[Oophorectomy or resection of ovaries	[50-100]]
[Hysterectomy (subtotal)	[125-150]]
[Hysterectomy (total)	[100-200]]
[Myomectomy	[95-190]]
[Uterine flexions, etc., correction (plus surgery of tubes and ovaries)	[45-90]]
[Uterine flexions, with vaginal plastic work	[90-180]]
[Salpingectomy	[45-90]]
[Tubal ligation (independent procedure)	[30-60]]
[Salpingo-oophorectomy	[75-150]]
[Cystocele	[45-90]]
[Rectocele	[55-110]]
[Vulvectomy	[115-130]]
[Vulvectomy with groin dissection	[150-300]]]

[19. PRELIMINARY ENDOSCOPY

[Bronchoscopy, diagnostic, preceding surgery	[20-40]]
[Bronchoscopy, Operative	[35-70]]
[Cystoscopy, observation	[10-20]]
[Cystoscopy Ureteral catheterization	[15-30]]
[Cystoscopy Operative	[30-60]]
[Gastroscopy	[15-30]]
[Gastroscopy Operative	[25-50]]]

[Laryngoscopy, diagnostic (by Laryngoscopy)	[10-20]]
[Laryngoscopy, Operative	[30-60]]
[Sigmoidoscopy and biopsy	[10-20]]
[Esophagoscopy	[15-30]]
[Vesiculectomy	[75-150]]
[Variocoelectomy	[40-80]]
[Orchidectomy, simple	[40-80]]
[Orchidectomy, bilateral, with gland dissection	[65-130]]
[Cystotomy or cystostomy	[85-170]]
[Cystostomy with fulguration	[50-100]]
[Cystectomy	[150-300]]
[Ureter transplantation, single	[105-210]]
[Bladder tumor, diverticula, etc, (resection) open operation	[55-110]]
[Urethra-lithotomy	[65-130]]
[Nephrotomy	[105-210]]
[Nephrostomy	[50-100]]
[Nephrectomy	[145-290]]
[Nephropexy	[125-250]]
[Plastic on pelvis and ureter	[105-110]]
[Heminephrectomy	[150-300]]
[Excision and suture of urinary Fistula-suprapubic	[95-190]]
[Vaginal	[10-20]]
[Penis amputation	[70-140]]
[Penis amputation with groin dissection	[135-270]]
[Plastic hypospadias or epispadias	[90-180]]
[Meatotomy	[10-20]]
[Caruncle excision, fulguration	[20-40]]

[20. THORACIC SURGERY

[Pneumolysis	[145-290]]
[Pleura, paracentesis	[10-20]]
[Empyema, closed drainage	[30-60]]
[Empyema, rib section	[60-120]]
[Phrenic nerve crushing	[50-100]]
[Thoracoplasty (First state or partial), complete	[150-300]]
[Lobectomy	[140-280]]
[Induction of artificial pneumothorax	[10-20]]

21. [OTOLOGY (Science of the Ear)

[Aural polyp	[10-20]]
[Paracentesis, tympani	[10-20]]
[Mastoidectomy, acute single, bilateral	[100-200]]
[Mastoidectomy, radical single	[105-210]]
[Myringotomy	[10-20]]
[Fenestration for otosclerosis	[80-160]]

22. [NOSE AND THROAT

[Nasal polyps, removal	[10-20]]
[Antrum, Caldwell-Luc	[45-90]]
[Ethmoidectomy	[65-130]]
[Frontal sinus, radical	[85-170]]
[Turbinectomy	[30-60]]
[Submucous resection	[50-100]]
[Palatorrhaphy	[90-180]]
[Tonsillectomy and adenoidectomy under age 12	[30-60]]
[Tonsillectomy and adenoidectomy age 12 and over	[35-75]]
[Laryngectomy	[150-300]]

[Tracheotomy	[10-20]]
[Malignant disease accessory sinuses, radical operation, one sinus	[110-220]]
[Malignant disease, tonsil and pharynx, radical operation	[70-140]]
[Antrum puncture and irrigation	[5-10]]
[Antrum window	[25-50]]]

[23. BREASTS

[Breast abscess	[25-50]]
[Breast cyst or abscess, aspiration	[5-10]]
[Breast tumor or benign, removal	[40-80]]
[Breast, radical removal, including auxiliary dissection	[110-220]]
[Breast, simple removal	[65-130]]]

24. [OPERABLE BRAIN INJURIES

[Extradural hematoma, subdural hematoma	[120-240]]
[Exploratory trephination, one and two sides	[80-160]]
[Arterio-venous fistula, intracranial	[150-300]]]

CHANGE IN AMOUNT OF BENEFITS

Any change in the amount of Benefits due to a change in Your Eligible Class will be effective on the first of the month following Your having worked and been paid for the minimum required hours, provided You make any required premium payment for the change to be effective.

Changes in amount of Benefits due to a Policy amendment will take effect for You and Your Dependents on the amendment date.

Benefit payment will be based on the Benefits in effect when the treatment, service or supply was provided.

SECTION 6 – EXCLUSIONS AND LIMITATIONS FROM COVERAGE

The Policy does not provide any Benefits for the following confinements, visits, charges, treatment, services or supplies for or related to:

1. Preventive Services which are not Medically Necessary for the treatment of Illness or Injury[, except as specified in the Preventive Care Indemnity Benefit, if shown as included in the Schedule of Benefits]; or
2. Any treatment, service or supply which is not due to an Illness or Injury; or
3. Any treatment, service or supply which is not recommended by a Doctor; or
4. Any treatment, service or supply which is not Medically Necessary; or
5. Treatment, services or supplies for which no charge is made or for which the Covered Person is not required to pay; or
6. [Any treatment, service or supply provided by a government owned or operated facility or by government employed health care providers, unless the Covered Person is legally required to pay the charges incurred; or]
7. Hospital and Doctor charges for weekend Hospital admissions occurring between noon on any Friday and noon the following Sunday for non-emergency procedures, unless Medically Necessary or unless surgery is scheduled for the next day; or
8. An Illness or Injury which arises out of or in the course of any employment for wage or profit or an Illness or Injury for which the Covered Person has or had a right to recovery under any Workers' Compensation or Occupational Disease Law; or
9. Physical or psychological examinations required by any third party, such as by a court or for employment, licensing, insurance, school, sports or recreational purposes; or
10. [An Illness or Injury incurred while on active duty with the military of any country or international organization; or]
11. An Illness or Injury resulting from war or any act of war (declared or undeclared) or the participation in a riot or insurrection; or
12. An Illness or Injury incurred (a) during the commission or attempted commission of a crime or felony or while engaged in an illegal act; or (b) while imprisoned; or
13. Treatment, services or supplies for any loss sustained, incurred due to, or contracted as a consequence of a Covered Person (a) being intoxicated; or (b) being under the influence of any illegal narcotic, barbiturate, hallucinatory or other drug, unless administered by a Doctor and taken in accordance with the prescribed dosage. A Covered Person is conclusively determined to be intoxicated by drug or alcohol if a chemical test administered in the jurisdiction where the loss or cause of loss occurred is at or above the legal limit set by that jurisdiction; or
14. Treatment, services or supplies to improve the appearance or self-perception of a Covered Person, which does not restore a bodily function including, but not limited to, cosmetic or plastic surgery, hair loss or skin wrinkling, or the complications of any such treatment; or
15. Treatment, services or supplies for (a) breast augmentation; (b) the removal of breast implants unless Medically Necessary and related to surgery performed as reconstructive surgery due to an Illness; and (c) breast reduction surgery unless Medically Necessary due to an Illness; or
16. Surgery to correct refractive errors, such as radial keratotomy or radial keratectomy; or
17. Routine eye exams, glasses, visual therapy, or contact lenses[; except as specified in the Vision Benefit Rider, if shown as included in the Schedule of Benefits]; or
18. Routine hearing exams to assess the need for, or change to, hearing aids; and the purchase, fittings or adjustments of hearing aids; or
19. Penile implants and fertility and sterility studies; or
20. Treatment, services or supplies: (a) to restore or enhance fertility; or (b) for voluntary sterilization, including vasectomy or tubal ligation; or (c) to reverse sterilization; or
21. Impregnation techniques such as: (a) artificial insemination; or (b) in vitro fertilization; including but not limited to: artificial insemination, in vitro zygote and intra-fallopian transfers, gamete intra-fallopian transfer, genetic counseling, and all charges related to such in vitro fertilization; or
22. Voluntary abortion; except if the life of the mother would be in danger if the fetus were carried to term, or except for complications of a voluntary abortion; or
23. Mental Illness Disorders [except as specified in the Inpatient Mental Illness Disorders Indemnity Benefit if such Benefit is shown as included in the Schedule of Benefits]; or
24. Substance Abuse [except as specified in the Inpatient Substance Abuse Indemnity Benefit if such Benefit is shown as included in the Schedule of Benefits]; or

25. Treatment, services or supplies to eliminate or reduce a dependency on or an addiction to tobacco, including but not limited to: nicotine withdrawal programs; nicotine products, such as transdermal patches and gums; hypnotism; and goal oriented behavioral modification; or
26. Marriage or family counseling, recreational therapy, equine therapy, educational therapy, social therapy, or sex therapy; or
27. Sexual reassignments or sexual dysfunctions or inadequacies; or
28. Meridian therapy (acupuncture); or
29. Treatment, services or supplies related to paring or removal of corns, calluses, bunions or toenails (other than partial or complete removal of nail roots); or
30. Treatment, services or supplies related to the feet by means of posting or strapping, or range of motion studies; or
31. Orthotics; or
32. Treatment, services or supplies for obesity, morbid obesity, or weight reduction, including, but not limited to, wiring of the teeth and all forms of Surgery including, but not limited to, bariatric Surgery, intestinal bypass Surgery and complications resulting from such Surgeries; or
33. Treatment, services or supplies received from a Doctor or other provider if such person is: (a) a person who ordinarily resides in Your household, (b) a Close Relative or (c) the Policyholder; or
34. Custodial Care, regardless of who prescribes or renders such care; or
35. Treatment, services or supplies received or purchased outside the United States unless the charges are incurred while traveling on business or for pleasure, for a period not to exceed [90] days, and the charges are incurred for an Emergency, provided the treatment, services or supplies used in connection with the Emergency are approved for use in the United States; or
36. Telephone and email consultations, missed appointment fees, fees for completing claim forms, and fees related to the costs of obtaining medical records as necessary under the Required Information provision; or
37. Treatment, services or supplies for complications of conditions that are not covered under the Policy except for complications of a voluntary abortion; or
38. Outpatient Prescription Medications[, except as specified in the Outpatient Prescription Medication Indemnity Benefit, if shown as included in the Schedule of Benefits]; or
39. Treatment, services or supplies related to: (a) the teeth; and (b) the gums; and any other associated structures except for tumors, cuts and Injuries; (c) the prevention or correction of teeth irregularities and malocclusion of jaws by wire appliances, braces or other mechanical aids; and (d) dental implants, regardless of the cause; except as specified in the Dental Benefit Rider, if shown as included in the Schedule of Benefits]; or
40. Treatment, services or supplies as the result of prognathism, retrognathism, micrognathism, or any treatment, services or supplies to reposition the maxilla (upper jaw) mandible (lower jaw), or both maxilla and mandible, unless due to an Injury, which occurs while covered under the Policy, to Sound Natural Teeth, provided that such treatment is received within [12 months] following the date of Injury; or
41. Treatment, services or supplies provided for temporomandibular joint (TMJ) dysfunction; or
42. Physical, speech and occupational therapy; or
43. Hospice Care; or
44. Home Health Care.

[OTHER INSURANCE WITH THIS INSURER LIMITATION:

If the Covered Person is covered under the Policy as the Eligible Person and also covered as a Dependent, the Benefits will be paid for the Employee up to the specific Benefit maximums or limitations and [Calendar] [Plan] Year maximum Benefits, as shown in the Schedule of Benefits. After the specific Benefit maximum is reached further Benefits will be paid for the Dependent up to the Benefit maximums or limitations and [Calendar] [Plan] Year maximum Benefits, as shown in the Schedule of Benefits. Benefits will not be duplicated. The same Covered Benefit will not be paid under Employee and under the Dependent Coverage.]

SECTION 7 – TERMINATION

[Termination of Retiree's Coverage

Coverage for a Retiree and his or her Dependents shall automatically terminate on the earliest of the following dates:

1. The date of termination of the Policy;
2. The date of termination of any section or part of the Policy with respect to insurance under such section or part;
3. The date the Policy is amended to terminate the eligibility of any class of Retirees of which the Retiree is a member; or
4. The date the Retiree or the Policyholder fails to pay the required premium.]

Termination of an Eligible Person's Coverage

Coverage for an Eligible Person shall automatically terminate on the earliest of the following dates:

1. The date of termination of the Policy;
2. The date of termination of any section or part of the Policy with respect to insurance under such section or part;
3. The last day of the [Benefit Period] [month] in which You are no longer eligible for insurance under the Policy;
4. The date You or the Policyholder fails to pay the required premium;
5. [The date You enter the armed forces of any country, state or international organization, other than for reserve duty of 30 days or less or as provided under the Statement of Uniform Services Employment and Reemployment Rights Act of 1994 provision;] or
6. The date You are no longer in an Eligible Class under the Policy.

Termination of a Dependent's Coverage

Coverage for an Eligible Person with respect to Dependents shall terminate on the earliest of the following dates:

1. The date of termination of the Policy;
2. The date of termination of any section or part of the Policy with respect to insurance under such section or part; including the date that insurance Coverage for Dependents is no longer offered under the Policy;
3. The date Your insurance terminates;
4. The date You or the Policyholder fails to pay the required premium;
5. The last day of the month in which a Dependent ceases to meet the definition of "Dependent";
6. [The date the Dependent enters the armed forces of any country, state or international organization, other than for reserve duty of 30 days or less or as provided under the Uniform Services Employment and Reemployment Rights Act of 1994;]
7. With respect to an Eligible Person's Dependent Spouse, the premium due date coinciding with or next following the date on which the Eligible Person is divorced or legally separated from such Spouse; or
8. The date of the Dependent's death.

If upon attaining any limiting age specified in the definition of Dependent Child, because of Mental or Physical Incapacity, a Dependent Child is incapable of earning his or her own living and is Chiefly Dependent upon You for support and maintenance, Coverage for the Dependent Child may be continued during the continuance of such incapacity, providing that:

- a. Medical proof, in writing, of such incapacity must be given to Us within 31 days after the date on which the Dependent Child attains a limiting age;
- b. We shall have the right any time during the continuance of insurance under this provision to require due proof of the continuance of the incapacity and to have the Dependent Child examined by Doctors designated by Us at any time during the first 2 years of such continuance and not more than once each year thereafter; and
- c. You continue paying the required premium for the Dependent Child.

The continuance described herein shall cease in the event of the occurrence of any of the circumstances described in paragraphs 1. through 7., above.

For the purposes of this provision, the following definitions apply:

Mental or Physical Incapacity means a mental or physical impairment that results in anatomical, physiological or psychological abnormalities which are demonstrated by medically acceptable clinical, laboratory or diagnostic techniques and which are expected to last for a continuous period of time not less than 12 months in duration.

Chiefly Dependent means the covered Dependent Child receives the majority of his/her financial support from You.

CONTINUATION OF COVERAGE [(Applicable to Employees of Employers with less than 20 Employees not eligible for Continuation of Coverage under COBRA)]

An Employee whose insurance would otherwise terminate because of termination of active employment shall be entitled to continue their insurance under the Policy for themselves and their Dependents with respect to whom they were insured on the date of termination.

A Dependent Spouse [or Domestic Partner] [or Domestic Same Sex Partner] of an Employee may elect continuation of Dependent Spouse [or Domestic Partner] [or Domestic Same Sex Partner] and Dependent Child coverage for a period of coverage not to exceed 18 months after: (1) the date of the death of the Employee; (2) the date of the Spouse's divorce [or Domestic Partner's separation] [or Domestic Same Sex Partner's separation] from the Employee; or (3) the date that the Employee becomes entitled to Medicare benefits.

A Dependent Child of an Employee may elect continuation of his or her coverage for a period not to exceed 18 months after the Child ceases to be a Dependent of the Employee.

Continuation shall be available to an Employee or Dependent who has been continuously insured under the Group Policy, or for similar benefits under any other Group Policy that it replaced, during the period of (3) consecutive months immediately before the date of termination.

Continuation shall not be available for any person who is or could be covered by any other arrangement of hospital, surgical or medical coverage for individuals in a group, whether insured or uninsured, within 31 days immediately following the date of termination, or whose insurance terminated because of fraud or because he failed to pay any required contribution for the insurance, or who is eligible for continuation under the provisions of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) or who becomes entitled to Medicare benefits.

In order to be eligible for continuation, the Employee or Dependent [or Domestic Partner] [or Domestic Same Sex Partner] must make a written election of continuation on a form furnished Us and pay the first premium in advance, before the date on which the Employee's or Dependent's insurance would otherwise terminate. The continuation premium shall not be more than the full group rate that would be applicable to the Employee or Dependent under the Policy on the due date of each payment.

Continuation of insurance under the Policy for any person shall terminate on the earliest of the following dates:

1. The date 18 months after the date the Employee's insurance under the Policy would otherwise have terminated because of termination of employment or membership;
2. The date ending the period for which the Employee or Dependent last makes his or her required contribution, if he or she discontinues his or her contributions;
3. The date the Employee or Dependent becomes or is eligible to become covered for similar benefits under any arrangement of coverage for individuals in a group, whether insured or uninsured;
4. The date on which the Policy is terminated;
5. The date the surviving Spouse or former Spouse of the Employee remarries and becomes covered under a group health plan; or
6. The date the Employee or Dependent becomes entitled to benefits under Medicare.

EXTENSION OF COVERAGE DUE TO TOTAL DISABILITY

Benefits will continue to be payable under the Policy when Coverage terminates, if the Covered Person:

1. Is Totally Disabled; and
2. Is confined to a Hospital or a Skilled Nursing Facility for an Illness or Injury causing the Covered Person's Total Disability before the date Coverage would otherwise terminate.

Benefits paid under this Extension of Coverage provision will be paid until the earliest of:

1. The date which is 90 days from the date Coverage would have otherwise terminated; or
2. The date on which the Totally Disabled Covered Person's Daily Inpatient and Skilled Nursing Facility Indemnity Benefit has reached the [Calendar Year] [Plan Year] Maximum Amount, or the Lifetime Maximum Benefit While Insured, whichever occurs first; or
3. The date the Covered Person is no longer confined as an Inpatient in a Hospital or Skilled Nursing Facility.

This Extension of Coverage applies only to the Totally Disabled Covered Person and no premium is due. With respect to other Covered Persons not Totally Disabled Coverage will not be extended past the date of termination.

SECTION 8 – GENERAL PROVISIONS

Entire Contract

The entire contract is made up of: (a) the Policy; (b) the Policyholder application; and (c) any individual Eligible Person applications. No agent, Employer, Eligible Person, Employee, or other individual, except Our President, Vice President, Secretary or Assistant Secretary can: (a) approve a change to the Policy; or (b) extend the time for payment of any premium. No change will be valid unless it is made: (a) by an Endorsement or Rider to the Policy; or (b) by an Amendment signed by Our President, Vice President, Secretary or Assistant Secretary. Any change made will be binding on each Eligible Person and on any other individual(s) referred to in the Policy.

Modification of the Employer's Plan

The Policy may be modified at any time by written agreement between the Policyholder and Us, without the consent of any Covered Person. The Policy may be modified to reflect a modification to the terms of Coverage provided by the Policy at any time by written notification to the Policyholder by Us. Such modification shall not require the consent of the Policyholder or any Covered Person.

Any modification to the Policy shall be effective for the Policyholder and any Covered Persons on the first day of the month following the date on which such modification becomes effective.

Contestability

In the absence of fraud, statements made by any Eligible Person or the Policyholder are representations and not warranties. After the Eligible Person has been covered under the Policy for 2 consecutive years, only fraudulent misstatements in the application may be used to void an Eligible Person's Coverage under the Policy or deny any claim for loss incurred or disability starting after the 2-year period. After the Policy has been in force for 2 consecutive years, only fraudulent misstatements in the Policyholder application may be used to void the Policy. If a Covered Person's age was misstated, We will provide the amount of insurance for the correct age and an equitable premium adjustment will be made so that We will receive the correct premium for the true age.

Notice of Claim

Written notice of claim must be given to Us: (a) within [20] [60] days after the date on which the claim was incurred; or (b) as soon as reasonably possible thereafter. Notice can be sent to Our authorized administrator or Our Home Office. The notice should include the Covered Person's name and Policy number.

[Assignments]

A Covered Person may authorize Us or Our authorized administrator to pay Benefits directly to a Doctor or other health care provider from whom he or she receives services.]

Proof of Loss

Written proof of loss which includes any other Required Information that We request to make the Benefit determination, must be given to Us or Our authorized Administrator within 90 days of the date on which the claim was incurred. If it was not possible for proof to be given within the 90 days, We will not deny the Benefit provided proof is given as soon as reasonably possible. The date on which the claim was incurred is the date on which the services or supplies were provided. Notwithstanding the forgoing, proof must be sent no later than one year from the date on which the claim was incurred unless the Covered Person is legally incapacitated.

Time of Payment of Claims

Benefits will be paid subject to written proof of loss. Any balance unpaid at the end of liability will be paid on receipt of written proof of loss. Benefits paid under the Policy will be paid within [30] [45] days following the date on which Our Administrator receives written proof of loss. Benefits payable under the Policy are overdue if not paid within [30] [45] days after We, or Our authorized administrator, receives proof of loss and necessary medical information or other information required by Us essential to administer the provisions of the Policy. If such information is not supplied as to the entire claim, the amount supported by reasonable proof is overdue if not paid within [30] [45] days. Any part or all of the remainder of the claim that is later supported by such proof is over due if not paid within [30] [45] days.

Payment of Claims

Benefits will be payable to the Eligible Person [unless they are assigned to a Doctor or other health care provider. Any notice of assignment of Benefits must be in writing and mailed to Us or Our authorized administrator. Notice of the assignment of Benefits received from a Doctor or other health care provider will be sufficient to cause Benefits to be paid to such Doctor, Hospital or other health care provider. You may revoke an assignment of Benefits at any time by providing written notice of such revocation to Us or Our authorized administrator. Any such written revocation of an assignment of Benefits shall be valid as to both You and the Doctor or other health care provider].

Recovery of Overpayments

We reserve the right to deduct from any Benefits properly payable under the Policy the amount of any payment that has been made:

1. In error;
2. Pursuant to a misstatement contained in a proof of loss;
3. Pursuant to fraud or misrepresentation made to obtain Coverage under the Policy within 2 years after the date such Coverage commences;
4. With respect to an ineligible person; or
5. Pursuant to a claim for which benefits are recoverable under any Policy or act of law providing Coverage for occupational Injury or disease to the extent that such benefits are recovered.

Such deduction may be against any future claim for Benefits under the Policy made by a Covered Person if claim payments previously were made with respect to such Covered Person.

Conformity with Federal and State Laws

Any provision of the Policy which is in conflict with federal laws or any applicable state law is hereby amended to meet the minimum requirements of the law.

Appeal

Under ERISA or state law, You have certain administrative appeal rights. If You disagree with any Benefit determination made by Us or Our authorized administrator, You must complete all administrative appeals to which You are entitled before You may demand arbitration.

Arbitration

Disputes, disagreements or controversies arising out of, in connection with, or relating to the terms, conditions, limitations, exclusions or provisions of the Coverage under the Policy or breach thereof (including any issue related to arbitrability) which cannot be resolved to the satisfaction of all parties shall be resolved by arbitration. Arbitration shall be conducted in accordance with the rules of the American Arbitration Association ("AAA"), before a panel of 3 neutral arbitrators who are knowledgeable in the field of insurance and appointed from a panel list provided by the AAA.

Each party waives the right to a jury trial with respect to any dispute, disagreement or controversy between them. The arbitration panel shall have no power to ignore or vary the terms of the Policy.

The factual basis and legal conclusions of the award, including the law relied upon, must be identified. The decision in arbitration is confidential, final, binding and conclusive upon all parties and may not be disclosed by any party. The decision in arbitration cannot be reviewed in court by a judge and jury. Judgment upon the award rendered by the arbitration panel may be entered in any court have jurisdiction.

If any provision of this subsection is found to be unenforceable, such provision shall be considered severed from the remaining provisions of this subsection, which shall remain in full force and effect.

Arbitration Action

No arbitration action may be brought to recover Benefits under the Policy prior to the expiration of: (1) 60 days after written proof of loss has been furnished, (2) You have completed all administrative appeals required by the Policy, and (3) You notify Us of Your intent to demand arbitration 60 days prior to the filing of such demand for arbitration. No such action will be brought after the expiration of 2 years following the date written proof of loss was required to be furnished.

Ambiguities

Any terms or conditions specified in the Policy that are determined as a result of arbitration to be ambiguous or in conflict with state or federal laws shall be considered separately and shall not void or affect the legality of the remaining terms and conditions that are included in the Policy.

Physical Examination

We have the right, at Our own expense, to have a Covered Person examined as often as is reasonable while a claim is pending.

Certificate of Insurance

We will provide to the Policyholder a Certificate of Insurance for each Eligible Person, which shall state the essential features of the insurance to which each Covered Person is entitled, to whom Benefits are payable, and the requirements for payment of Benefits.

Waiver of Rights

If We fail to enforce any provision of the Policy, such failure will not affect Our right to do so at a later date; nor will it affect Our right to enforce any other provision of the Policy. Any waiver of rights must be in writing and signed by Our President, Vice President Secretary or Assistant Secretary or an individual authorized by them to agree to such waiver.

Required Information

The Eligible Person agrees to provide to Us any information or data that We reasonably request for the proper administration of the Policy including; but not limited to, information pertaining to medical history, medical records, the names of all health care providers from whom Covered Persons have received treatment or services, marriage license, documentation of adoption or placement for adoption, documentation of legal custody of a Dependent, student status information, and treating provider statements.

Effective Date

No insurance under the Policy shall become effective until notice in writing is given to the Policyholder by Us or Our authorized administrator. Issuance of a Certificate of Insurance with a Schedule of Benefits will be deemed proper notification, provided premium due has been paid in accordance with the terms of the Policy.

[Subrogation/Right Of Reimbursement

As a condition to receiving Benefits under the Policy, Covered Person(s) agree to transfer to Us their right to recover damages to the extent of Benefits paid by Us when an Illness or Injury occurs through the act or omission of another person. If a Covered Person received payment from another person or entity on account of, due to, or arising out of an Illness or Injury, the Covered Person agrees to reimburse Us to the full extent of the amount paid by Us. If a repayment agreement is required to be signed, all rights of recovery are transferred to Us regardless of whether it is actually signed. It is only necessary that the Illness or Injury occur through the act or omission of another person or entity. Our rights of full recovery may be from any other person or entity, any liability or other insurance covering such other person or entity party, the Covered Person's own uninsured motorist insurance, underinsured motorist insurance, any medical payments, no-fault, workers compensation or school insurance Coverages which are paid or payable. We may enforce Our reimbursement rights by requiring the Covered Person to assert a claim to any of the foregoing Coverages to which the Covered Person may be entitled. Covered Person(s) shall provide all requested accident and insurance information to Us. We shall not be required to pay any portion of Covered Person's attorneys' fees or other costs associated with a claim/lawsuit.]

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.

SCHEDULE OF BENEFITS

We will provide the Benefits shown. Any change in Benefit is subject to the Change in Amount of Benefits provision.

LIMITED MEDICAL BENEFITS [FOR YOU] [PER COVERED PERSON]

[[PLAN 1]
[XX Hours]

[PLAN 2]
[XX Hours]

[PLAN 3]
[XX Hours]

[PLAN 4]
[XX or more Hours]

[PLAN 5]
[Waived Class][No
hours requirement]]

[Eligibility for Plans [1] through [4] is based on a rolling [XX-day] average of hours worked per week. Eligibility for Plan [5] requires a completed waiver form signed by the employee.]

[FIRST DAY HOSPITAL ADMISSION INDEMNITY BENEFIT: [Included] [Not Included]

This Benefit is payable only once in a single sum for any period of Inpatient confinement.

[[PLAN 1]	[PLAN 2]	[PLAN 3]	[PLAN 4]	[PLAN 5]
[Not Applicable]	[Not Applicable]	[Not Applicable]	[Not Applicable]	[Not Applicable]
[\$X,XXX]	[\$X,XXX]	[\$X,XXX]	[\$X,XXX]	
[[Calendar] [Plan] Year	[[Calendar] [Plan] Year	[[Calendar] [Plan] Year	[[Calendar] [Plan] Year	
Maximum Benefit:	Maximum Benefit:	Maximum Benefit:	Maximum Benefit:	
[\$X,XXX]	[\$X,XXX]	[\$X,XXX]	[\$X,XXX]	
[[Calendar] [Plan] Year	[[Calendar] [Plan] Year	[[Calendar] [Plan] Year	[[Calendar] [Plan] Year	
Maximum Benefit: [X]	Maximum Benefit: [X]	Maximum Benefit: [X]	Maximum Benefit: [X]	
Confinements]]	Confinements]]	Confinements]]	Confinements]]	

[HOSPITAL INPATIENT DAILY INDEMNITY BENEFIT: [Included] [Not Included]

[Does not include [Mental Illness Disorders] [Substance Abuse] [Inpatient Skilled Nursing Facility]]

[[PLAN 1]	[PLAN 2]	[PLAN 3]	[PLAN 4]	[PLAN 5]
[Not Applicable]	[Not Applicable]	[Not Applicable]	[Not Applicable]	[Not Applicable]
[\$X,XXX] per day	[\$X,XXX] per day	[\$X,XXX] per day	[\$X,XXX] per day	
[[Calendar] [Plan] Year	[[Calendar] [Plan] Year	[[Calendar] [Plan] Year	[[Calendar] [Plan] Year	
Maximum Benefit: [[XX]	Maximum Benefit: [[XX]	Maximum Benefit: [[XX]	Maximum Benefit: [[XX]	
Inpatient days]	Inpatient days]	Inpatient days]	Inpatient days]	
[[XXX,XXX] [X]	[[XXX,XXX] [X]	[[XXX,XXX] [X]	[[XXX,XXX] [X]	
Inpatient confinements]	Inpatient confinements]	Inpatient confinements]	Inpatient confinements]	
[Lifetime Maximum	[Lifetime Maximum	[Lifetime Maximum	[Lifetime Maximum	
Benefit While Insured:	Benefit While Insured:	Benefit While Insured:	Benefit While Insured:	
[[XXX] Inpatient days]	[[XXX] Inpatient days]	[[XXX] Inpatient days]	[[XXX] Inpatient days]	
[[X,XXX,XXX]]	[[X,XXX,XXX]]	[[X,XXX,XXX]]	[[X,XXX,XXX]]	

[DAILY HOSPITAL INTENSIVE CARE UNIT INDEMNITY BENEFIT: [Included] [Not Included]

[Does not include [Mental Illness Disorders] [Substance Abuse] [Inpatient Skilled Nursing Facility]]

[PLAN 1]	[PLAN 2]	[PLAN 3]	[PLAN 4]	[PLAN 5]
[Not Applicable]	[Not Applicable]	[Not Applicable]	[Not Applicable]	[Not Applicable]
[Double] the Hospital Inpatient Daily Indemnity Benefit above]	[Double] the Hospital Inpatient Daily Indemnity Benefit above]	[Double] the Hospital Inpatient Daily Indemnity Benefit above]	[Double] the Hospital Inpatient Daily Indemnity Benefit above]	
[\$X,XXX] per day	[\$X,XXX] per day	[\$X,XXX] per day	[\$X,XXX] per day	
[[Calendar] [Plan] Year Maximum Benefit: [[XX] Inpatient days]	[[Calendar] [Plan] Year Maximum Benefit: [[XX] Inpatient days]	[[Calendar] [Plan] Year Maximum Benefit: [[XX] Inpatient days]	[[Calendar] [Plan] Year Maximum Benefit: [[XX] Inpatient days]	
[\$XXX,XXX] [[X] Inpatient confinements]				
[Lifetime Maximum Benefit While Insured: [[XXX] Inpatient days] [\$X,XXX,XXX]]	[Lifetime Maximum Benefit While Insured: [[XXX] Inpatient days] [\$X,XXX,XXX]]	[Lifetime Maximum Benefit While Insured: [[XXX] Inpatient days] [\$X,XXX,XXX]]	[Lifetime Maximum Benefit While Insured: [[XXX] Inpatient days] [\$X,XXX,XXX]]	

[INPATIENT MENTAL ILLNESS DISORDERS INDEMNITY BENEFIT: [Included] [Not Included]

[(Other Inpatient Indemnity Benefits are not payable)]:

[PLAN 1]	[PLAN 2]	[PLAN 3]	[PLAN 4]	[PLAN 5]
[Not Applicable] [[XX%] of the Hospital Inpatient Daily Indemnity Benefit above]	[Not Applicable] [[XX%] of the Hospital Inpatient Daily Indemnity Benefit above]	[Not Applicable] [[XX] of the Hospital Inpatient Daily Indemnity Benefit above]	[Not Applicable] [[XX%] of the Hospital Inpatient Daily Indemnity Benefit above]	[Not Applicable]
[\$X,XXX] per day	[\$X,XXX] per day	[\$X,XXX] per day	[\$X,XXX] per day	
[[Calendar] [Plan] Year Maximum Benefit: [[XX] Inpatient days]	[[Calendar] [Plan] Year Maximum Benefit: [[XX] Inpatient days]	[[Calendar] [Plan] Year Maximum Benefit: [[XX] Inpatient days]	[[Calendar] [Plan] Year Maximum Benefit: [[XX] Inpatient days]	
[\$XXX,XXX] [[X] Inpatient confinements]	[\$XXX,XXX] [[X] Inpatient confinements]	[\$XXX,XXX] [[X] Inpatient confinements]	[\$XXX,XXX] [[X] Inpatient confinements]	
[Lifetime Maximum Benefit While Insured: [[XXX] Inpatient days] [\$X,XXX,XXX]]	[Lifetime Maximum Benefit While Insured: [[XXX] Inpatient days] [\$X,XXX,XXX]]	[Lifetime Maximum Benefit While Insured: [[XXX] Inpatient days] [\$X,XXX,XXX]]	[Lifetime Maximum Benefit While Insured: [[XXX] Inpatient days] [\$X,XXX,XXX]]	

[INPATIENT SUBSTANCE ABUSE INDEMNITY BENEFIT: [Included] [Not Included]

[(Other Inpatient Indemnity Benefits are not payable)]:

[PLAN 1]	[PLAN 2]	[PLAN 3]	[PLAN 4]	[PLAN 5]
[Not Applicable] [[XX] of the Hospital Inpatient Daily Indemnity Benefit]	[Not Applicable] [[XX] of the Hospital Inpatient Daily Indemnity Benefit]	[Not Applicable] [[XX] of the Hospital Inpatient Daily Indemnity Benefit]	[Not Applicable] [[XX] of the Hospital Inpatient Daily Indemnity Benefit]	[Not Applicable]
[\$X,XXX] per day	[\$X,XXX] per day	[\$X,XXX] per day	[\$X,XXX] per day	
[[Calendar] [Plan] Year Maximum Benefit: [[XX] Inpatient days]	[[Calendar] [Plan] Year Maximum Benefit: [[XX] Inpatient days]	[[Calendar] [Plan] Year Maximum Benefit: [[XX] Inpatient days]	[[Calendar] [Plan] Year Maximum Benefit: [[XX] Inpatient days]	
[\$XXX,XXX] [[X] Inpatient confinements]				
[Lifetime Maximum Benefit While Insured: [[XXX] Inpatient days] [\$X,XXX,XXX]]	[Lifetime Maximum Benefit While Insured: [[XXX] Inpatient days] [\$X,XXX,XXX]]	[Lifetime Maximum Benefit While Insured: [[XXX] Inpatient days] [\$X,XXX,XXX]]	[Lifetime Maximum Benefit While Insured: [[XXX] Inpatient days] [\$X,XXX,XXX]]	

[INPATIENT SKILLED NURSING FACILITY INDEMNITY BENEFIT: [Included] [Not Included]

[[PLAN 1]	[PLAN 2]	[PLAN 3]	[PLAN 4]	[PLAN 5]
[Not Applicable] [[XX]	[Not Applicable] [[XX]	[Not Applicable] [[XX]	[Not Applicable] [[XX]	[Not Applicable]
of the Hospital	of the Hospital	of the Hospital	of the Hospital	
Inpatient Daily	Inpatient Daily	Inpatient Daily	Inpatient Daily	
Indemnity Benefit	Indemnity Benefit	Indemnity Benefit	Indemnity Benefit	
above]	above]	above]	above]	
[\$X,XXX] per day]	[\$X,XXX] per day]	[\$X,XXX] per day]	[\$X,XXX] per day]	
[[Calendar] [Plan] Year	[[Calendar] [Plan] Year	[[Calendar] [Plan] Year	[[Calendar] [Plan] Year	
Maximum Benefit: [[XX]	Maximum Benefit: [[XX]	Maximum Benefit: [[XX]	Maximum Benefit: [[XX]	
Inpatient days]	Inpatient days]	Inpatient days]	Inpatient days]	
[\$XXX,XXX] [[X]	[\$XXX,XXX] [[X]	[\$XXX,XXX] [[X]	[\$XXX,XXX] [[X]	
Inpatient confinements]	Inpatient confinements]	Inpatient confinements]	Inpatient confinements]	
[Lifetime Maximum	[Lifetime Maximum	[Lifetime Maximum	[Lifetime Maximum	
Benefit While Insured:	Benefit While Insured:	Benefit While Insured:	Benefit While Insured:	
[[XXX] Inpatient days]	[[XXX] Inpatient days]	[[XXX] Inpatient days]	[[XXX] Inpatient days]	
[\$X,XXX,XXX]]]	[\$X,XXX,XXX]]]	[\$X,XXX,XXX]]]	[\$X,XXX,XXX]]]	

[[MISCELLANEOUS INPATIENT HOSPITAL SERVICES INDEMNITY BENEFIT: [Included] [Not Included]

[Benefit is not included unless Hospital Inpatient Daily Indemnity Benefit is included.]

[[PLAN 1]	[PLAN 2]	[PLAN 3]	[PLAN 4]	[PLAN 5]
[Not Applicable] [\$XXX]	[Not Applicable] [\$XXX]	[Not Applicable] [\$XXX]	[Not Applicable] [\$XXX]	[Not Applicable]
per day	per day	per day	per day	
[[Calendar] [Plan] Year	[[Calendar] [Plan] Year	[[Calendar] [Plan] Year	[[Calendar] [Plan] Year	
Maximum Benefit: [[XX]	Maximum Benefit: [[XX]	Maximum Benefit: [[XX]	Maximum Benefit: [[XX]	
Inpatient days]	Inpatient days]	Inpatient days]	Inpatient days]	
[\$XXX,XXX] [[X]	[\$XXX,XXX] [[X]	[\$XXX,XXX] [[X]	[\$XXX,XXX] [[X]	
Inpatient	Inpatient	Inpatient	Inpatient	
confinements]]]	confinements]]]	confinements]]]	confinements]]]	

[[FIRST DAY HOSPITAL ADMISSION] [HOSPITAL INPATIENT DAILY INDEMNITY BENEFIT] [DAILY HOSPITAL INTENSIVE CARE UNIT INDEMNITY BENEFIT] [INPATIENT MENTAL ILLNESS DISORDERS INDEMNITY BENEFIT] [INPATIENT SUBSTANCE ABUSE INDEMNITY BENEFIT] [INPATIENT SKILLED NURSING FACILITY INDEMNITY BENEFIT] [and] [MISCELLANEOUS INPATIENT HOSPITAL SERVICES INDEMNITY BENEFIT]
 Combined [[Calendar] [Plan] Year Maximum Benefit: [\$X,XXX,XXX]] [Lifetime Maximum Benefit While Insured: [[X,XXX,XXX]]]

[EMERGENCY ROOM VISIT INDEMNITY BENEFIT [(ILLNESS ONLY)]: [Included] [Not Included]

[[PLAN 1]	[PLAN 2]	[PLAN 3]	[PLAN 4]	[PLAN 5]
[Not Applicable]	[Not Applicable]	[Not Applicable]	[Not Applicable]	[Not Applicable]
[\$X,XXX] per visit	[\$X,XXX] per visit	[\$X,XXX] per visit	[\$X,XXX] per visit	
[[Calendar] [Plan] Year	[[Calendar] [Plan] Year	[[Calendar] [Plan] Year	[[Calendar] [Plan] Year	
Maximum Benefit: [[X]	Maximum Benefit: [[X]	Maximum Benefit: [[X]	Maximum Benefit: [[X]	
visits] [[X,XXX]]]	visits] [[X,XXX]]]	visits] [[X,XXX]]]	visits] [[X,XXX]]]	

[DOCTOR'S INITIAL OFFICE VISIT INDEMNITY BENEFIT: [Included] [Not Included]

[This Benefit is payable only once per each separate Illness or Injury]]

[PLAN 1]	[PLAN 2]	[PLAN 3]	[PLAN 4]	[PLAN 5]
[Not Applicable] [\$XXX] per visit [[Calendar] [Plan] Year Maximum Benefit: [\$\$,XXX] [[XX] initial visits [per Eligible Person, and [XX] initial visits per Covered Dependent Spouse, and [XX] initial visits per Covered Dependent Child]]]	[Not Applicable] [\$XXX] per visit [[Calendar] [Plan] Year Maximum Benefit: [\$\$,XXX] [[XX] initial visits [per Eligible Person, and [XX] initial visits per Covered Dependent Spouse, and [XX] initial visits per Covered Dependent Child]]]	[Not Applicable] [\$XXX] per visit [[Calendar] [Plan] Year Maximum Benefit: [\$\$,XXX] [[XX] initial visits [per Eligible Person, and [XX] initial visits per Covered Dependent Spouse, and [XX] initial visits per Covered Dependent Child]]]	[Not Applicable] [\$XXX] per visit [[Calendar] [Plan] Year Maximum Benefit: [\$\$,XXX] [[XX] initial visits [per Eligible Person, and [XX] initial visits per Covered Dependent Spouse, and [XX] initial visits per Covered Dependent Child]]]	[Not Applicable]

[DOCTOR'S OFFICE VISITS INDEMNITY BENEFIT: [Included] [Not Included]

[PLAN 1]	[PLAN 2]	[PLAN 3]	[PLAN 4]	[PLAN 5]
[Not Applicable] [\$XXX] per visit [[Calendar] [Plan] Year Maximum Benefit: [\$\$,XXX] [[X] visits [per Eligible Person, and [XX] visits per Covered Dependent Spouse, and [XX] initial visits per Covered Dependent Child]]]	[Not Applicable] [\$XXX] per visit [[Calendar] [Plan] Year Maximum Benefit: [\$\$,XXX] [[X] visits [per Eligible Person, and [XX] visits per Covered Dependent Spouse, and [XX] initial visits per Covered Dependent Child]]]	[Not Applicable] [\$XXX] per visit [[Calendar] [Plan] Year Maximum Benefit: [\$\$,XXX] [[X] visits [per Eligible Person, and [XX] visits per Covered Dependent Spouse, and [XX] initial visits per Covered Dependent Child]]]	[Not Applicable] [\$XXX] per visit [[Calendar] [Plan] Year Maximum Benefit: [\$\$,XXX] [[X] visits [per Eligible Person, and [XX] visits per Covered Dependent Spouse, and [XX] initial visits per Covered Dependent Child]]]	[Not Applicable]

[PREVENTIVE CARE INDEMNITY BENEFIT: [Included] [Not Included]

[PLAN 1]	[PLAN 2]	[PLAN 3]	[PLAN 4]	[PLAN 5]
[Not Applicable] [\$XXX] per visit [[Calendar] [Plan] Year Maximum Benefit: [\$\$,XXX] [[X] visits [per Eligible Person, and [XX] visits per Covered Dependent Spouse, and [XX] initial visits per Covered Dependent Child]]]	[Not Applicable] [\$XXX] per visit [[Calendar] [Plan] Year Maximum Benefit: [\$\$,XXX] [[X] visits [per Eligible Person, and [XX] visits per Covered Dependent Spouse, and [XX] initial visits per Covered Dependent Child]]]	[Not Applicable] [\$XXX] per visit [[Calendar] [Plan] Year Maximum Benefit: [\$\$,XXX] [[X] visits [per Eligible Person, and [XX] visits per Covered Dependent Spouse, and [XX] initial visits per Covered Dependent Child]]]	[Not Applicable] [\$XXX] per visit [[Calendar] [Plan] Year Maximum Benefit: [\$\$,XXX] [[X] visits [per Eligible Person, and [XX] visits per Covered Dependent Spouse, and [XX] initial visits per Covered Dependent Child]]]	[Not Applicable]

[OUTPATIENT DIAGNOSTIC LAB TEST AND X-RAY INDEMNITY BENEFIT: [Included] [Not Included]

[PLAN 1]	[PLAN 2]	[PLAN 3]	[PLAN 4]	[PLAN 5]
[Not Applicable] [\$\$,XXX] per [day] [visit] [test] [Limited to [X] test per day] [[Calendar] [Plan] Year Maximum Benefit: [[X] [tests] [visits]] [\$\$,XXX]]]	[Not Applicable] [\$\$,XXX] per [day] [visit] [test] [Limited to [X] test per day] [[Calendar] [Plan] Year Maximum Benefit: [[X] [tests] [visits]] [\$\$,XXX]]]	[Not Applicable] [\$\$,XXX] per [day] [visit] [test] [Limited to [X] test per day] [[Calendar] [Plan] Year Maximum Benefit: [[X] [tests] [visits]] [\$\$,XXX]]]	[Not Applicable] [\$\$,XXX] per [day] [visit] [test] [Limited to [X] test per day] [[Calendar] [Plan] Year Maximum Benefit: [[X] [tests] [visits]] [\$\$,XXX]]]	[Not Applicable]

[OUTPATIENT DIAGNOSTIC ADVANCED STUDIES INDEMNITY BENEFIT: [Included] [Not Included]

[[PLAN 1]	[PLAN 2]	[PLAN 3]	[PLAN 4]	[PLAN 5]
[Not Applicable]	[Not Applicable]	[Not Applicable]	[Not Applicable]	[Not Applicable]
[\$X,XXX] per [day] [visit]				
[Advanced Study]	[Advanced Study]	[Advanced Study]	[Advanced Study]	
[Limited to [X]]	[Limited to [X]]	[Limited to [X]]	[Limited to [X]]	
Advanced Study per day]				
[[Calendar] [Plan] Year	[[Calendar] [Plan] Year	[[Calendar] [Plan] Year	[[Calendar] [Plan] Year	
Maximum Benefit: [[X]	Maximum Benefit: [[X]	Maximum Benefit: [[X]	Maximum Benefit: [[X]	
[Advanced Studies]	[Advanced Studies]	[Advanced Studies]	[Advanced Studies]	
[visits]] [[\$X,XXX]]	[visits]] [[\$X,XXX]]	[visits]] [[\$X,XXX]]	[visits]] [[\$X,XXX]]	

[INPATIENT SURGICAL INDEMNITY BENEFIT: [Included] [Not Included]

[[PLAN 1]	[PLAN 2]	[PLAN 3]	[PLAN 4]	[PLAN 5]
[Not Applicable] [Benefit is based on the Payment Factor shown in the Schedule of Surgical Indemnity Benefits in Section 5-Benefits, times the Surgical Procedural Units [XX]] [Benefit is [[XXX%] of the Medicare National Fee Schedule] [\$XX,XXX] per each Inpatient Surgery	[Not Applicable] [Benefit is based on the Payment Factor shown in the Schedule of Surgical Indemnity Benefits in Section 5-Benefits, times the Surgical Procedural Units [XX]] [Benefit is [[XXX%] of the Medicare National Fee Schedule] [\$XX,XXX] per each Inpatient Surgery	[Not Applicable] [Benefit is based on the Payment Factor shown in the Schedule of Surgical Indemnity Benefits in Section 5-Benefits, times the Surgical Procedural Units [XX]] [Benefit is [[XXX%] of the Medicare National Fee Schedule] [\$XX,XXX] per each Inpatient Surgery	[Not Applicable] [Benefit is based on the Payment Factor shown in the Schedule of Surgical Indemnity Benefits in Section 5-Benefits, times the Surgical Procedural Units [XX]] [Benefit is [[XXX%] of the Medicare National Fee Schedule] [\$XX,XXX] per each Inpatient Surgery	[[Not Applicable]]
[[Calendar] [Plan] Year	[[Calendar] [Plan] Year	[[Calendar] [Plan] Year	[[Calendar] [Plan] Year	
Maximum Benefit: [[X]	Maximum Benefit: [[X]	Maximum Benefit: [[X]	Maximum Benefit: [[X]	
Surgical Procedures]	Surgical Procedures]	Surgical Procedures]	Surgical Procedures]	
[\$XXX,XXX]]	[\$XXX,XXX]]	[\$XXX,XXX]]	[\$XXX,XXX]]	

[OUTPATIENT SURGICAL INDEMNITY BENEFIT: [Included] [Not Included]

[This Benefit is not paid if Benefits are paid under the Outpatient Minor Surgical Indemnity Benefit [or the Outpatient Venipuncture Indemnity Benefit]]

[[PLAN 1]	[PLAN 2]	[PLAN 3]	[PLAN 4]	[PLAN 5]
[Not Applicable] [Benefit is based on the Payment Factor shown in the Schedule of Surgical Indemnity Benefits in Section 5-Benefits, times the Surgical Procedural Units [XX]] [Benefit is [[XXX%] of the Medicare National Fee Schedule] [\$XX,XXX] per each Outpatient Surgery	[Not Applicable] [Benefit is based on the Payment Factor shown in the Schedule of Surgical Indemnity Benefits in Section 5-Benefits, times the Surgical Procedural Units [XX]] [Benefit is [[XXX%] of the Medicare National Fee Schedule] [\$XX,XXX] per each Outpatient Surgery	[Not Applicable] [Benefit is based on the Payment Factor shown in the Schedule of Surgical Indemnity Benefits in Section 5-Benefits, times the Surgical Procedural Units [XX]] [Benefit is [[XXX%] of the Medicare National Fee Schedule] [\$XX,XXX] per each Outpatient Surgery	[Not Applicable] [Benefit is based on the Payment Factor shown in the Schedule of Surgical Indemnity Benefits in Section 5-Benefits, times the Surgical Procedural Units [XX]] [Benefit is [[XXX%] of the Medicare National Fee Schedule] [\$XX,XXX] per each Outpatient Surgery	[Not Applicable]
[[Calendar] [Plan] Year	[[Calendar] [Plan] Year	[[Calendar] [Plan] Year	[[Calendar] [Plan] Year	
Maximum Benefit: [[X]	Maximum Benefit: [[X]	Maximum Benefit: [[X]	Maximum Benefit: [[X]	
Surgical procedures]	Surgical procedures]	Surgical procedures]	Surgical procedures]	
[\$XXX,XXX]]	[\$XXX,XXX]]	[\$XXX,XXX]]	[\$XXX,XXX]]	

[OUTPATIENT MINOR SURGICAL INDEMNITY BENEFIT: [Included] [Not Included]

[(This Benefit is not paid if Benefits are paid under the Outpatient Surgical Indemnity Benefit [or the Outpatient Venipuncture Indemnity Benefit])]

[[PLAN 1]	[PLAN 2]	[PLAN 3]	[PLAN 4]	[PLAN 5]
[Not Applicable]	[Not Applicable]	[Not Applicable]	[Not Applicable]	[Not Applicable]
[\$XX,XXX] per each	[\$XX,XXX] per each	[\$XX,XXX] per each	[\$XX,XXX] per each	
Outpatient Minor	Outpatient Minor	Outpatient Minor	Outpatient Minor	
Surgery	Surgery	Surgery	Surgery	
[[Calendar] [Plan] Year	[[Calendar] [Plan] Year	[[Calendar] [Plan] Year	[[Calendar] [Plan] Year	
Maximum Benefit: [[X]	Maximum Benefit: [[X]	Maximum Benefit: [[X]	Maximum Benefit: [[X]	
Minor Surgical	Minor Surgical	Minor Surgical	Minor Surgical	
procedures]	procedures]	procedures]	procedures]	
[\$XX,XXX]]]	[\$XX,XXX]]]	[\$XX,XXX]]]	[\$XX,XXX]]]	

[OUTPATIENT SURGERY FACILITY INDEMNITY BENEFIT: [Included] [Not Included]

[[PLAN 1]	[PLAN 2]	[PLAN 3]	[PLAN 4]	[PLAN 5]
[Not Applicable]	[Not Applicable]	[Not Applicable]	[Not Applicable]	[Not Applicable]
[\$XX,XXX] per each	[\$XX,XXX] per each	[\$XX,XXX] per each	[\$XX,XXX] per each	
Outpatient Surgery	Outpatient Surgery	Outpatient Surgery	Outpatient Surgery	
[[Calendar] [Plan] Year	[[Calendar] [Plan] Year	[[Calendar] [Plan] Year	[[Calendar] [Plan] Year	
Maximum Benefit: [[X]	Maximum Benefit: [[X]	Maximum Benefit: [[X]	Maximum Benefit: [[X]	
Surgical procedures]	Surgical procedures]	Surgical procedures]	Surgical procedures]	
[\$XXX,XXX]]]	[\$XXX,XXX]]]	[\$XXX,XXX]]]	[\$XXX,XXX]]]	

[OUTPATIENT VENIPUNCTURE INDEMNITY BENEFIT: [Included] [Not Included]

[(This Benefit is not paid if Benefits are paid under the Outpatient Surgical Indemnity Benefit [or the Outpatient Minor Surgical Indemnity Benefit])]

[[PLAN 1]	[PLAN 2]	[PLAN 3]	[PLAN 4]	[PLAN 5]
[Not Applicable]	[Not Applicable]	[Not Applicable]	[Not Applicable]	[Not Applicable]
[\$X,XXX] per each	[\$X,XXX] per each	[\$X,XXX] per each	[\$X,XXX] per each	
Outpatient Venipuncture	Outpatient Venipuncture	Outpatient Venipuncture	Outpatient Venipuncture	
procedure	procedure	procedure	procedure	
[[Calendar] [Plan] Year	[[Calendar] [Plan] Year	[[Calendar] [Plan] Year	[[Calendar] [Plan] Year	
Maximum Benefit: [[X]	Maximum Benefit: [[X]	Maximum Benefit: [[X]	Maximum Benefit: [[X]	
Outpatient Venipuncture	Outpatient Venipuncture	Outpatient Venipuncture	Outpatient Venipuncture	
procedures]	procedures]	procedures]	procedures]	
[\$XX,XXX]]]	[\$XX,XXX]]]	[\$XX,XXX]]]	[\$XX,XXX]]]	

[OUTPATIENT SURGERY FACILITY INDEMNITY BENEFIT, [OUTPATIENT SURGICAL INDEMNITY BENEFIT], [OUTPATIENT MINOR SURGICAL INDEMNITY BENEFIT] [and OUTPATIENT VENIPUNCTURE INDEMNITY BENEFIT]: Combined [[Calendar] [Plan] Year Maximum Benefit: [\$XXX,XXX]]

[DOCTOR VISIT WHILE HOSPITAL CONFINED INDEMNITY BENEFIT: [Included] [Not Included]

[[PLAN 1]	[PLAN 2]	[PLAN 3]	[PLAN 4]	[PLAN 5]
[Not Applicable] [\$XXX]	[Not Applicable] [\$XXX]	[Not Applicable] [\$XXX]	[Not Applicable] [\$XXX]	[Not Applicable]
per visit	per visit	per visit	per visit	
[Limited to [X] Inpatient				
Doctor visits per day]				
[[Calendar] [Plan] Year	[[Calendar] [Plan] Year	[[Calendar] [Plan] Year	[[Calendar] [Plan] Year	
Maximum Benefit: [[XX]	Maximum Benefit: [[XX]	Maximum Benefit: [[XX]	Maximum Benefit: [[XX]	
Inpatient days]	Inpatient days]	Inpatient days]	Inpatient days]	
[\$X,XXX] [[X] Inpatient	[\$X,XXX] [[X] Inpatient	[\$X,XXX] [[X] Inpatient	[\$X,XXX] [[X] Inpatient	
confinements]]]	confinements]]]	confinements]]]	confinements]]]	

[ANESTHESIOLOGY INDEMNITY BENEFIT: [Included] [Not Included]

[PLAN 1]	[PLAN 2]	[PLAN 3]	[PLAN 4]	[PLAN 5]
[Not Applicable] [\$X,XXX] per each Outpatient Surgery] [\$X,XXX] per each Inpatient Surgery] [Benefit is equal to [XX%] of the Benefit paid under the [Inpatient Surgical Indemnity Benefit] [or] [the Outpatient Surgical Indemnity Benefit] [or] [the Outpatient Minor Surgical Indemnity Benefit] [or] [the Outpatient Venipuncture Indemnity Benefit]] [[Calendar] [Plan] Year Maximum Benefit: [[XX] Inpatient and [[XX] Outpatient [combined] surgeries] [[\$XX,XXX]]]	[Not Applicable] [\$X,XXX] per each Outpatient Surgery] [\$X,XXX] per each Inpatient Surgery] [Benefit is equal to [XX%] of the Benefit paid under the [Inpatient Surgical Indemnity Benefit] [or] [the Outpatient Surgical Indemnity Benefit] [or] [the Outpatient Minor Surgical Indemnity Benefit] [or] [the Outpatient Venipuncture Indemnity Benefit]] [[Calendar] [Plan] Year Maximum Benefit: [[XX] Inpatient and [[XX] Outpatient [combined] surgeries] [[\$XX,XXX]]]	[Not Applicable] [\$X,XXX] per each Outpatient Surgery] [\$X,XXX] per each Inpatient Surgery] [Benefit is equal to [XX%] of the Benefit paid under the [Inpatient Surgical Indemnity Benefit] [or] [the Outpatient Surgical Indemnity Benefit] [or] [the Outpatient Minor Surgical Indemnity Benefit] [or] [the Outpatient Venipuncture Indemnity Benefit]] [[Calendar] [Plan] Year Maximum Benefit: [[XX] Inpatient and [[XX] Outpatient [combined] surgeries] [[\$XX,XXX]]]	[Not Applicable] [\$X,XXX] per each Outpatient Surgery] [\$X,XXX] per each Inpatient Surgery] [Benefit is equal to [XX%] of the Benefit paid under the [Inpatient Surgical Indemnity Benefit] [or] [the Outpatient Surgical Indemnity Benefit] [or] [the Outpatient Minor Surgical Indemnity Benefit] [or] [the Outpatient Venipuncture Indemnity Benefit]] [[Calendar] [Plan] Year Maximum Benefit: [[XX] Inpatient and [[XX] Outpatient [combined] surgeries] [[\$XX,XXX]]]	[[Not Applicable]]

[AMBULANCE INDEMNITY BENEFIT: [Included] [Not Included]

[PLAN 1]	[PLAN 2]	[PLAN 3]	[PLAN 4]	[PLAN 5]
[Not Applicable] [\$X,XXX] [per conveyance] [per [air] [ground] [water] conveyance] [[Calendar] [Plan] Year Maximum Benefit: [[X] conveyances] [[\$XX,XXX]]]	[Not Applicable] [\$X,XXX] [per conveyance] [per [air] [ground] [water] conveyance] [[Calendar] [Plan] Year Maximum Benefit: [[X] conveyances] [[\$XX,XXX]]]	[Not Applicable] [\$X,XXX] [per conveyance] [per [air] [ground] [water] conveyance] [[Calendar] [Plan] Year Maximum Benefit: [[X] conveyances] [[\$XX,XXX]]]	[Not Applicable] [\$X,XXX] [per conveyance] [per [air] [ground] [water] conveyance] [[Calendar] [Plan] Year Maximum Benefit: [[X] conveyances] [[\$XX,XXX]]]	[Not Applicable]

[OUTPATIENT PRESCRIPTION MEDICATION INDEMNITY BENEFIT: [Included] [Not Included]

[PLAN 1]	[PLAN 2]	[PLAN 3]	[PLAN 4]	[PLAN 5]
[Not Applicable] [(After Copayment: [\$XX] per each [Generic] [Brand] Prescription Medication)] [\$XX] per each [Generic] [Brand] Prescription Medication [Maximum Benefit per Coverage Month: [[X] [[XXX] [per each [Generic and Brand] [for all] Prescription Medications]] [[Calendar] [Plan] Year Maximum Benefit: [[XX] [\$X,XXX] [per each [Generic and Brand] [for all] Prescription Medications]] [No Coverage for Brand Medication]]]	[Not Applicable] [(After Copayment: [\$XX] per each [Generic] [Brand] Prescription Medication)] [\$XX] per each [Generic] [Brand] Prescription Medication [Maximum Benefit per Coverage Month: [[X] [[XXX] [per each [Generic and Brand] [for all] Prescription Medications]] [[Calendar] [Plan] Year Maximum Benefit: [[XX] [\$X,XXX] [per each [Generic and Brand] [for all] Prescription Medications]] [No Coverage for Brand Medication]]]	[Not Applicable] [(After Copayment: [\$XX] per each [Generic] [Brand] Prescription Medication)] [\$XX] per each [Generic] [Brand] Prescription Medication [Maximum Benefit per Coverage Month: [[X] [[XXX] [per each [Generic and Brand] [for all] Prescription Medications]] [[Calendar] [Plan] Year Maximum Benefit: [[XX] [\$X,XXX] [per each [Generic and Brand] [for all] Prescription Medications]] [No Coverage for Brand Medication]]]	[Not Applicable] [(After Copayment: [\$XX] per each [Generic] [Brand] Prescription Medication)] [\$XX] per each [Generic] [Brand] Prescription Medication [Maximum Benefit per Coverage Month: [[X] [[XXX] [per each [Generic and Brand] [for all] Prescription Medications]] [[Calendar] [Plan] Year Maximum Benefit: [[XX] [\$X,XXX] [per each [Generic and Brand] [for all] Prescription Medications]] [No Coverage for Brand Medication]]]	[Not Applicable]

[MAJOR ORGAN TRANSPLANT INDEMNITY BENEFIT: [Included] [Not Included]

[PLAN 1]	[PLAN 2]	[PLAN 3]	[PLAN 4]	[PLAN 5]
[Not Applicable] [Benefit Waiting Period: [None] [[XX] days] [\$XX,XXX] [per each Major Organ Transplant] [[per Eligible Person] [\$XX,XXX per Covered Dependent Spouse; [\$XX,XXX per Covered Dependent Child] [Lifetime Maximum Benefit While Insured:[\$XX,XXX]] [[X] Major Organ Transplants]]]	[Not Applicable] [Benefit Waiting Period: [None] [[XX] days] [\$XX,XXX] [per each Major Organ Transplant] [[per Eligible Person] [\$XX,XXX per Covered Dependent Spouse; [\$XX,XXX per Covered Dependent Child] [Lifetime Maximum Benefit While Insured:[\$XX,XXX]] [[X] Major Organ Transplants]]]	[Not Applicable] [Benefit Waiting Period: [None] [[XX] days] [\$XX,XXX] [per each Major Organ Transplant] [[per Eligible Person] [\$XX,XXX per Covered Dependent Spouse; [\$XX,XXX per Covered Dependent Child] [Lifetime Maximum Benefit While Insured:[\$XX,XXX]] [[X] Major Organ Transplants]]]	[Not Applicable] [Benefit Waiting Period: [None] [[XX] days] [\$XX,XXX] [per each Major Organ Transplant] [[per Eligible Person] [\$XX,XXX per Covered Dependent Spouse; [\$XX,XXX per Covered Dependent Child] [Lifetime Maximum Benefit While Insured:[\$XX,XXX]] [[X] Major Organ Transplants]]]	[Not Applicable]

[DURABLE MEDICAL EQUIPMENT INDEMNITY BENEFIT: [Included] [Not Included]

[PLAN 1]	[PLAN 2]	[PLAN 3]	[PLAN 4]	[PLAN 5]
[Not Applicable] [[XXXX] per each Durable Medical Equipment] [[Calendar] [Plan] Year Maximum Benefit: [\$XXX]]]	[Not Applicable] [[XXXX] per each Durable Medical Equipment] [[Calendar] [Plan] Year Maximum Benefit: [\$XXX]]]	[Not Applicable] [[XXXX] per each Durable Medical Equipment] [[Calendar] [Plan] Year Maximum Benefit: [\$XXX]]]	[Not Applicable] [[XXXX] per each Durable Medical Equipment] [[Calendar] [Plan] Year Maximum Benefit: [\$XXX]]]	[Not Applicable]

[LIMITED MEDICAL BENEFITS FOR YOUR COVERED DEPENDENTS

[FIRST DAY HOSPITAL ADMISSION INDEMNITY BENEFIT: This Benefit is payable only once in a single sum for any period of Inpatient confinement.	[Included] [Not Included] [\$X,XXX] [[Calendar] [Plan] Year Maximum Benefit: [\$X,XXX]] [[Calendar] [Plan] Year Maximum Benefit: [X] Confinements]]]
[Hospital Inpatient Daily Indemnity Benefit: [Does not include [Mental Illness Disorders] [Substance Abuse] [Inpatient Skilled Nursing Facility]]]	[Included] [Not Included] [\$X,XXX] per day [[Calendar] [Plan] Year Maximum Benefit: [[XX] Inpatient days] [[XXX,XXX] [[X] Inpatient confinements] [Lifetime Maximum Benefit While Insured: [[XXX] Inpatient days] [[X,XXX,XXX]]]
[Daily Hospital Intensive Care Unit Indemnity Benefit: [Does not include [Mental Illness Disorders] [Substance Abuse] [Inpatient Skilled Nursing Facility]]]	[Included] [Not Included] [Double] the Hospital Inpatient Daily Indemnity Benefit above [[X,XXX] per day] [[Calendar] [Plan] Year Maximum Benefit: [[XX] Inpatient days] [[XXX,XXX] [[X] Inpatient confinements] [Lifetime Maximum Benefit While Insured: [[XXX] Inpatient days] [[X,XXX,XXX]]]
[Inpatient Mental Illness Disorders Indemnity Benefit: [(Other Inpatient Indemnity Benefits are not payable):]	[Included] [Not Included] [[XX] of the Hospital Inpatient Daily Indemnity Benefit above] [[X,XXX] per day] [[Calendar] [Plan] Year Maximum Benefit: [[XX] Inpatient days] [[XXX,XXX] [[X] Inpatient confinements] [Lifetime Maximum Benefit While Insured: [[XXX] Inpatient days] [[X,XXX,XXX]]]

<p>[Inpatient Substance Abuse Indemnity Benefit: [(Other Inpatient Indemnity Benefits are not payable)]</p>	<p>[Included] [Not Included] [[XX] of the Hospital Inpatient Daily Indemnity Benefit] [[\$X,XXX] per day] [[Calendar] [Plan] Year Maximum Benefit: [[XX] Inpatient days] [[\$XXX,XXX] [[X] Inpatient confinements] [Lifetime Maximum Benefit While Insured: [[XXX] Inpatient days] [[\$X,XXX,XXX]]]</p>
<p>[Inpatient Skilled Nursing Facility Indemnity Benefit:</p>	<p>[Included] [Not Included] [[XX] of the Hospital Inpatient Daily Indemnity Benefit above] [[\$X,XXX] per day] [[Calendar] [Plan] Year Maximum Benefit: [[XX] Inpatient days] [[\$XXX,XXX] [[X] Inpatient confinements] [Lifetime Maximum Benefit While Insured: [[XXX] Inpatient days] [[\$X,XXX,XXX]]]</p>
<p>[[Miscellaneous Inpatient Hospital Services Indemnity Benefit: [Benefit is not included unless Hospital Inpatient Daily Indemnity Benefit is included.]</p>	<p>[Included] [Not Included] [\$XXX] per day [[Calendar] [Plan] Year Maximum Benefit: [[XX] Inpatient days] [[\$XXX,XXX] [[X] Inpatient confinements]]]</p>
<p>[[FIRST DAY HOSPITAL ADMISSION] [HOSPITAL INPATIENT DAILY INDEMNITY BENEFIT] [DAILY HOSPITAL INTENSIVE CARE UNIT INDEMNITY BENEFIT] [INPATIENT MENTAL ILLNESS DISORDERS INDEMNITY BENEFIT] [INPATIENT SUBSTANCE ABUSE INDEMNITY BENEFIT] [INPATIENT SKILLED NURSING FACILITY INDEMNITY BENEFIT] [and] [MISCELLANEOUS INPATIENT HOSPITAL SERVICES INDEMNITY BENEFIT] Combined [[Calendar] [Plan] Year Maximum Benefit: [\$X,XXX,XXX]] [Lifetime Maximum Benefit While Insured: [[\$X,XXX,XXX]]]</p>	
<p>[Emergency Room Visit Indemnity Benefit [(Illness Only)]:</p>	<p>[Included] [Not Included] [\$X,XXX] per visit [[Calendar] [Plan] Year Maximum Benefit: [[X] visits] [[\$XX,XXX]]]</p>
<p>[Doctor's Initial Office Visit Indemnity Benefit: [This Benefit is payable only once per each separate Illness or Injury]]</p>	<p>[Included] [Not Included] [\$XXX] per visit [[Calendar] [Plan] Year Maximum Benefit: [[[\$X,XXX] [[XX] initial visits per Covered Dependent Spouse, and [XX] initial visits per Covered Dependent Child]]]</p>
<p>[Doctor's Office Visits Indemnity Benefit:</p>	<p>[Included] [Not Included] [\$XXX] per visit [[Calendar] [Plan] Year Maximum Benefit: [[[\$X,XXX] [[X] visits per Covered Dependent Spouse, and [XX] initial visits per Covered Dependent Child]]]</p>
<p>[Preventive Care Indemnity Benefit:</p>	<p>[Included] [Not Included] [\$XXX] per visit [[Calendar] [Plan] Year Maximum Benefit: [[[\$X,XXX] [[X] visits per Covered Dependent Spouse, and [XX] initial visits per Covered Dependent Child]]]</p>
<p>[Outpatient Diagnostic Lab Test and X-Ray Indemnity Benefit:</p>	<p>[Included] [Not Included] [\$X,XXX] per [day] [visit] [test] [Limited to [X] test per day] [[Calendar] [Plan] Year Maximum Benefit: [[X] [tests] [visits]] [[\$X,XXX]]]</p>
<p>[Outpatient Diagnostic Advanced Studies Indemnity Benefit:</p>	<p>[Included] [Not Included] [\$X,XXX] per [day] [visit] [Advanced Study] [Limited to [X] Advanced Study per day] [[Calendar] [Plan] Year Maximum Benefit: [[X] [Advanced Studies] [visits]] [[\$X,XXX]]]</p>

<p>[Inpatient Surgical Indemnity Benefit:</p>	<p>[Included] [Not Included] [Benefit is based on the Payment Factor shown in the Schedule of Surgical Indemnity Benefits in Section 5-Benefits, times the Surgical Procedural Units [XX]] [Benefit is [[XXX%] of the Medicare National Fee Schedule] [\$XX,XXX] per each Inpatient Surgery [[Calendar] [Plan] Year Maximum Benefit: [[X] Surgical Procedures] [[XXX,XXX]]</p>
<p>[Outpatient Surgical Indemnity Benefit: [This Benefit is not paid if Benefits are paid under the Outpatient Minor Surgical Indemnity Benefit [or the Outpatient Venipuncture Indemnity Benefit]]</p>	<p>[Included] [Not Included] [Benefit is based on the Payment Factor shown in the Schedule of Surgical Indemnity Benefits in Section 5-Benefits, times the Surgical Procedural Units [XX]] [Benefit is [[XXX%] of the Medicare National Fee Schedule] [\$XX,XXX] per each Outpatient Surgery [[Calendar] [Plan] Year Maximum Benefit: [[X] Surgical procedures] [[XXX,XXX]]]</p>
<p>[Outpatient Minor Surgical Indemnity Benefit: [(This Benefit is not paid if Benefits are paid under the Outpatient Surgical Indemnity Benefit [or the Outpatient Venipuncture Indemnity Benefit])]</p>	<p>[Included] [Not Included] [\$XX,XXX] per each Outpatient Minor Surgery [[Calendar] [Plan] Year Maximum Benefit: [[X] Minor Surgical procedures] [[XX,XXX]]]</p>
<p>[Outpatient Surgery Facility Indemnity Benefit:</p>	<p>[Included] [Not Included] [\$XX,XXX] per each Outpatient Surgery [[Calendar] [Plan] Year Maximum Benefit: [[X] Surgical procedures] [[XXX,XXX]]]</p>
<p>[Outpatient Venipuncture Indemnity Benefit: [(This Benefit is not paid if Benefits are paid under the Outpatient Surgical Indemnity Benefit [or the Outpatient Minor Surgical Indemnity Benefit])]</p>	<p>[Included] [Not Included] [\$X,XXX] per each Outpatient Venipuncture procedure [[Calendar] [Plan] Year Maximum Benefit: [[X] Outpatient Venipuncture procedures] [[XX,XXX]]]</p>
<p>[Outpatient Surgery Facility Indemnity Benefit, [Outpatient Surgical Indemnity Benefit,] [Outpatient Minor Surgical Indemnity Benefit] [and Outpatient Venipuncture Indemnity Benefit]: Combined [[Calendar] [Plan] Year Maximum Benefit: [XXX,XXX]]</p>	
<p>[Doctor Visit While Hospital Confined Indemnity Benefit:</p>	<p>[Included] [Not Included] [\$XXX] per visit [Limited to [X] Inpatient Doctor visits per day] [[Calendar] [Plan] Year Maximum Benefit: [[XX] Inpatient days] [[X,XXX] [[X] Inpatient confinements]]]</p>
<p>[Anesthesiology Indemnity Benefit:</p>	<p>[Included] [Not Included] [[X,XXX] per each Outpatient Surgery] [[X,XXX] per each Inpatient Surgery] [Benefit is equal to [XX%] of the Benefit paid under the [Inpatient Surgical Indemnity Benefit] [or] [the Outpatient Surgical Indemnity Benefit] [or] [the Outpatient Minor Surgical Indemnity Benefit] [or] [the Outpatient Venipuncture Indemnity Benefit]] [[Calendar] [Plan] Year Maximum Benefit: [[XX] Inpatient and [[XX] Outpatient [combined] surgeries] [[XX,XXX]]]</p>
<p>[Ambulance Indemnity Benefit:</p>	<p>[Included] [Not Included] [\$X,XXX] [per conveyance] [per [air] [ground] [water] conveyance] [[Calendar] [Plan] Year Maximum Benefit: [[X] conveyances] [[XX,XXX]]]</p>

[Outpatient Prescription Medication Indemnity Benefit: [(After Copayment: [\$XX] per each [Generic] [Brand] Prescription Medication)]	[Included] [Not Included] [No Coverage for Brand Medication] [\$XX] per each [Generic] [Brand] Prescription Medication [Maximum Benefit per Coverage Month: [[X] [[XXX] [per each [Generic and Brand] [for all] Prescription Medications]] [[Calendar] [Plan] Year Maximum Benefit: [[XX] [[X,XXX] [per each [Generic and Brand] [for all] Prescription Medications]]]
[Major Organ Transplant Indemnity Benefit:	[Included] [Not Included] [Benefit Waiting Period: [None] [[XX] days] [\$XX,XXX] [per each Major Organ Transplant] [[XX,XXX per Covered Dependent Spouse; [\$XX,XXX per Covered Dependent Child] [Lifetime Maximum Benefit While Insured:[\$XX,XXX]] [[X] Major Organ Transplants]]]
[Durable Medical Equipment Indemnity Benefit:	[Included] [Not Included] [[XXX] per each Durable Medical Equipment] [[Calendar] [Plan] Year Maximum Benefit: [[XXX]]]

[[OPTIONAL] BENEFIT RIDERS]

[TERM LIFE INSURANCE BENEFIT RIDER [Included] [Not Included]

[Term Life Insurance Benefit – For You

[[PLAN 1]	[PLAN 2]	[PLAN 3]	[PLAN 4]	[PLAN 5]
Term Life Insurance Benefit: [Not Covered] [\$XXX,XXX]	[Not Applicable]			

[Reduction of Benefits: Benefits reduce due to age: The Term Life Insurance Benefits reduce [XX]% of the original Benefit amount upon attainment of age [XX], and by an additional [XX]% each five year period thereafter.]

[Term Life Insurance Benefit – For Your Covered Dependents

[[PLAN 1]	[PLAN 2]	[PLAN 3]	[PLAN 4]	[PLAN 5]
[Dependent Spouse Term Life Insurance Benefit Amount: [Not Covered] [[XXX,XXX] [[XX] of Eligible Person's Term Life Insurance Benefit Amount]]	[Dependent Spouse Term Life Insurance Benefit Amount: [Not Covered] [[XXX,XXX] [[XX] of Eligible Person's Term Life Insurance Benefit Amount]]	[Dependent Spouse Term Life Insurance Benefit Amount: [Not Covered] [[XXX,XXX] [[XX] of Eligible Person's Term Life Insurance Benefit Amount]]	[Dependent Spouse Term Life Insurance Benefit Amount: [Not Covered] [[XXX,XXX] [[XX] of Eligible Person's Term Life Insurance Benefit Amount]]	[Not Applicable]
[Dependent Child Term Life Insurance Benefit Amount: [Not Covered] [[XX,XXX] [[XX] of Eligible Person's Term Life Insurance Benefit Amount]]]	[Dependent Child Term Life Insurance Benefit Amount: [Not Covered] [[XX,XXX] [[XX] of Eligible Person's Term Life Insurance Benefit Amount]]]	[Dependent Child Term Life Insurance Benefit Amount: [Not Covered] [[XX,XXX] [[XX] of Eligible Person's Term Life Insurance Benefit Amount]]]	[Dependent Child Term Life Insurance Benefit Amount: [Not Covered] [[XX,XXX] [[XX] of Eligible Person's Term Life Insurance Benefit Amount]]]	

[ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFIT RIDER [Included] [Not Included]

[Accidental Death and Dismemberment Insurance Benefit – For You

[[PLAN 1]	[PLAN 2]	[PLAN 3]	[PLAN 4]	[PLAN 5] [Not Applicable]
Accidental Death and Dismemberment Insurance Benefit				
Principal Sum: [Not Covered]				
[\$XXX,XXX]]	[\$XXX,XXX]]	[\$XXX,XXX]]	[\$XXX,XXX]]	

[Reduction of Benefits: Benefits reduce due to age: The Principal Sum for Accidental Death and Dismemberment Insurance benefit will be reduced [XX]% of the original Benefit amount upon attainment of age [XX], and by an additional [XX]% each five year period thereafter.]

[Accidental Death and Dismemberment Insurance Benefit – For Your Covered Dependents

[[PLAN 1]	[PLAN 2]	[PLAN 3]	[PLAN 4]	[PLAN 5] [Not Applicable]
[Dependent Spouse	[Dependent Spouse	[Dependent Spouse	[Dependent Spouse	
Accidental Death and Dismemberment Insurance Benefit				
Amount: [Not Covered]	Amount: [Not Covered]	Amount: [Not Covered]	Amount: [Not Covered]	
[\$XXX,XXX]] [[XX] of Eligible Person's				
Accidental Death and Dismemberment Insurance Benefit Amount]]				
[Dependent Child	[Dependent Child	[Dependent Child	[Dependent Child	
Accidental Death and Dismemberment Insurance Benefit				
Amount: [Not Covered] [\$XX,XXX]]				
[[XX] of [Eligible Person's Term Life Insurance Benefit Amount]]]	[[XX] of [Eligible Person's Term Life Insurance Benefit Amount]]]	[[XX] of [Eligible Person's Term Life Insurance Benefit Amount]]]	[[XX] of [Eligible Person's Term Life Insurance Benefit Amount]]]	

[NON-OCCUPATIONAL WEEKLY DISABILITY INCOME INSURANCE BENEFIT RIDER [Included] [Not Included]
NON-OCCUPATIONAL WEEKLY DISABILITY INCOME INSURANCE BENEFITS – FOR YOU

[[PLAN 1]	[PLAN 2]	[PLAN 3]	[PLAN 4]	[PLAN 5] [Not Applicable]
Benefit: [XXX%] of the Basic Weekly Earnings to a Maximum Benefit of [\$X,XXX] per week rounded to the next \$1.	Benefit: [XXX%] of the Basic Weekly Earnings to a Maximum Benefit of [\$X,XXX] per week rounded to the next \$1.	Benefit: [XXX%] of the Basic Weekly Earnings to a Maximum Benefit of [\$X,XXX] per week rounded to the next \$1.	Benefit: [XXX%] of the Basic Weekly Earnings to a Maximum Benefit of [\$X,XXX] per week rounded to the next \$1.	
[Benefit Waiting Period: [None] [X,XXX] days.]]				
[Benefits begin on the [X th ,] [[XX th] day.]	[Benefits begin on the [X th ,] [[XX th] day.]	[Benefits begin on the [X th ,] [[XX th] day.]	[Benefits begin on the [X th ,] [[XX th] day.]	
[Maximum Period of Weekly Disability Benefit: [XX] weeks]	[Maximum Period of Weekly Disability Benefit: [XX] weeks]	[Maximum Period of Weekly Disability Benefit: [XX] weeks]	[Maximum Period of Weekly Disability Benefit: [XX] weeks]	

[Basic Weekly Earnings – means Your weekly earnings, excluding commissions, bonuses, incentive pay, unscheduled overtime or other compensation earned from the Policyholder in the prior Policy Year or during the period worked, whichever is less. The amount will be updated on the Policy Anniversary date, as specified in the Policy, each year thereafter.]]

[CRITICAL CARE INDEMNITY BENEFIT RIDER [Included] [Not Included]

[Critical Care Indemnity Benefit – For You

[[PLAN 1]	[PLAN 2]	[PLAN 3]	[PLAN 4]	[PLAN 5] [Not Applicable]
[Not Covered] [First Occurrence [[X st] through [XX th] day Benefit: [\$XX,XXX]]	[Not Covered] [First Occurrence [[X st] through [XX th] day Benefit: [\$XX,XXX]]	[Not Covered] [First Occurrence [[X st] through [XX th] day Benefit: [\$XX,XXX]]	[Not Covered] [First Occurrence [[X st] through [XX th] day Benefit: [\$XX,XXX]]	
First Occurrence Benefit: [\$XX,XXX] [First Occurrence Benefit for Heart Bypass: [[XX%] of First Occurrence Benefit] [\$XX,XXX]]	First Occurrence Benefit: [\$XX,XXX] [First Occurrence Benefit for Heart Bypass: [[XX%] of First Occurrence Benefit] [\$XX,XXX]]	First Occurrence Benefit: [\$XX,XXX] [First Occurrence Benefit for Heart Bypass: [[XX%] of First Occurrence Benefit] [\$XX,XXX]]	First Occurrence Benefit: [\$XX,XXX] [First Occurrence Benefit for Heart Bypass: [[XX%] of First Occurrence Benefit] [\$XX,XXX]]	
[First Occurrence Benefit for Cancer In-Situ: [[XX%] of First Occurrence Benefit] [\$XX,XXX]]	[First Occurrence Benefit for Cancer In-Situ: [[XX%] of First Occurrence Benefit] [\$XX,XXX]]	[First Occurrence Benefit for Cancer In-Situ: [[XX%] of First Occurrence Benefit] [\$XX,XXX]]	[First Occurrence Benefit for Cancer In-Situ: [[XX%] of First Occurrence Benefit] [\$XX,XXX]]	
[First Occurrence Maximum Benefit: [\$XXX,XXX]]				

[Critical Care Indemnity Benefit – For Your Covered Dependents

[[PLAN 1]	[[PLAN 2]	[[PLAN 3]	[[PLAN 4]	[[PLAN 5] [Not Applicable]]
[Dependent Spouse First Occurrence [[X st] through [XX th] day: Benefit: [\$XX,XXX] [[XX%] of Eligible Person's First Occurrence Benefit]]	[Dependent Spouse First Occurrence [[X st] through [XX th] day: Benefit: [\$XX,XXX] [[XX%] of Eligible Person's First Occurrence Benefit]]	[Dependent Spouse First Occurrence [[X st] through [XX th] day: Benefit: [\$XX,XXX] [[XX%-XX] of Eligible Person's First Occurrence Benefit]]	[Dependent Spouse First Occurrence [[X st] through [XX th] day: Benefit: [\$XX,XXX] [[XX%-XX] of Eligible Person's First Occurrence Benefit]]	
[Dependent Spouse First Occurrence Benefit: [\$XX,XXX] [[XX%] of Eligible Person's First Occurrence Benefit]]	[Dependent Spouse First Occurrence Benefit: [\$XX,XXX] [[XX%] of Eligible Person's First Occurrence Benefit]]	[Dependent Spouse First Occurrence Benefit: [\$XX,XXX] [[XX%] of Eligible Person's First Occurrence Benefit]]	[Dependent Spouse First Occurrence Benefit: [\$XX,XXX] [[XX%] of Eligible Person's First Occurrence Benefit]]	
[Dependent Spouse First Occurrence Maximum Benefit: [\$XXX,XXX]]	[Dependent Spouse First Occurrence Maximum Benefit: [\$XXX,XXX]]	[Dependent Spouse First Occurrence Maximum Benefit: [\$XXX,XXX]]	[Dependent Spouse First Occurrence Maximum Benefit: [\$XXX,XXX]]	
[Dependent Child First Occurrence [[X st] through [XX th] day: Benefit: [\$XX,XXX] [[XX%] of Eligible Person's First Occurrence Benefit]]	[Dependent Child First Occurrence [[X st] through [XX th] day: Benefit: [\$XX,XXX] [[XX%] of Eligible Person's First Occurrence Benefit]]	[Dependent Child First Occurrence [[X st] through [XX th] day: Benefit: [\$XX,XXX] [[XX%] of Eligible Person's First Occurrence Benefit]]	[Dependent Child First Occurrence [[X st] through [XX th] day: Benefit: [\$XX,XXX] [[XX%] of Eligible Person's First Occurrence Benefit]]	
[Dependent Child First Occurrence Benefit: [\$XX,XXX] [[XX%] of Eligible Person's First Occurrence Benefit]]	[Dependent Child First Occurrence Benefit: [\$XX,XXX] [[XX%] of Eligible Person's First Occurrence Benefit]]	[Dependent Child First Occurrence Benefit: [\$XX,XXX] [[XX%] of Eligible Person's First Occurrence Benefit]]	[Dependent Child First Occurrence Benefit: [\$XX,XXX] [[XX%] of Eligible Person's First Occurrence Benefit]]	
[Dependent Child First Occurrence Maximum Benefit: [\$XX,XXX]]	[Dependent Child First Occurrence Maximum Benefit: [\$XX,XXX]]	[Dependent Child First Occurrence Maximum Benefit: [\$XX,XXX]]	[Dependent Child First Occurrence Maximum Benefit: [\$XX,XXX]]	

[ACCIDENT EXPENSE BENEFIT RIDER [Included [- See Attached Rider]] [Not Included]]

[DENTAL BENEFIT RIDER [Included] [Not Included]

[Dental Benefits – For You [Not Covered]]

[Plan [1] [2] [3] [4]]

[[Calendar] [Plan] Year Dental Deductible [per Covered Person]: [\$XXX] [Preventive Care: \$XX] [Basic Care, Major Care, [and Orthodontia [and Prosthodontics] [(combined): [\$XXX]]]

[[Calendar] [Plan] Year Dental Deductible Family Maximum: [\$XXX] [[X] per family]]

[[Calendar] [Plan] Year Maximum Benefit [per Covered Person]: [\$X,XXX] [\$X,XXX [Preventive Care, Basic Care, Major Care [and Orthodontia [and Prosthodontics] [(combined)] [Orthodontia: [\$X,XXX]]]

[[Lifetime Maximum Benefit While Insured: [\$X,XXX] [\$X,XXX] Orthodontia]]

[Dental Benefit Waiting Period:
[Preventive Care (Type 1): [None] [[XX] Months]
[Basic Care (Type 2): [None] [[XX] Months]]
[Major Care (Type 3): [None] [[XX] Months]]
[Orthodontia (Type 4) [and Prosthodontics]: [None] [[XX] Months]]

[Covered Dental Procedures: Dental Coinsurance Percentage: [XX%]
[Preventive Care: [XX%]
[Basic Care: [XX%]
[Major Care: [XX%]
[Orthodontia [for Covered [Dependent Children] [Persons] under age [XX]] [and Prosthodontics] [XX%]]

[Predetermination of Benefits: Predetermination Amount: [Not Applicable] [\$100-\$500]]]]

[Dental Benefits – For Your Covered Dependents

[Plan [1] [2] [3] [4]]

[[Calendar] [Plan] Year Dental Deductible per Covered Dependent: [\$XXX] [Preventive Care: \$X] [Basic Care, Major Care, [and Orthodontia [and Prosthodontics] [(combined): [\$XXX]]]

[[Calendar] [Plan] Year Dental Deductible Family Maximum: [\$XXX] [[X] per family]]

[[Calendar] [Plan] Year Maximum Benefit per Covered Dependent: [\$X,XXX] [\$X,XXX [Preventive Care, Basic Care, Major Care [and Orthodontia [and Prosthodontics] [(combined)] [Orthodontia: [\$X,XXX]]]

[[Lifetime Maximum Benefit While Insured: [\$X,XXX] [\$X,XXX] Orthodontia]]

[Dental Benefit Waiting Period:
[Preventive Care (Type 1): [None] [[XX] Months]
[Basic Care (Type 2): [None] [[XX] Months]]
[Major Care (Type 3): [None] [[XX] Months]]
[Orthodontia (Type 4) [and Prosthodontics]: [None] [[XX] Months]]

[Covered Dental Procedures: Dental Coinsurance Percentage: [XXX%]
[Preventive Care: [XXX%]
[Basic Care: [XXX%]
[Major Care: [XXX%]
[Orthodontia [for Covered [Dependent Children] [XXX%]]

[Persons] under age [XX] [and Prosthodontics] [XXX%]

[Predetermination of Benefits: Predetermination Amount: [Not Applicable] [\$XXX]]

[Dental Benefits – PPO Dental Plan [– For You [Not Covered]]

[Plan [1] [2] [3] [4]]

[[Calendar] [Plan] Year Dental Deductible [per Covered Person]: **In-Network:** [\$XXX] [Preventive Care: [\$XXX]] [Basic Care, Major Care, [and Orthodontia [and Prosthodontics] [(combined): [\$X,XXX]]]

Out-of-Network: [\$XXX] [Preventive Care: [\$XXX]] [Basic Care, Major Care, [and Orthodontia [and Prosthodontics] [(combined): [\$XXX]]]

[[Calendar] [Plan] Year Dental Deductible Family Maximum: **In-Network:** [\$XXX] [[X] per family]]

Out-of-Network: [\$X,XXX] [[X] per family]]

[[Calendar] [Plan] Year Maximum Benefit [per Covered Person]: **[In-Network:]** [\$X,XXX] [\$X,XXX] [Preventive Care, Basic Care, Major Care [and Orthodontia [and Prosthodontics] [(combined)] [Orthodontia: [\$X,XXX]]]

[Out-of-Network: [\$X,XXX] [\$X,XXX] [Preventive Care, Basic Care, Major Care [and Orthodontia [and Prosthodontics] [(combined)] [Orthodontia: [\$X,XXX]]]

[[Lifetime Maximum Benefit While Insured: [\$X,XXX] [\$X,XXX] Orthodontia]]

[Dental Benefit Waiting Period: [None] [[XX] Months]
[Preventive Care (Type 1): [None] [[XX] Months]]
[Basic Care (Type 2): [None] [[XX] Months]]
[Major Care (Type 3): [None] [[XX] Months]]
[Orthodontia (Type 4) [and Prosthodontics]: [None] [[XX] Months]]

	[In-Network:	Out-of-Network:]
[Covered Dental Procedures: Dental Coinsurance Percentage:	[XXX%]	[XXX%]
[Preventive Care:	[XXX%]	[XXX%]
[Basic Care:	[XXX%]	[XXX%]
[Major Care:	[XXX%]	[XXX%]
[Orthodontia [for Covered [Dependent Children] [Persons] under age [XX] [and Prosthodontics]	[XXX%]	[XXX%]

[Predetermination of Benefits: Predetermination Amount: [Not Applicable] [\$XXX]]

[Dental Benefits – PPO Dental Plan – For Your Covered Dependents

[Plan [1] [2] [3] [4]]

[[Calendar] [Plan] Year Dental Deductible Covered Dependent: **In-Network:** [\$XXX] [Preventive Care: [\$XXX]] per [Basic Care, Major Care, [and Orthodontia [and Prosthodontics] [(combined): [\$XXX]]]

Out-of-Network: [\$XXX] [Preventive Care: [\$XXX]] [Basic Care, Major Care, [and Orthodontia [and Prosthodontics] [(combined): [\$XXX]]]

[[Calendar] [Plan] Year Dental Deductible Family Maximum: **In-Network:** [\$XXX] [[X] per family]
Out-of-Network: [\$X,XXX] [[X] per family]]

[[Calendar] [Plan] Year Maximum Benefit per Covered Dependent: **[In-Network:]** [\$X,XXX] [\$X,XXX]
 [Preventive Care, Basic Care, Major Care [and Orthodontia [and Prosthodontics] [(combined)]
 [Orthodontia: [\$X,XXX]]

[Out-of-Network: [\$X,XXX] [\$X,XXX] [Preventive Care, Basic Care, Major Care [and Orthodontia [and Prosthodontics] [(combined)] [Orthodontia: [\$X,XXX]]

[[Lifetime Maximum Benefit While Insured: [\$X,XXX] [\$X,XXX] Orthodontia]]

[Dental Benefit Waiting Period: [None] [[XX] Months]
 [Preventive Care (Type 1): [None] [[XX] Months]]
 [Basic Care (Type 2): [None] [[XX] Months]]
 [Major Care (Type 3): [None] [[XX] Months]]
 [Orthodontia (Type 4) [and Prosthodontics]: [None] [[XX] Months]]

	[In-Network:	Out-of-Network:]
[Covered Dental Procedures: Dental Coinsurance Percentage:	[XXX%]	[XXX%]
[Preventive Care:	[XXX%]	[XXX%]
[Basic Care:	[XXX%]	[XXX%]
[Major Care:	[XXX%]	[XXX%]
[Orthodontia [for Covered [Dependent Children] [Persons] under age [XX]] [and Prosthodontics]	[XXX%]	[XXX%]

[Predetermination of Benefits: Predetermination Amount: [Not Applicable] [\$XXX]]

[VISION BENEFIT RIDER [Included] [Not Included]
Vision Benefits [- For You [Not Covered]]
[Plan [1] [2] [3] [4]]

Vision Coinsurance Percentage
 [Per Covered Person] for Covered Vision Charges: [XXX%]

[[Calendar] [Plan] Year Maximum Benefit [per Covered Person]: [\$X,XXX]]

[Routine Eye Examinations Limit [per Covered Person]: [X] examination in [any [X] consecutive month period] [each [Calendar] [Plan] Year]]

[Eyeglasses or Contact Lenses Limit [per Covered Person]: [X] pair of eyeglasses or [X] pair of contact lenses [in any [XX] consecutive month period] [every XX [Calendar] [Plan] Years]]

**[Vision Benefits – For Your Covered Dependents
[Plan [1] [2] [3] [4]]**

Vision Coinsurance Percentage

Per Covered Dependent for Covered Vision Charges: [XXX%]

[[Calendar] [Plan] Year Maximum Benefit per Covered Dependent: [\$X,XXX]]

[Routine Eye Examinations Limit per Covered Dependent: [X] examination in [any [X] consecutive month period]
[each [Calendar] [Plan] Year]]

[Eyeglasses or Contact Lenses Limit per Covered Dependent: [X] pair of eyeglasses or [X] pair of contact lenses [in
in any [XX] Consecutive Month Period any [XX] consecutive month period] [every XX
[Calendar] [Plan] Years]]]

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.
[P.O. Box 5008, Madison, WI 53705]

GROUP LIMITED BENEFIT HEALTH INSURANCE EMPLOYER APPLICATION

A. EMPLOYER NAME

	Tax ID # _____
Street Address _____	Contact Name _____
City _____ State _____ ZIP _____	Address _____
P.O. Box _____	_____
City _____ State _____ ZIP _____	Telephone () _____
[Industry _____]	Email Address _____
[Section 125 ____ Yes ____ No]	Fax Number () _____

B. ELIGIBILITY INFORMATION

1. TOTAL NUMBER OF [ELIGIBLE] EMPLOYEES [not including contract staff [and retirees]] AT ALL LOCATIONS (including those not applying for Coverage under this plan): _____

2. REQUESTED EFFECTIVE DATE: _____

3. EMPLOYER CONTRIBUTION: _____
[% of the Employee [contract staff and retirees] cost paid by the Employer _____]
[% of the Dependent's cost paid by the Employer _____]

- [4. All Domestic Partners Eligible: Yes No]

- [5. Same Sex Domestic Partners Eligible and Opposite Sex Domestic Partners Not Eligible: Yes No]

- [6.] Are there any employees currently absent due to illness or injury, family medical leave or receiving disability benefits?
 Yes No
If yes, provide names and details:

- [7. COVERAGE WAITING PERIOD FOR SALARIED EMPLOYEES:
 None 30 60 90 180 days of continuous employment]

- [8. The Coverage Waiting Period selected for Salaried Employees will apply to:
 Employees hired after the effective date All current and future employees]

- [9. COVERAGE WAITING PERIOD FOR HOURLY EMPLOYEES:
 None 30 60 90 180 days of continuous employment]

- [10. The Coverage Waiting Period selected for Hourly Employees will apply to:
 Employees hired after the effective date All current and future employees]

- [11. OPEN ENROLLMENT PERIOD:
 None 31 days prior to the Policy Anniversary Date Other _____]

- [12. HOUR BANK REQUESTED FOR HOURLY EMPLOYEES (if applicable):
 40 80 100 120 130 140 160 180 Other _____]

C. **COVERAGE INFORMATION** (Coverage is not in effect until approved by the Company, subject to Eligible Person and Dependent Eligibility and Effective Date Requirements):

BENEFIT DESCRIPTION	[PLAN 1] [1 to 15 Hours]	[PLAN 2] [16 to 22 Hours]	[PLAN 3] [23 to 32 Hours]	[PLAN 4] [33 or more Hours]	[PLAN 5] [Waived Class]	[PLAN 6] [Dependents]
<u>BENEFIT [(Basic)] [(Required)]</u>						
[Hospital Inpatient Daily Indemnity Benefit Amount:	[N/A] [\$300]	[N/A] [\$500]	[N/A] [\$800]	[N/A] [\$1,000]	[N/A]	[N/A] [\$500]
[Daily Hospital Intensive Care Indemnity Benefit Amount:	[N/A] [\$300]	[N/A] [\$500]	[N/A] [\$800]	[N/A] [\$1,000]	[N/A]	[N/A] [\$500]
[Doctor's Office Visits Indemnity Benefit Amount/(Maximum):	[N/A] [[\$300]/ [\$1,000]]	[N/A] [[\$500]/ [\$1,000]]	[N/A] [[\$800] / [\$1,500]]	[N/A] [[\$1,000]/ [\$2,000]]	[N/A]	[N/A] [[\$500]/ [\$1,000]]
[Inpatient Surgical Indemnity Benefit Amount:	[N/A] [\$300]	[N/A] [\$500]	[N/A] [\$800]	[N/A] [\$1,000]	[N/A]	[N/A] [\$500]
<u>[BENEFIT (Optional)]</u>						
[Doctor's Initial Office Visit Indemnity Benefit Amount:	[N/A] [\$300]	[N/A] [\$500]	[N/A] [\$800]	[N/A] [\$1,000]	[N/A]	[N/A] [\$500]
[First Day Hospital Admission Indemnity Benefit Amount:	[N/A] [\$300]	[N/A] [\$500]	[N/A] [\$800]	[N/A] [\$1,000]	[N/A]	[N/A] [\$500]
[Emergency Room Visit Indemnity Benefit Amount/(Maximum):	[N/A] [[\$300]/ [\$1,000]]	[N/A] [[\$500]/ [\$1,000]]	[N/A] [[\$800] / [\$1,500]]	[N/A] [[\$1,000]/ [\$2,000]]	[N/A]	[N/A] [[\$500]/ [\$1,000]]
[Anesthesiology Indemnity Benefit Amount:	[N/A] [\$300]	[N/A] [\$500]	[N/A] [\$800]	[N/A] [\$1,000]	[N/A]	[N/A] [\$500]
[Outpatient Diagnostic Lab Test and X-Ray Indemnity Benefit Amount/(Maximum):	[N/A] [[\$300]/ [\$1,000]]	[N/A] [[\$500]/ [\$1,000]]	[N/A] [[\$800] / [\$1,500]]	[N/A] [[\$1,000]/ [\$2,000]]	[N/A]	[N/A] [[\$500]/ [\$1,000]]
[Outpatient Diagnostic Advanced Studies Indemnity Benefit Amount/(Maximum):	[N/A] [[\$300]/ [\$1,000]]	[N/A] [[\$500]/ [\$1,000]]	[N/A] [[\$800] / [\$1,500]]	[N/A] [[\$1,000]/ [\$2,000]]	[N/A]	[N/A] [[\$500]/ [\$1,000]]
[Ambulance Indemnity Benefit Amount:	[N/A] [\$300]	[N/A] [\$500]	[N/A] [\$800]	[N/A] [\$1,000]	[N/A]	[N/A] [\$500]
[Preventive Care Indemnity Benefit Amount/(Maximum):	[N/A] [[\$300]/ [\$1,000]]	[N/A] [[\$500]/ [\$1,000]]	[N/A] [[\$800] / [\$1,500]]	[N/A] [[\$1,000]/ [\$2,000]]	[N/A]	[N/A] [[\$500]/ [\$1,000]]
[Outpatient Prescription Medication Indemnity Benefit Amount:	[N/A] [\$300]	[N/A] [\$500]	[N/A] [\$800]	[N/A] [\$1,000]	[N/A]	[N/A] [\$500]
[Accident Expense Benefit [Per Injury Deductible/]Amount:	[N/A] [[\$300]/ [\$1,000]]	[N/A] [[\$500]/ [\$1,000]]	[N/A] [[\$800] / [\$1,500]]	[N/A] [[\$1,000]/ [\$2,000]]	[N/A]	[N/A] [[\$500]/ [\$1,000]]
[Critical Care Indemnity Benefit Amount: [(If selected, must be selected for all plans)]	[N/A] [[\$300]/ [\$1,000]]	[N/A] [[\$500]/ [\$1,000]]	[N/A] [[\$800] / [\$1,500]]	[N/A] [[\$1,000]/ [\$2,000]]	[N/A]	[N/A] [[\$500]/ [\$1,000]]

[Employee Term Life Insurance Benefit Amount: [N/A] [\$10,000] [N/A] [\$25,000] [N/A] [\$50,000] [N/A] [\$100,000] [N/A] [N/A]]

[Employee Accidental Death & Dismemberment Insurance Benefit Amount: [N/A] [\$10,000] [N/A] [\$25,000] [N/A] [\$50,000] [N/A] [\$100,000] [N/A] [N/A]]

[Dependent Term Life Insurance Benefit [Spouse Amount/Child] Amount: [N/A] [\$10,000] [N/A] [\$25,000] [N/A] [\$50,000] [N/A] [\$100,000] [N/A] [N/A]]

[Dependent Accidental Death & Dismemberment Insurance [Spouse Amount/Child] Amount: [N/A] [\$10,000] [N/A] [\$25,000] [N/A] [\$50,000] [N/A] [\$100,000] [N/A] [N/A]]

[Dental Benefit Amount [N/A] [\$300] [N/A] [\$500] [N/A] [\$800] [N/A] [\$1,000] [N/A] [N/A] [N/A] [\$500]]

[Dental Benefit: Orthodontia Coverage [Dependent] [Children] under age 19: Yes No]

[Dental Benefit: Prosthodontics Coverage: Yes No]

[Vision Benefit Amount: [N/A] [\$300] [N/A] [\$500] [N/A] [\$800] [N/A] [\$1,000] [N/A] [N/A] [N/A] [\$500]]

[Non-Occupational Weekly Disability Income Insurance Benefit Amount: [N/A] [\$300] [N/A] [\$500] [N/A] [\$800] [N/A] [\$1,000] [N/A] [N/A] [N/A] [\$500]]

[Benefit Waiting Period: [N/A] [7 days] [N/A]]

[Benefit Duration: [N/A] [26 weeks] [N/A]]

NOTE: THIS POLICY IS NOT INTENDED TO REPLACE COMPREHENSIVE MAJOR MEDICAL INSURANCE. [If coverage is approved, the Acceptance Letter will confirm your Policy selections.] [The [Term Life] [and Accidental Death and Dismemberment] Insurance [coverage is [coverages are] underwritten by [Reliance Standard Life Insurance Company].]

RATES: [See attached rate quote]

	[PLAN 1]	[PLAN 2]	[PLAN 3]	[PLAN 4]	[PLAN 5]	[PLAN 6]
Employee:	_____	_____	_____	_____	_____	_____
Employee + Spouse [or Domestic Partner] [or Same Sex Partner]	_____	_____	_____	_____	_____	_____
Employee + Child/Children	_____	_____	_____	_____	_____	_____
Employee + Family	_____	_____	_____	_____	_____	_____
Optional Benefit Rates (when applicable)	_____	_____	_____	_____	_____	_____

D. [If applying for Dental Benefits PLEASE COMPLETE THIS SECTION:

[Dental Preferred Provider Network Selected: _____]

Will this plan replace other Dental insurance coverage? Yes No

If yes, please provide the following information for the past 12 months and attach a copy of the most recent billing statement from the prior Dental insurance carrier.

Prior Dental Carrier:	Policy Number:	Effective Date (mm/dd/yyyy)	Termination Date (mm/dd/yyyy)	Orthodontia coverage included?
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No

1. An initial deposit is included with this application to apply to the first premium payment due for the Coverage, if issued. The amount of such deposit is to be equal to the first premium payable based on the number of Covered Persons (Eligible Employees and Dependents) as of the Effective Date of Coverage. If Coverage is not approved, the deposit will be returned.
2. Payment of the first premium by the Employer shall constitute acceptance of the terms and conditions contained in the Coverage so issued.
3. It is understood and agreed that:
 - (a) all necessary administrative information concerning all Covered Persons shall be subject to the provisions of the Policy and shall be furnished to Us by the Employer.
 - (b) this Application is subject to the approval of Madison National Life Insurance Company, Inc. at its Home Office or its authorized administrator and that nothing contained herein shall be binding upon said Company until this Application has been so approved.
 - (c) all benefits will be in accordance with the benefits proposed and agreed upon between Madison National Life Insurance Company, Inc. and the Employer as set forth in the Policy.
 - (d) benefits are not payable for certain treatment, services or supplies specifically excluded from Coverage under the Policy, including: (a) in case of Illness or Injury arising out of or in the course of any employment for wage or profit; or (b) for any Illness or Injury for which the person on whom the claim is presented has or had a right to recovery under Workers' Compensation or similar occupational disease law.

EMPLOYER RESPONSIBILITIES UNDER THIS POLICY

Employer agrees: (1) to maintain the records necessary to the administration of the Coverage; (2) to report additions, changes, terminations and other information necessary to the administration of the Coverage to the Insurer within 30 days after the Effective Date of such additions, changes and terminations; (3) that if Employer does not notify the Insurer of any insured ineligibility or termination within 30 days, Employer shall forfeit any premium refund/credit that would otherwise have been due; (4) to make all such records, including payroll records, tax returns, and personnel files and other documentation as determined by the Insurer available upon request to the Insurer or its authorized administrator; (5) to pay all premiums in accordance with the terms of this Policy; (6) for purposes of the Employee Retirement Income Security Act (ERISA) and the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Employer is deemed the Plan Administrator; and (7) to notify all Employees, [Contract Staff and Retirees] of any termination or rescission of Coverage which affects them and refund the appropriate premium.

[By the signature below of its duly authorized representative, the proposed Employer hereby applies for the Madison National Life Insurance Company, Inc. Policy of Group Limited Benefit Health insurance; and the proposed Employer understands and agrees that it shall be subject to the provisions set forth herein.]

[The Employer also agrees no liability is created for, or assumed by, the Insurer until this application has been approved in writing; acceptance of the check submitted with the application does not constitute approval or guarantee coverage; and if for any reason this application is not so approved in writing, the sole obligation of the Insurer will be, and the Employer shall be entitled to only, a refund of any monies paid.]

It is understood that all of the answers the Employer has provided are representations and not warranties.

[FRAUD WARNING]

[Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines, confinement in prison and/or denial of insurance benefits.]

[For Proposed Insureds in Arizona

Any person who knowingly makes a false or fraudulent statement or representation in or relative to an application for insurance, or who makes any such statement to obtain a fee, commission, money or benefit is guilty of a class 2 misdemeanor.]

[For Proposed Insureds in California

For your protection California law requires the following to appear on this form:

Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be

subject to fines and confinement in state prison.

“California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.”]

[For Proposed Insureds in **Colorado**

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.]

[For Proposed Insureds in **District of Columbia**

It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.]

[For Proposed Insureds in **Florida**

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony in the third degree.]

[For Proposed Insureds in **Georgia**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information, or, for the purpose of misleading, conceals information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.]

[For Proposed Insureds in **Kentucky**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.]

[For Proposed Insureds in **Louisiana**

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.]

[For Proposed Insureds in **Maine**

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.]

[For Proposed Insureds in **Maryland**

Any person who knowingly [and/or] willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly [and/or] willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.]

[For Proposed Insureds in **Nebraska**

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines, confinement in prison and/or denial of insurance benefits.]

[For Proposed Insureds in **New Hampshire**

Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim or an application for insurance containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638.20.]

[For Proposed Insureds in **New Mexico**

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents

false information in an application for insurance is guilty of a crime and may be subject to civil fines, and criminal penalties.]

[For Proposed Insureds in Oregon

Any person who knowingly and with intent to defraud or solicit another to defraud an insurer by submitting an application, or by filing a claim containing a false statement as to any material fact, may be violating state law.]

[For Proposed Insureds in Pennsylvania

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.]

[For Proposed Insureds in Tennessee

It is a crime to knowingly supply false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.]

[For Proposed Insureds in Washington

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.]

Dated at _____ this _____, 20 ____

Agent _____

Employer Name: _____

Signed By: _____

Title: _____

Date: _____

AGENT'S STATEMENT

I hereby certify that: (a) all information set forth above is correct to the best of my knowledge; (b) I have complied fully with the underwriting rules; (c) I have explained the proposed insurance Policy in detail; and (d) to the best of my knowledge the proposed Employer is financially sound.

I further certify that all agents involved in presentation of this account (a) are licensed by Madison National Life Insurance Company, Inc. or (b) have submitted the necessary paperwork to become a licensed agent with Madison National Life Insurance Company, Inc.

SERVICING AGENT:

Name _____

Tax ID No.: _____

Agency Name: _____

Telephone No.: _____

License No.: _____

Fax No.: _____

Address: _____

Email Address: _____

City: _____ State _____ Zip _____

Agent Signature: _____

- Initial Enrollment/Employee
- Newly Hired Employee
- Contract Staff
- Retiree
- Special Enrollment]

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.

[P.O. Box 5008, Madison, WI 53705]

[Contract Site]

Employee Enrollment Application

Group Limited Indemnity Benefit Health Insurance

PLEASE PRINT OR TYPE

Name (Last)		(First)	(MI)	[Gender]	[Date of Birth MM/DD/YY]	[Social Security No.]
				<input type="checkbox"/> M <input type="checkbox"/> F]	/ /	- -
[Address]		City	State	Zip]	[Home Phone]	
					() -	
Employer Name	[Group Number]	[Eligibility Status]		[Date of Hire/Retirement]	[Business Phone]	
		<input type="checkbox"/> Salaried Employee <input type="checkbox"/> Hourly Employee <input type="checkbox"/> Contract Staff <input type="checkbox"/> Retiree]		/ /	() -	
[Average Weekly Hours]	[Earnings \$]		[Job Title[Occupation]] [Job Status: Part-Time/Full-Time]		[Dept. or Branch]	
	<input type="checkbox"/> Hourly <input type="checkbox"/> Annually]					

[[YES,] I want the following Plan offered by the Employer: [Plan 1 Plan 2 Plan 3]]

Coverage Type	Applying for coverage for:			Waiving coverage for:		
	[Myself/Employee]	Spouse/ [Domestic Partner]	Children	[Myself/Employee]	Spouse/ [Domestic Partner]	Children
[Limited Benefit Health Insurance]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
[Term Life]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
[Accidental Death & Dismemberment]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
[Critical Care Indemnity Benefit]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
[Dental]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
[Vision]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
[Weekly Disability Income]	<input type="checkbox"/>			<input type="checkbox"/>		
[Accident Indemnity]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

No, I do not want any coverage.]
 [Is the reason You are declining coverage because You currently have other health coverage? Yes No]

[If offered to You and You are applying for Term Life Insurance [and/or Accidental Death and Dismemberment Insurance] for Yourself [and/or Your Dependents], PLEASE COMPLETE THIS SECTION:

Have You, or Your spouse if applying for this coverage, used tobacco products in the last 12 months? Yes No
 Spouse? Yes No

Please designate Your Beneficiary(ies) and their relationship to You. Your Beneficiary, if living, will receive Your life insurance benefit upon Your death. When specifying multiple beneficiaries, you must indicate the percentage of distribution for each. You are the beneficiary for any death benefits payable upon the death of Your covered Dependents.

Last Name, First, Middle Initial:

Name: _____ Relationship: _____ % _____
 Name: _____ Relationship: _____ % _____
 Name: _____ Relationship: _____ % _____

If You do not designate a beneficiary or Your beneficiary is not living when You die, Your beneficiary will be the first of the following living persons: (1) Your spouse; (2) Your natural and adopted children, equally; (3) Your parents, equally; or (4) Your brothers and sisters, equally. If none of the above persons are living, then We will pay the benefit to Your estate.

You may designate or change Your Beneficiary at any time by filing a Change of Beneficiary Form. This designation or change must be made on forms or by means of a process We provide. [The [Term Life] [and Accidental Death and Dismemberment] Insurance [coverage is] [coverages are] underwritten by [Reliance Standard Life Insurance Company].]

[If offered to You and You are a NEW EMPLOYEE applying for Dental Benefits for Yourself [and/or Your Dependents], PLEASE COMPLETE THIS SECTION: [(If you are an Employee applying with the Employer's initial enrollment You do not need to complete this Section)]

Will this plan replace other Dental insurance coverage? Yes No

If yes, please provide the following information for the past 12 months and attach a copy of the most recent billing statement from the prior Dental insurance carrier.

Prior Dental Carrier:	Policy Number:	Effective Date (mm/dd/yyyy)	Termination Date (mm/dd/yyyy)	Orthodontia coverage included?
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No]

[LIST ALL DEPENDENTS TO BE COVERED. DOCUMENTATION IS NEEDED FOR ADOPTED/FOSTER/STEP CHILDREN OR SPOUSES [OR DOMESTIC PARTNERS] [OR DOMESTIC SAME SEX PARTNERS] WITHOUT THE SAME SURNAME.

Name (Last, First, MI)	Date of Birth MM/DD/YY	Gender	Social Security No.	Relationship
	/ /	<input type="checkbox"/> Male <input type="checkbox"/> Female	- -	Spouse/[Domestic Partner] [Domestic Same Sex Partner]
	/ /	<input type="checkbox"/> Male <input type="checkbox"/> Female	- -	<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Adopted <input type="checkbox"/> Other
	/ /	<input type="checkbox"/> Male <input type="checkbox"/> Female	- -	<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Adopted <input type="checkbox"/> Other
	/ /	<input type="checkbox"/> Male <input type="checkbox"/> Female	- -	<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Adopted <input type="checkbox"/> Other
	/ /	<input type="checkbox"/> Male <input type="checkbox"/> Female	- -	<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Adopted <input type="checkbox"/> Other

[Are any of the children age 19 or over a full-time student? Yes No

If Yes, proof of school enrollment attached proof to be provided]

Check this box if your Spouse is also employed by the same Employer

If any dependent has a different last name, You must submit a marriage certificate, birth certificate or other supporting documentation to prove dependency.]

I hereby declare that I am in an Eligible Class of the Employer indicated above and that I work at or from the employment location [Department or Branch] indicated. All information given by me on this form at Madison National Life Insurance Company, Inc.'s request is true and complete and is offered to Madison National Life Insurance Company, Inc. as inducement to grant insurance.

[FRAUD WARNING]

[Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines, confinement in prison and/or denial of insurance benefits.]

[For Proposed Insureds in Arizona

Any person who knowingly makes a false or fraudulent statement or representation in or relative to an application for insurance, or who makes any such statement to obtain a fee, commission, money or benefit is guilty of a class 2 misdemeanor.]

[For Proposed Insureds in California

For your protection California law requires the following to appear on this form:

Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

“California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.”]

[For Proposed Insureds in **Colorado**

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.]

[For Proposed Insureds in **District of Columbia**

It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.]

[For Proposed Insureds in **Florida**

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony in the third degree.]

[For Proposed Insureds in **Georgia**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information, or, for the purpose of misleading, conceals information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.]

[For Proposed Insureds in **Kentucky**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.]

[For Proposed Insureds in **Louisiana**

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.]

[For Proposed Insureds in **Maine**

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.]

[For Proposed Insureds in **Maryland**

Any person who knowingly [and/or] willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly [and/or] willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.]

[For Proposed Insureds in **Nebraska**

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines, confinement in prison and/or denial of insurance benefits.]

[For Proposed Insureds in **New Hampshire**

Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim or an application for insurance containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638.20.]

[For Proposed Insureds in **New Mexico**

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines, and criminal penalties.]

[For Proposed Insureds in **Oregon**

Any person who knowingly and with intent to defraud or solicit another to defraud an insurer by submitting an application, or by filing a claim containing a false statement as to any material fact, may be violating state law.]

[For Proposed Insureds in **Pennsylvania**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for

insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.]

[For Proposed Insureds in **Tennessee**

It is a crime to knowingly supply false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.]

[For Proposed Insureds in **Washington**

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.]

Applicant Signature

Date

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.
[P.O. Box 5008, Madison, WI 53705]

**AMENDATORY ENDORSEMENT
HOUR BANK ACCOUNTING**

It is hereby understood that the Policy and Certificate to which this Amendatory Endorsement is attached is amended as follows with respect to an hourly Employee on whose behalf an Employer, subject to the requirements of the Davis-Bacon and Services Contract Acts, has established a program of health benefits using an hour bank accounting system to administer irrevocable contributions made to the Employer on behalf of such Employee.

A. SECTION 2 – DEFINITIONS, the following changes are hereby made:

1. The **Employee** definition is deleted and replaced with:

Employee – an Employee of the Employer who has accumulated and is maintaining the minimum number of Hours of Work Credit (as defined) selected by the Employer and as shown in Your Validation of Coverage. At the usual location(s) where the business of the Employer is transacted, or other location to which the Employee is required to travel to perform the regular duties of his employment, including approved leave of absence not to exceed a continuous period of 90 consecutive days, such as holiday or vacation.

2. The following Definitions are added:

Hours of Work Credit means the hours worked by an Employee for which contributions have been made on his behalf to the Reserve Account established by the Employer.

Reserve Account means an account established by the Employer for each Employee showing the number of Hours of Work Credit.

The Reserve Account established for an Employee will cease to exist [12] [24] months after the day the Employee was last eligible to accumulate Hours of Work Credit.

B. SECTION 3 – ELIGIBILITY FOR INSURANCE AND EFFECTIVE DATE OF COVERAGE, the following is added:

HOUR BANK ACCOUNTING

In accordance with the Davis-Bacon and Services Contract Acts an Employer may require a minimum number of Hours of Work Credit (known as the Employment Waiting Period) as shown on the Validation of Coverage in order for an Employee to become covered for the insurance provided by the Policy.

An Employee will continue to be covered by the Policy as long as he has credited to him from his Reserve Account at least the minimum number of Hours of Work Credit required by his Employer. Any excess Hours of Work Credit in each Employee's Reserve Account not used to maintain his Coverage will be held in the Reserve Account. Hours of Work Credit in the Reserve Account will be drawn upon and used to continue the Employee's Coverage. However, no more than [12] [24] months of Hours of Work Credit, depending upon the Employer's election, will be permitted to accumulate in an Employee's Reserve Account after the deduction for the current month's Coverage is made.

The amount of Hours of Work Credit, as specified in the Employer's application, that must be credited to Your Reserve Account before You are eligible for Coverage, shall remain in effect until the Employer notifies us of its desire to amend such requirement. Such notification shall be given to Our authorized administrator, postmarked at least two calendar months prior to the desired effective date of the change in the Hours of Work Credit. Upon receipt of the notice, We shall then have 45 business days in which to approve the desired change. In the event that We notify the Employer of Our refusal to approve the change within the 45-day period mentioned above, the Hours of Work Credit requirements shall remain unchanged.

C. SECTION 7 – TERMINATION, the following is added to **Termination of an Eligible Person’s Coverage** provision:

7. The last day of any calendar month in which the Hours of Work Credit in The Eligible Person’s Reserve Account does not equal at least the minimum number of Hours of Work Credit required by the Employer.

An Eligible Person whose Coverage under the Policy has terminated for this reason may qualify for reinstatement within 90 days from the date his Coverage terminated. Such Eligible Person’s Coverage will be reinstated effective on the premium due date of the calendar month following a month in which the number of Hours of Work Credit in his Reserve Account total at least the minimum number of Hours of Work Credit required by the Employer.

The Reserve Account established for an Employee will cease to exist [12] [24] months after the day the Employee was last eligible to accumulate Hours of Work Credit.

This Amendatory Endorsement takes effect on the Effective Date of the Policy and, for the Eligible Person, on the Effective Date as the Certificate to which it is attached, unless a different Endorsement date is specified by an attached Endorsement.

This Endorsement will terminate in accordance with Section 7 – Termination.

This Amendatory Endorsement is subject to all provisions of the Policy which are not in conflict with the provisions of this Endorsement. Nothing in this Endorsement will be held to vary, alter, waive, or extend any of the terms, conditions, provisions, agreements, or limitations of the Policy other than stated above.

IN WITNESS WHEREOF, the Insurance Company has caused this Amendatory Endorsement to be signed by its President.

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.



Larry R. Graber
President

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.
[P.O. Box 5008, Madison, WI 53705]

[OPTIONAL] ACCIDENT EXPENSE BENEFIT RIDER

This Rider is made a part of the Policy and Certificate to which it is attached. This Rider is subject to all provisions of the Policy which are not in conflict with the provisions of this Rider. We will provide this Benefit in consideration of the payment of any applicable premium for this Rider.

When a Covered Person is covered under the Accident Expense Benefit Rider, We will pay the Benefits described in this Benefit Rider when a Covered Person incurs charges as a result of a covered Accidental Bodily Injury which occurs while the Covered Person's coverage is in force under this Benefit Rider. [Initial charges for the covered Injury must be incurred within [90 days] of the date of a covered Injury and while the Covered Person's coverage is continuously in force under this Benefit Rider.]

A. Benefits

Benefits, as specified in the Accident Expense Benefit Schedule, for covered charges are subject to the following:

1. The Per Injury Deductible;
2. The Benefit Period;
3. [The [Calendar] [Plan] Year Maximum Benefit;]

Benefits [for each Benefit Period] will be paid for the following treatments, services and supplies:

1. Medical, dental or surgical treatment or supplies; and
2. [Confinement in a Hospital; and]
3. Lab Tests, X-rays and Advanced Studies; and
4. Registered nurses; and
5. Prescription Medications.

ACCIDENT EXPENSE BENEFIT SCHEDULE

Per Injury Deductible:	[Not Applicable] [\$100-\$1,000]
Per Accidental Bodily Injury Benefit:	[The lesser of the actual expenses incurred for covered charges or [\$200-\$10,000] per Accidental Bodily Injury]
[Per each Hospital Inpatient Confinement Benefit:	[The lesser of the actual expenses incurred for covered charges or [\$2,000-\$10,000]]
Benefit Period:	[Not Applicable] [[52] consecutive weeks following the date of each covered Accidental Bodily Injury]
[[Calendar] [Plan] Year Maximum Benefit:	[[(\$500-\$15,000) [[1-3] Accidental Bodily Injuries]]

[If the Injury results in a Hospital Inpatient Confinement only the Hospital Inpatient Confinement Benefit is paid, the per Accidental Bodily Injury Benefit is also not paid.]

B. Definitions

All capitalized terms used herein shall have the same meaning as in the Policy unless otherwise stated herein. The following definitions are applicable to the Accident Expense Benefit Rider. When used in this Rider these terms are capitalized.

Accidental Bodily Injury/Injury: Bodily Injury resulting directly from an accident and independently of all other causes occurring while a Covered Person's Coverage is in force under this Accident Expense Benefit Rider. It does not include an intentional, self-inflicted Injury.

All Injuries sustained in any one accident, including all related conditions and recurrent symptoms of these Injuries, are considered a single Injury.

Per Injury Deductible: The amount of Covered Benefits that a Covered Person must first incur for each Benefit Period for each separate covered Accidental Bodily Injury. The Per Injury Deductible, if applicable, must be satisfied before Benefits under this Accident Benefit are paid.

Benefit Period: The period of time commencing on the date of the Covered Person's Accidental Bodily Injury. When the Benefit Period ends no further Accident Benefits are payable for the same or related Accidental Bodily Injury. A separate Benefit Period will apply to each covered Accidental Bodily Injury.

This Rider is effective on the Effective Date of the Policy; and, for the Eligible Person, on the Effective Date as the Certificate to which it is attached unless a different Rider date is specified by an attached Endorsement.

This Rider will terminate in accordance with Section 7 – Termination.

This Rider is subject to all provisions of the Policy which are not in conflict with the provisions of this Rider. Nothing in this Rider will be held to vary, alter, waive, or extend any of the terms, conditions, provisions, agreements, or limitations of the Policy other than stated above.

IN WITNESS WHEREOF, the Insurance Company has caused this Rider to be signed by its President.

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.



Larry R. Graber
President

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.
[P.O. Box 5008, Madison, WI 53705]

**[OPTIONAL] ACCIDENTAL DEATH AND DISMEMBERMENT
INSURANCE BENEFIT RIDER**

[[Eligible Person Only]]

This Rider is made a part of the Policy and Certificate to which it is attached. This Rider is subject to all provisions of the Policy which are not in conflict with the provisions of this Rider. We will provide this Benefit in consideration of the payment of any applicable premium for this Rider.

When [a Covered] [an Eligible] Person is covered under the Accidental Death and Dismemberment Insurance Benefit Rider, as selected by the Policyholder and if specified as included in the Schedule of Benefits, We will pay the following benefit subject to the terms and conditions of the Policy and this Benefit Rider.

The Benefit amount may be reduced for a loss occurring on or after the date the Eligible Person attains a certain age. See the Schedule of Benefits. [Reduction in the benefit amount of insurance because of a change in age are effective on the first of the month [coinciding with] [following] the date the Eligible Person attains the age in the new age bracket.]

If [You] [the Covered Person] sustain[s] an Accidental Bodily Injury, and within [90] days following the date on which the Accidental Bodily Injury occurred, [You] [the Covered Person] suffer[s] one of the losses below, We will pay all or a portion of the Accidental Death and Dismemberment Insurance Principal Sum according to the table below. The Principal Sum is specified in the Schedule of Benefits. The Accidental Bodily Injury and the loss both must occur while [You] [the Covered Person] [is] [are] covered by the Policy and this Rider.

<u>Loss</u>	<u>Benefit</u>
Life	Principal Sum
Both Hands	Principal Sum
Both Feet	Principal Sum
Sight of Both Eyes	Principal Sum
One Hand and One Foot	Principal Sum
One Hand and Sight of One Eye	Principal Sum
One Foot and Sight of One Eye	Principal Sum
One Hand	1/2 of Principal Sum
One Foot	1/2 of Principal Sum
Sight of One Eye	1/2 of Principal Sum

If more than one Loss occurs due to the same accident, We will only pay one benefit amount not to exceed the amount payable for the greater of the two Losses. [(Dependents are not eligible for Accidental Death and Dismemberment benefits.)]

Accidental Death and Dismemberment Benefits are not payable for any Loss caused directly by:

1. Intentionally self-inflicted Injury or suicide [while sane or insane];
2. Illness including any medical or Surgical treatment of an Illness;
3. Infections, except pyogenic infection resulting from an Accidental Bodily Injury or resulting from accidental ingestion of a contaminated substance;
4. Participation in a riot or insurrection. "Participation" means taking an active part in common with others. "Riot" means any use or threat to use force or violence by three or more persons without authority of law;
5. Active duty as a member of any military, naval or air force;
6. War or any act of war, declared or not;
7. Commission or attempted commission of a felony, assault or illegal action;
8. Voluntary use of any alcohol, drug or narcotic unless prescribed by a Doctor and taken as prescribed;
9. Voluntary inhalation of any kind of gas including carbon monoxide;
10. Travel or flight in, or descent from, any aircraft except as a fare paying passenger of a commercial airline flying on regularly scheduled routes between definitely established airports; or
11. Driving a vehicle while legally intoxicated according to the laws of the area where the accident occurred. Intoxication by drug or alcohol will be conclusively determined if a chemical test administered in the jurisdiction where the Loss or cause of Loss occurred is at or above the legal limit set by that jurisdiction.

DEFINITIONS

All capitalized terms used herein shall have the same meaning as in the Policy unless otherwise stated herein. The following definitions are applicable to this Accidental Death and Dismemberment Insurance Benefit Rider. When used in this Rider these terms are capitalized

Beneficiary. The person indicated on the enrollment form or during the enrollment process as the person entitled to receive the Accidental Death and Dismemberment benefit upon the death of the Eligible Person. [The Eligible Person is the Beneficiary of the Dependent's Accidental Death and Dismemberment benefits upon the death of the covered Dependent.]

Loss. With respect to the Accidental Death and Dismemberment benefit, death or Accidental Bodily Injury as follows:

1. For death, which is the direct result of a covered Accidental Bodily Injury occurring while covered under this Rider;
2. For a hand, total, complete and permanent severance of all four fingers, or total, complete and permanent severance of the entire hand at or above the wrist joint;
3. For a foot, total, complete and permanent severance of the entire foot at or above the ankle joint;
4. For an eye, total and irrecoverable loss of sight.

For an Eligible Person's death, the benefit will be paid to the Beneficiary. For a Loss other than death, the benefit will be paid to the Eligible Person. [For a covered Dependent's Loss the benefit will be paid to the Eligible Person.]

Principal Sum. This is the amount of the Accidental Death and Dismemberment benefit as specified in the Schedule of Benefits.

This Rider is effective on the Effective Date of the Policy; and, for the Eligible Person, on the Effective Date as the Certificate to which it is attached unless a different Rider date is specified by an attached Endorsement.

This Rider will terminate in accordance with Section 7 – Termination.

This Rider is subject to all provisions of the Policy which are not in conflict with the provisions of this Rider. Nothing in this Rider will be held to vary, alter, waive, or extend any of the terms, conditions, provisions, agreements, or limitations of the Policy other than stated above.

IN WITNESS WHEREOF, the Insurance Company has caused this Rider to be signed by its President.

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.



Larry R. Graber
President

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.
[P.O. Box 5008, Madison, WI 53705]

[OPTIONAL] CRITICAL CARE INDEMNITY BENEFIT RIDER

This Rider is made a part of the Policy and Certificate to which it is attached. This Rider is subject to all provisions of the Policy which are not in conflict with the provisions of this Rider. We will provide this Benefit in consideration of the payment of any applicable premium for this Rider.

When a Covered Person is covered under the Critical Care Indemnity Benefit Rider as selected by the Policyholder and if specified as included in the Schedule of Benefits, We will pay the following Benefits subject to the terms and conditions of the Policy and this Benefit Rider.

DESCRIPTION OF BENEFITS

We will pay the First Occurrence Benefit shown in the Schedule of Benefits if one of the following Specified Health Events First Occurs for the first time in the Covered Person's lifetime and while this Rider is in force with respect to the Covered Person:

1. [Heart Attack;
2. Stroke;
3. Life Threatening Internal Cancer;
4. End Stage Renal Failure;
5. Major Organ Transplant; or
6. Permanent Paralysis.]

[When such a Specified Health Event First Occurs during the first [30] days immediately following the Covered Person's effective date under this Rider, or as a result of diagnostic testing performed during the first [30] days immediately following the Covered Person's effective date under this Rider, We will pay the First Occurrence [1st through 30th] day Benefit shown in the Schedule of Benefits.]

[We will pay the First Occurrence Benefit for Heart By-Pass shown in the Schedule of Benefits if Heart By-Pass is performed for the first time in the Covered Person's lifetime and while this Rider is in force with respect to the Covered Person.]

[We will pay the First Occurrence Benefit for Cancer In-Situ shown in the Schedule of Benefits if Cancer In-Situ is diagnosed for the first time in the Covered Person's lifetime and while this Rider is in force with respect to the Covered Person.]

The Company must be provided with a diagnosis by a Doctor accompanied by documentation supported by clinical, radiological, histological and laboratory evidence satisfactory to the Company. The Company may, at its expense, require an examination or further tests by a Doctor of its choice.

Once the First Occurrence Maximum Benefit has been paid for a Covered Person, Coverage under this Critical Care Indemnity Benefit Rider terminates for that Covered Person and no further Critical Care benefits are payable for the Covered Person.

DEFINITIONS

All capitalized terms used herein shall have the same meaning as in the Policy unless otherwise stated herein. The following definitions are applicable to this Critical Care Indemnity Benefit Rider. When used in this Rider these terms are capitalized.

[Cancer In-Situ means the cancer cells are confined to the tissue where the cancer cells started, without invasion of the basement membrane, and the likelihood of subsequent invasive growth is presumed to be high.]

[End-Stage Renal Failure means irreversible failure of the function of both kidneys requiring a Covered Person to undergo regular hemodialysis or peritoneal dialysis at least weekly.]

First Occurs or First Occurrence means the date, following the Covered Person's Coverage effective date under this Rider, that the Covered Person was positively diagnosed by a legally qualified Doctor as having a Specified Health Event for the first time. The First Occurrence diagnosis or procedure is the first time the Covered Person has ever undergone that specific procedure or been diagnosed with that specific condition as a covered Specified Health Event.

[Heart Attack means the death of a portion of heart muscle (myocardium) resulting from a blockage of one or more coronary arteries.]

[Heart By-Pass means a part of a coronary artery which has been narrowed is by-passed using another section of healthy vein or artery. A positive diagnosis must be supported by EKG changes (new confirmatory electrocardiac changes) and elevated levels of specific cardiac enzymes.]

[Life Threatening Internal Cancer means a malignant tumor characterized by the uncontrolled growth and spread of malignant cells and invasion of tissue including leukemia and Hodgkin's Disease (except Stage 1 of Hodgkin's Disease). The disease must be supported by histological evidence of malignancy.]

[Life Threatening Internal Cancer does not include:

1. Pre-malignant tumors or polyps;
2. Cancer in-situ;
3. Intraductal non-invasive carcinoma of the breast;
4. Carcinoma of the appendix;
5. Stage 1 transitional carcinoma of the urinary bladder;
6. Any skin cancers other than melanomas;
7. Stage 1 Hodgkin's Disease; or
8. Tumors in presence of HIV.]

[Major Organ Transplant means a surgery in which a Covered Person receives, as a result of a surgical transplant, one or more of the following organs:

1. Kidney;
2. Liver;
3. Heart;
4. Heart-lung;
5. Lung; or
6. Pancreas.

It does not include transplants involving mechanical or nonhuman organs.]

[Permanent Paralysis means spinal cord injuries resulting in paraplegia or quadriplegia (complete and total loss of use of two or more limbs) confirmed by the Covered Person's attending Doctor.]

Specified Health Event means one of the following conditions, as defined herein: [Heart Attack, Stroke, Life Threatening Internal Cancer, End-Stage Renal Failure, Major Organ Transplant, Permanent Paralysis, Heart By-Pass, or Cancer In-Situ.]

[Stroke means an acute cerebral vascular incident producing permanent, neurological impairment and resulting in paralysis of other measurable objective neurological defect persisting for at least 30 days. Diagnosis of a Stroke must be evidenced by a clinical picture of permanent neurological damage provided from a CAT scan and/or an MRI, or such other diagnostic tests as may be required. It does not include Transient, Ischemic Attacks and attacks of Vertebrobasilar Ischemia.]

PRE-EXISTING CONDITION LIMITATION

Benefits are not payable in connection with a Pre-Existing Condition during the initial [12] consecutive months the Covered Person has been covered under the Policy and this Rider. A Specified Health Event resulting from a Pre-Existing Condition commencing thereafter will be covered unless excluded by the Policy.

A Pre-Existing Condition means any Illness or Injury for which a Covered Person received any diagnosis, medical advice or treatment or had taken any Prescription Medication during the [12] months immediately preceding the Effective Date of the Covered Person's Coverage under the Policy and this Rider.

This Rider is effective on the Effective Date of the Policy; and, for the Eligible Person, on the Effective Date as the Certificate to which it is attached, unless a different Rider date is specified by an attached Endorsement.

This Rider will terminate in accordance with Section 7 – Termination.

This Rider is subject to all provisions of the Policy which are not in conflict with the provisions of this Rider. Nothing in this Rider will be held to vary, alter, waive, or extend any of the terms, conditions, provisions, agreements, or limitations of the Policy other than stated above.

IN WITNESS WHEREOF, the Insurance Company has caused this Rider to be signed by its President.

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.

A handwritten signature in black ink, appearing to read "Larry R. Graber". The signature is written in a cursive style with a large initial "L".

Larry R. Graber
President

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.
[P.O. Box 5008, Madison, WI 53705]

[OPTIONAL] DENTAL BENEFIT RIDER

This Rider is made a part of the Policy and Certificate to which it is attached. This Rider is subject to all provisions of the Policy which are not in conflict with the provisions of this Rider. We will provide this Benefit in consideration of the payment of any applicable premium for this Rider.

When You are covered under the Dental Benefit Rider, as selected by the Policyholder and if specified as included in the Schedule of Benefits, We will pay for Covered Dental Charges incurred in connection with the dental treatment, services or supplies described in this Dental Benefit Rider. Benefits for Covered Dental Charges are subject to the following:

1. The Maximum Benefits specified in the Schedule of Benefits;
2. Section 6 - Exclusions and Limitations from Coverage and the Exclusions and Limitations contained in this Dental Benefit Rider; and
3. All other terms and conditions of the Policy.

A. Benefits

We will reimburse You for dental treatment, services or supplies furnished to a Covered Person. Dental benefits payable under this Rider for Covered Dental Charges are subject to the following, if specified in the Schedule of Benefits:

1. The Dental Coinsurance Percentage;
2. The [Calendar] [Plan] Year Dental Deductible;
3. The Dental Benefit Waiting Period; [and]
4. The [Calendar] [Plan] Year Maximum Benefit; [and]
5. [The Lifetime Maximum Benefit While Insured.]

If there is more than one course of treatment to treat a particular dental condition, using the dental profession's accepted standards of practice, if a less expensive procedure, service or supply would be appropriate Benefits for Covered Dental Charges will then be payable for the least expensive course of treatment.

Covered Dental Charges are always subject to the least expensive customary, professionally adequate treatment including Charges incurred for the following treatments, services, or supplies:

1. Gold or porcelain, if silver or some other material would be acceptable or appropriate;
2. For partial dentures, any material other than cast chrome or acrylic;
3. Personalized fillings, inlays, or onlays or other restorations;
4. The use of special techniques, if standard techniques would be acceptable or appropriate; or
5. Replacement of a denture or bridge that could have been repaired or modified.

B. Covered Procedures

Preventive Care (Type 1) includes the following:

1. Prophylaxis (the cleaning and scaling of teeth, limited to [one] treatment in any continuous period of [6] months;
2. Routine oral exams, initial or periodic, limited to [one] exam in any continuous period of [6] months ;
3. One topical application of sodium fluoride or stannous fluoride for covered Dependent Children to age [16], limited to [one] application in any continuous period of [12] months;
4. Full mouth x-rays limited to [one] set in any continuous period of [36] months;
5. Bitewing x-rays limited to [one] set in any continuous period of [6] months;
6. Periapicals;
7. Tests and laboratory exams related to dental procedures and second opinions;
8. Emergency treatment if no other service was rendered except x-rays;
9. Space maintainers: the initial appliance for covered Dependent Children to age [19], including all adjustments within the [six] month period immediately following installation; and
10. Sealants for covered Dependent Children under age [14] limited to [one] treatment per tooth (permanent posterior only) or quadrant during a [36] consecutive month period.

Basic Care (Type 2) includes the following:

1. Simple extractions; Abscesses;
2. Oral surgery and anesthesia or I.V. sedation for same, except for pre-orthodontics;
3. Amalgam, silicate, acrylic and composite fillings;

4. Maintenance prosthodontics, limited to [one] denture relining or rebasing in a [24] consecutive month period;
5. Tissue conditioning, limited to [two] treatments per arch within a [24] consecutive month period; and
6. Other restoration.

Major Care (Type 3) includes the following:

1. Endodontic treatment (pulp capping, pulpotomy, and root canal therapy);
2. Periodontal treatment and treatment of other diseases of the gums and tissues of the mouth, except splinting;
3. Inlays, onlays, crowns (single restorations); and
4. [Prosthodontics; Installation of bridges or partial or full dentures, including adjustments made within [6] months after installation (Treatment must begin after the Covered Person's Effective Date of Coverage under the Policy and the Dental Benefit Rider).]

C. [Additional Covered Procedures

[1.] Orthodontia (Type 4) includes the following:

Orthodontia [and Orthodontic procedures, including oral surgery and anesthesia or I.V. sedation for same,] (for Covered [Persons] [Dependent Children] under age [19]).

[2.] [Prosthodontics; Installation of bridges or partial or full dentures, including adjustments made within [6] months after installation (Treatment must begin after the Covered Person's Effective Date of Coverage under the Policy and the Dental Benefit Rider).]

D. [Predetermination Of Benefits

Except in an Emergency, if a Covered Person requires dental services which will cost more than the Predetermination Amount in the Schedule of Benefits, before beginning the dental treatment the Covered Person's Dentist must submit an advance notice of dental treatment to Us that describes the treatment necessary and the anticipated charges. We have the right to request any additional information We deem necessary to evaluate the proposed course of treatment and charges. This includes, but is not limited to, dental records and X-rays. Predetermination of Dental Treatment is not required for Emergency treatment or oral examinations and prophylaxis.

We will prepare and return to You and the Covered Person's Dentist an estimate of the Benefit payable under the Policy for the course of treatment. This estimate is not, and should not be considered, a guarantee of payment by Us.

If a description of the procedures to be performed and an estimate of the dental charges are not submitted in advance, We will still consider Covered Dental Charges for which the Covered Person has not obtained prior approval, taking into account alternate procedures, services or courses of treatment based upon professional endorsed standard of dental care.[A Predetermination of Dental Treatment must be provided for Orthodontia, if Orthodontia Coverage is specified as included in the Schedule of Benefits.]]

E. Exclusions And Limitations

Charges for the following dental treatment, services or supplies will not be considered Covered Dental Charges under the Dental Benefit Rider and no Benefits will be paid for such charges which:

1. The Covered Person would not be required to pay, which are covered by other insurance, or which would not have been billed if no insurance existed;
2. Are related to self-inflicted injuries [while sane or insane];
3. Are related to war or an act of war, whether or not declared;
4. Are related to the Covered Person's commission of a felony or an assault on another person;
5. Are related to a riot, nuclear accident, or a major disaster;
6. Are caused by, related to, or as a condition of employment, including self-employment, or which arises out of or in the course of employment. This exclusion applies even if Workers' Compensation or any Occupational Disease or similar law does not cover the charges;
7. Are in excess of the Reasonable and Customary charges;
8. Are incurred, or for which treatment began, before the Covered Person's Effective Date of Coverage under the Dental Benefit Rider or after the Covered Person's termination of Coverage;
9. Are not appropriate and customary for the necessary care or treatment of the condition, or are primarily for cosmetic reasons;
10. Are Experimental/Investigational;
11. Are related to surgical implants or transplants of any type (including prosthetic devices attached to them);
12. Are related to temporomandibular joint syndrome;
13. Are related to periodontal splinting;
14. Are related to facings on crowns, or pontics posterior to the 2nd bicuspid;
15. Are for the replacement of partial or full dentures, fixed bridge work, crowns, gold restorations and jackets more often than once in any [5] year period;
16. Are related to relining of dentures more often than once in any [2] year period;

17. [Are related to lost, stolen, or missing dentures or bridges or for duplicates;]
18. Are related to fixed or removable bridgework involving replacement of a natural tooth or teeth which was lost prior to the Covered Person's Effective Date of Coverage under the Dental Benefit Rider. Benefits may be payable for bridgework required for loss of teeth while insured under the Rider, if such bridgework is not an abutment for non-covered bridgework;
19. Are related to Prescription Medication and analgesia pre-medication;
20. Are related to charges for telephone consultations, failure to keep a scheduled appointment, to complete claim forms or attending Doctor statements, and any other services or supplies which are not part of the direct treatment of the Covered Person;
21. Are not made by a Dentist;
22. Are related to dental education or training programs (this includes oral hygiene or plaque control programs);
23. Are related to counseling on diet and nutrition;
24. Are received from a Dentist who (i) is the Covered Person's Close Relative, (ii) resides with the Covered Person, or (iii) is acting outside the scope of his/her license;
25. Are caused by or related to a Covered Person's military service, including service in a military reserve unit;
26. Are for services and supplies not included in a Covered Dental Charge;
27. Are related to orthodontia [and orthodontic procedures], [unless this Coverage is elected on the Policyholder's application and the required premium is paid;] [unless Orthodontia Coverage is specified as included in the Schedule of Benefits.]
28. [Are related to prosthodontics, unless this Coverage is elected on the Policyholder's Application and the required premium is paid;] [unless Prosthodontics Coverage is specified as included in the Schedule of Benefits.]
29. Are payable under any medical insurance;
30. Are made by any government entity unless the Covered Person is required to pay; or by any public entity from which coverage could have been obtained by application or enrollment even if application or enrollment was not actually made;
31. Are related to the use of materials, other than fluorides or sealants, to prevent tooth decay;
32. Are for bite registrations;
33. Are bacteriologic cultures in connection with a covered dental service; or
34. Are therapeutic injections administered by a Dentist.

[F.] [Replacement of Existing Dental Insurance

The following takeover provision[s] [is] [are] applicable when there is a group dental plan in force at the time of the Policyholder's application for the Policy and this Dental Benefit Rider: To be eligible for [this] [these] takeover provision[s], the Policyholder's dental plan must have been in effect immediately prior to the Effective Date of the Policy and this Dental Benefit Rider and the Covered Person must have been covered under the prior dental plan immediately prior to the Effective Date of Coverage. [This] [These] takeover provision[s] [do] [does] not apply to new Employees or Late Enrollees or to any Employee or Dependent not covered under the prior dental plan.

[Deductible Credit:

In the first [Calendar] [Plan] Year a Deductible credit will be given to a Covered Person who was insured under the Policyholder's dental plan on the date it terminated and is insured under this Dental Benefit Rider as of the Policy Effective Date. The Covered Person will receive credit up to the amount of the [Calendar] [Plan] Year Dental Deductible for any amounts paid under the prior dental plan and applied to that plan's dental deductible.]

[Benefit Waiting Period [Waiver] [Credit]:

[The Benefit Waiting Period will be waived for a Covered Person who was insured under the Policyholder's dental plan on the date it terminated and is insured under this Dental Benefit Rider as of the Policy Effective Date.] [Benefit Waiting Period credit will be given for the number of continuous uninterrupted months of coverage the Covered Person was covered under the Policyholder's dental plan on the date it terminated and is insured under this Dental Benefit Rider as of the Policy Effective Date.]]]

[F. Replacement of Existing Dental Insurance

The following takeover provision[s] [is] [are] applicable when the Covered Person was covered under a dental plan in force at the time of the Covered Person's application for coverage under the Policy and this Dental Benefit Rider: To be eligible for [this] [these] takeover provision[s] the Covered Person must have been covered under the prior dental plan immediately prior to the Effective Date of Coverage under the Policy and this Dental Benefit Rider.

[Deductible Credit:

In the first [Calendar] [Plan] Year a Deductible credit will be given to a Covered Person up to the amount of the [Calendar] [Plan] Year Dental Deductible for any amounts paid under the prior dental plan and applied to that plan's dental deductible.]

[Benefit Waiting Period [Waiver] [Credit]:

[The Benefit Waiting Period will be waived for a Covered Person who was insured under the prior dental plan immediately prior to the Effective Date of Coverage under the Policy and this Dental Benefit Rider.] [Benefit Waiting Period credit will be given for the number of continuous uninterrupted months of coverage the Covered Person was insured under the prior dental plan immediately prior to the Effective Date of Coverage under the Policy and this Dental Benefit Rider.]]

[G. Preferred Provider Organizations

This section is applicable when the Covered Person is covered under a PPO Dental Plan and the Schedule of Benefits provides In-Network and Out-of-Network provider Dental benefits.

Your Coverage for Dental benefits includes access to a Preferred Provider Organization (PPO). A Covered Person is free to obtain dental care from the Dentist of his or her choice, but the Covered Person's out-of-pocket expenses may be less in the case of treatment received from an In-Network Provider. The PPO Dental plan contains different levels of benefits based upon whether care is provided by In-Network Providers or Out-of-Network Providers. The In-Network Provider and Out-of-Network Provider Dental Deductible and Co-Insurance payable for a Covered Dental Charge is shown in the Schedule of Benefits.]

[H.] Definitions

All capitalized terms used herein shall have the same meaning as in the Policy unless otherwise stated herein. The following definitions are applicable to the Dental Benefit Rider. When used in this Rider these terms are capitalized.

Benefit Waiting Period: The period between the Effective Date of the Covered Person's Coverage under the Dental Benefit Rider and the date the Covered Person becomes eligible to receive covered dental Benefits. The Benefit Waiting Periods, if applicable, are shown in the Schedule of Benefits and may vary based on the type of dental treatment and care. Separate Benefit Waiting Periods may apply for Preventive Care, Basic Care [and] Major Care [and Orthodontia [and Prosthodontics]].

[Calendar Year Dental Deductible: The amount of Covered Dental Charges that each Covered Person must satisfy each Calendar Year before Benefits are paid for Covered Dental Charges. The Calendar Year Dental Deductible is shown in the Schedule of Benefits. [Any amounts of Covered Dental Charges incurred during the last three months of the Calendar Year and applied to the Covered Person's Calendar Year Dental Deductible will also apply toward meeting the Covered Person's Calendar Year Dental Deductible for the next Calendar Year.]]

Covered Dental Charge: The dental charges of a Dentist or Doctor for the dental services, treatment or supplies which are:

1. Recommended, approved or certified by a Dentist as necessary and reasonable treatment of the condition;
2. Commonly viewed by the America Dental Association as being proper treatment;
3. Performed or ordered by:
 - a. A licensed Dentist acting within the scope of his license; or
 - b. A licensed Doctor performing dental services within the scope of his license; or
 - c. A licensed dental hygienist acting under the supervision and direction of a Dentist;
4. Not in excess of the Reasonable and Customary charge for the services, treatment or supplies furnished;
5. Incurred while the Covered Person's Coverage under the Dental Benefit Rider is in force; and
6. Not otherwise excluded by the Dental Benefit Rider or the Policy.

Dental Coinsurance Percentage: The sharing of costs between Us and the Covered Person. The Dental Coinsurance Percentage is specified in the Schedule of Benefits. It is the percentage of Covered Dental Charges for which We are responsible after the Covered Person has paid any applicable [Calendar] [Plan] Year Dental Deductible.

Dentist. A person duly licensed to practice dentistry in the state in which the dental services are rendered as a Doctor of Dental Surgery (DDS) or Doctor of Medical Dentistry (DMM).

[In-Network Provider: A Dentist who is under contract with Us or Our subcontracted vendor and has agreed to provide services at a negotiated rate.]

[Out-of-Network Provider: A Dentist who is not under contract with Us or Our subcontracted vendor.]

[Plan Year Dental Deductible: The amount of Covered Dental Charges that each Covered Person must satisfy each Plan Year before Benefits are paid for Covered Dental Charges. The Plan Year Dental Deductible is shown in the Schedule of Benefits. [Any amounts of Covered Dental Charges incurred during the last three months of the Plan Year and applied to the Covered Person's Plan Year Dental Deductible will also apply toward meeting the Covered Person's Plan Year Dental Deductible for the next Plan Year.]]

[PPO Service Area: The geographical area in which We have arranged to provide PPO services to Covered Persons.]

[Preferred Provider Organization (PPO): A designated entity within the PPO Service Area under contract with Us or Our subcontracted vendors to provide certain services at a reduced reimbursement rate within a PPO Service Area. We or Our subcontracted vendors will contract with In-Network Providers to provide dental services covered by this Dental Benefit Rider.]

Reasonable and Customary Charge: The most common charge for similar professional services, drugs, procedures, devices, supplies or treatment within the geographic area in which the charge is incurred. The most common charge means the lesser of:

- the actual amount charged by the provider;
- the negotiated rate;
- the usual charge which would have been made by a provider (Dentist, Hospital, etc.) for the same or a comparable professional services, drugs, procedures, devices, supplies or treatment within the same geographic area.

This Rider is effective on the Effective Date of the Policy; and, for the Eligible Person, on the Effective Date as the Certificate to which it is attached unless a different Rider date is specified by an attached Endorsement.

This Rider will terminate in accordance with Section 7 – Termination.

This Rider is subject to all provisions of the Policy which are not in conflict with the provisions of this Rider. Nothing in this Rider will be held to vary, alter, waive, or extend any of the terms, conditions, provisions, agreements, or limitations of the Policy other than stated above.

IN WITNESS WHEREOF, the Insurance Company has caused this Rider to be signed by its President.

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.



Larry R. Graber
President

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.
[P.O. Box 5008, Madison, WI 53705]

[OPTIONAL] TERM LIFE INSURANCE BENEFIT RIDER

This Rider is made a part of the Policy and Certificate to which it is attached. This Rider is subject to all provisions of the Policy which are not in conflict with the provisions of this Rider. We will provide this Benefit in consideration of the payment of any applicable premium for this Rider.

When [a Covered] [an Eligible] Person is covered under the Term Life Insurance Benefit Rider, as selected by the Policyholder and if specified as included in the Schedule of Benefits [and evidence of insurability, satisfactory to Us, has been submitted if required], We will pay the following term life insurance benefit subject to the terms and conditions of the Policy and this Benefit Rider

A. TERM LIFE INSURANCE BENEFIT

When We receive proof of the Eligible Person's death while the Eligible Person was covered by this Term Life Insurance Benefit Rider, We will pay to the Beneficiary as indicated in the Enrollment Application, the Eligible Person's Term Life Insurance benefit specified in the Schedule of Benefits.

[When We receive proof of the Dependent's death while the Dependent was covered by the Policy, We will pay to the Eligible Person the Dependent's Term Life Insurance benefit specified in the Schedule of Benefits.]

B. GENERAL PROVISIONS

Designated Beneficiary

The Eligible Person may designate a person or entity as Beneficiary by completing an enrollment form or by completing the enrollment process. If two or more Beneficiaries are named, each will receive an equal share of the benefit unless the Eligible Person designates otherwise.

Any benefit due by reason of the death of an Eligible Person is payable to the Beneficiary. If no Beneficiary or family member is living to receive the death benefit, or if the benefit is payable to the Eligible Person's estate, We may pay up to \$2,000 to any person appearing to Us to be equitably entitled to the benefit by reason of having incurred funeral or other expenses incident to the last illness or death of the Eligible Person. Any payment We make in good faith fully discharges Us to the extent of Our payment.

The Eligible Person may change the Beneficiary at any time [unless an irrevocable Beneficiary is named or the insurance is assigned]. The change date is the last date on which the Eligible Person signed an enrollment form or by completing the enrollment process naming a new or different Beneficiary. If We pay the benefit before We receive the enrollment form or the enrollment process is completed changing the Beneficiary, We are released from further liability under the Policy to the extent of Our payment.

If the Beneficiary dies at the same time as the Eligible Person, or within 15 days of the Eligible Person's death, We will pay the benefit as if the Eligible Person survived the Beneficiary.

If the named Beneficiary is not living, or if no Beneficiary is named when the Eligible Person dies, We will pay the benefit to the first of the following living persons:

1. the Eligible Person's spouse;
2. the Eligible Person's natural and adopted children, equally;
3. the Eligible Person's parents, equally; or
4. the Eligible Person's brothers and sisters, equally.

If any Beneficiary is not legally competent, We will pay the benefit to the Beneficiary's legal guardian. If none of the above persons are living, then We will pay the benefit to the Eligible Person's estate.

Any payment We make in good faith fully discharges Us to the extent of Our payment.

[Assignment

The Term Life Insurance may be assigned. The assignment is not binding on Us until We receive and acknowledge a copy of it in writing before We pay the benefit. We do not warrant or guarantee the legal validity or effect of the assignment.]

Termination or Reduction of Benefit

Coverage may terminate or the benefit amount may be reduced on or after the date the Eligible Person attains a certain age. See the Schedule of Benefits. [Reduction in the benefit amount of insurance because of a change in age are effective on the first of the month [coinciding with] [following] the date the Eligible Person attains the age in the new age bracket.]

Suicide Limitation

Death by suicide, [while sane or insane] is not covered if death occurs within 12 months from the Covered Person's effective date under this Rider. In such event, We will only refund premiums paid for this benefit. At Our own expense, We have the right and opportunity to request an autopsy in case of death, where it is not prohibited by law, to determine whether the death was by or due to suicide.

Optional Modes of Settlement

Before we pay the benefit, the Eligible Person or Beneficiary may elect an optional mode of settlement other than a lump sum. The election must be in writing on forms We provide for any mode We offer at that time. An optional mode is only available if the benefit is at least [\$1,000] and is subject to Our approval.

Conversion Privilege

If an Eligible Person's insurance, or a portion of it, terminates because the Eligible Person is no longer in an Eligible Class as described in the Policy application, a Covered Person is entitled to have issued to him or her, without Evidence of Insurability, an individual policy of life insurance without disability or other supplementary benefits. Application for the individual policy and the first premium must be received by Us within 31 days from the insurance termination date.

The individual policy will be on any one of the forms then customarily issued by Us or our designee at the age and for the amount applied for, except for term insurance. The converted amount cannot exceed the terminated amount, less the amount of any life insurance for which the Covered Person becomes eligible under the same or any other group policy within 31 days from the termination date. The premium will be at Our then customary rate for the policy form and benefit amount, to the class of risk to which the Covered Person then belongs, and to the Covered Person's attained age on the policy effective date.

If the Policy terminates or is amended to terminate a class of Insureds, each Eligible Person who was insured by the Policy for at least five years before the termination date will be entitled to the same conversion privilege described above. However, the converted amount cannot exceed the lesser of: (1) the terminated amount less the amount of any life insurance for which the Eligible Person is or becomes eligible under a group policy issued by Us or another insurer within 31 days; or (2) \$10,000.

We will give notice to the Eligible Person of the right to convert within 15 days prior to the date the insurance terminates. If the notice is not given within that time, the Eligible Person has 15 days from the date of the notice to convert. But in no event can the Eligible Person convert after 60 days have ended from the last day of the 31 day conversion period. Written notice may be delivered or mailed to the Eligible Person by the Plan Administrator, Our Authorized Administrator or by Us to the last known address of the Eligible Person as known by the Plan Administrator.

Death During Conversion Period

If the Covered Person dies during the 31 days allowed to convert insurance and before the conversion policy is issued, We will pay the amount of benefit the Covered Person could have converted minus the premium due for the conversion.

C. DEFINITIONS

All capitalized terms used herein shall have the same meaning as in the Policy unless otherwise stated herein. The following definition is applicable to this Term Life Insurance Benefit Rider. When used in this Rider these terms are capitalized.

Beneficiary. The person named on the enrollment form or during the enrollment process as the person entitled to receive the Life Insurance benefit upon the death of the Eligible Person. [The Eligible Person is the Beneficiary of the Dependent's Term Life Insurance benefit amount upon the death of the covered Dependent.]

This Rider is effective on the Effective Date of the Policy; and, for the Eligible Person, on the Effective Date as the Certificate to which it is attached unless a different Rider date is specified by an attached Endorsement.

This Rider will terminate in accordance with Section 7 – Termination.

This Rider is subject to all provisions of the Policy which are not in conflict with the provisions of this Rider. Nothing in this Rider will be held to vary, alter, waive, or extend any of the terms, conditions, provisions, agreements, or limitations of the Policy other than stated above.

IN WITNESS WHEREOF, the Insurance Company has caused this Rider to be signed by its President.

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.

A handwritten signature in cursive script, reading "Larry R. Graber".

Larry R. Graber
President

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.
[P.O. Box 5008, Madison, WI 53705]

[OPTIONAL] VISION BENEFIT RIDER

This Rider is made a part of the Policy and Certificate to which it is attached. This Rider is subject to all provisions of the Policy which are not in conflict with the provisions of this Rider. We will provide this Benefit in consideration of the payment of any applicable premium for this Rider.

When a Covered Person is covered under the Vision Benefit Rider, as selected by the Policyholder and if specified as included in the Schedule of Benefits, We will pay the charges a Covered Person incurs in connection with vision treatment, services and supplies received while the Covered Person is insured under this Rider. Benefits for covered charges are subject to the following: (a) the Maximum Benefit specified in the Schedule of Benefits; (b) the Exclusions and Limitations contained in the Vision Benefit Rider; and (c) all other terms and conditions of the Policy.

A. Benefits

Vision Benefits payable under this Rider for covered vision charges are subject to the following, if specified in the Schedule of Benefits:

1. The Vision Coinsurance Percentage;
2. The [Calendar] [Plan] Year Maximum Benefit.

Charges by an Eye Doctor for routine eye examinations up to the limit specified in the Schedule of Benefits.

Charges for [[one pair of] eyeglass lenses and frames or [[one] pair of] contact lenses including disposable contacts up to the limit specified in the Schedule of Benefits. The eyeglasses or contact lenses must be prescribed by an Eye Doctor.

With regard to disposable contact lenses, "one pair of contact lenses" shall mean multiple pairs of contact lenses the cost of which do not exceed the cost of a single pair of permanent contact lenses.

B. Exclusions and Limitations

Benefits are not provided under this Rider for:

- Any medical or surgical treatment of the eye.
- Sunglasses, plain or prescription; or safety lenses or goggles.
- Orthoptics, vision training or aniseikonia.
- Scratch coating, tinting, and eye glass insurance.

C. Definitions

All capitalized terms used herein shall have the same meaning as in the Policy unless otherwise stated herein. The following definitions are applicable to the Vision Benefit Rider. When used in this Rider these terms are capitalized.

Eye Doctor: An ophthalmologist, optometrist or a person licensed to provide covered vision care within the scope of their license.

Vision Coinsurance Percentage: The sharing of costs between Us and the Covered Person. The Vision Coinsurance Percentage is specified in the Schedule of Benefits. It is the percentage of covered vision charges for which We are responsible.

This Rider is effective on the Effective Date of the Policy; and, for the Eligible Person, on the Effective Date as the Certificate to which it is attached unless a different Rider date is specified by an attached Endorsement.

This Rider will terminate in accordance with Section 7 – Termination.

This Rider is subject to all provisions of the Policy which are not in conflict with the provisions of this Rider. Nothing in this Rider will be held to vary, alter, waive, or extend any of the terms, conditions, provisions, agreements, or limitations of the Policy other than stated above.

IN WITNESS WHEREOF, the Insurance Company has caused this Rider to be signed by its President.

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.

A handwritten signature in cursive script, reading "Larry R. Graber".

Larry R. Graber
President

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.
[P.O. Box 5008, Madison, WI 53705]

**[OPTIONAL] NON-OCCUPATIONAL WEEKLY DISABILITY INCOME
INSURANCE BENEFIT RIDER
(Eligible Person Only)**

This Rider is made a part of the Policy and Certificate to which it is attached. This Rider is subject to all provisions of the Policy which are not in conflict with the provisions of this Rider. We will provide this Benefit in consideration of the payment of any applicable premium for this Rider.

When You are covered under the Weekly Disability Income Insurance Benefit Rider, as selected by the Policyholder and if specified as included in the Schedule of Benefits, We will pay a weekly disability income benefit as described in this Rider. Benefits are subject to the following:

1. The Maximum Benefits specified in the Schedule of Benefits;
2. The Limitations and Exclusions contained in the Non-Occupational Weekly Disability Income Benefit Rider; and
3. All other terms and conditions of the Policy.

1. Insuring Clause

- a. Upon receipt of written notice and due proof from the Eligible Person's Doctor, that an Eligible Person, as a result of non-occupational covered Illness or Injury, and before attaining his or her [sixty-fifth (65th)] birthday, becomes Totally Disabled, We shall pay, for each day the Eligible Person is so Totally Disabled, one-seventh (1/7th) of the applicable [the] Benefit percentage of the Basic Weekly Earnings as specified in the Schedule of Benefits. Benefits begin following the Benefit Waiting Period as specified in the Schedule of Benefits and are payable up to the Maximum Amount as specified in the Schedule of Benefits.
- b. Benefits for any period of Total Disability, whether due to one or more causes, shall not exceed the Maximum Period of Weekly Disability Benefit specified in the Schedule of Benefits.
- c. Successive periods of Total Disability will be considered as one continuous Total Disability period unless such separate periods are due to unrelated causes; or are due to the same or related cause or causes, but are separated by at least 2 weeks during which the Eligible Person has returned to work on a continuous Actively at Work status. The next subsequent Total Disability is considered a new period of Total Disability irrespective of its cause or causes. The Benefit Waiting Period cannot be satisfied during any period for which Total Disability benefits are being paid under this Rider.
- [d. Your premium and Your covered Dependent's premium for Coverage under the Policy will be waived during the period of time that the You are Totally Disabled and Benefits are being paid to You under this Rider.]

2. Limitations and Exclusions

Benefits are not payable for a Total Disability:

- a. For which the Eligible Person is not under the regular care of a Doctor;
- b. Which arises out of or in the course of any employment for profit or wage, or for which the Eligible Person has or had a right to compensation under any Worker's Compensation or occupational disease law;
- c. Resulting from attempted suicide or an intentionally self-inflicted Illness or Injury [while sane or insane];
- d. For a Pre-Existing Condition until a continuous period of [12] months has elapsed during which the Eligible Person was covered under the Policy;
- e. Resulting from war or any act of war, whether declared or undeclared;
- f. Resulting from active participation in a riot or insurrection;

- g. Resulting while serving in the military forces of any country, including non-military units supporting such forces;
- h. Resulting while under the influence of alcohol or drugs other than those taken in accordance with Doctor instructions;
or
- i. For any treatment, services or supplies for which Benefits are excluded under the Policy as listed in the Certificate of Insurance under Section 6 – Exclusions and Limitations from Coverage.

3. Definitions

All capitalized terms used herein shall have the same meaning as in the Policy unless otherwise stated herein. The following definitions are applicable to the Non-Occupational Weekly Disability Income Benefit Rider. When used in this Rider these terms are capitalized.

Basic Weekly Earnings: Your weekly earnings, excluding commissions, bonuses, incentive pay, unscheduled overtime or other compensation earned from the Policyholder in the prior Policy Year or during the period worked, whichever is less. The amount will be updated on the Policy Anniversary date, as specified in the Policy, each year thereafter.

Benefit Waiting Period: A continuous period beginning on each period of Total Disability. It begins on the day the Eligible Person is first treated by a Doctor after the Total Disability starts. The Benefit Waiting Period is shown in the Schedule of Benefits.

Own Occupation: Means an occupation of the same type the Eligible Person was performing when he or she became Totally Disabled. The Eligible Person's Own Occupation is not limited (1) to the specific job the Eligible Person was performing when he or she became Disabled or (2) to work at the same location or (3) to work for the same Employer. If the Eligible Person was not working when he or she became Disabled, the Eligible Person's Own Occupation means any occupation for which the Eligible Person is or may become reasonably qualified by education, training or prior experience.

Pre-Existing Condition: An Illness or Injury, or complications therefrom, for which treatment, services or supplies, including [the taking of] Prescription Medications, advice or consultation was rendered to an Eligible Person, or which produced distinct symptoms in an Eligible Person which would have caused an ordinarily prudent person to seek medical diagnosis or treatment within [12] months prior to the Effective Date of Coverage under the Policy.

Totally Disabled/Total Disability: An Eligible Person's continuous and complete inability to gainfully perform the duties of his or her Own Occupation. To be considered Totally Disabled for purposes of this Rider, the Eligible Person must be under the regular care of a Physician appropriate for the medical condition causing the Total Disability.

This Rider is effective on the Effective Date of the Policy; and, for the Eligible Person, on the Effective Date as the Certificate to which it is attached unless a different Rider date is specified by an attached Endorsement.

This Rider will terminate in accordance with Section 7 – Termination.

This Rider is subject to all provisions of the Policy which are not in conflict with the provisions of this Rider. Nothing in this Rider will be held to vary, alter, waive, or extend any of the terms, conditions, provisions, agreements, or limitations of the Policy other than stated above.

IN WITNESS WHEREOF, the Insurance Company has caused this Rider to be signed by its President.

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.



Larry R. Graber
President

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.
[P.O. Box 5008, Madison, WI 53705]

ARKANSAS AMENDATORY ENDORSEMENT

Notwithstanding anything in the Policy and Certificate of Insurance to the contrary, it is hereby understood and agreed that the Policy and any Certificate of Insurance to which this amendatory endorsement is attached are amended as follows:

A. **SECTION 3 – ELIGIBILITY FOR INSURANCE AND EFFECTIVE DATE OF COVERAGE**, the following changes are hereby made:

The **Newborn Children and Adopted Child** provisions under **Dependents Acquired After Effective Date** are deleted and replaced with:

Newborn Children: Your newborn Child is automatically covered from the moment of birth and coverage will remain in force for 90 days. Coverage for newborns shall be the same as for all other Dependents. You must notify Us in writing within 90 days of such birth, and pay the required additional premium, if any, in order to have Coverage for the newborn Child continue beyond such 90 day period.

Adopted Child: Coverage for an adopted Child or a minor under Your charge, care and control for whom You have filed a petition to adopt, is effective upon the earlier of the date of placement for the purpose of adoption, or the date of the entry of an order granting the adoptive parent custody of the Child for purposes of adoption. Coverage for such Child will be the same as for all other Dependents. Coverage will continue unless the placement is disrupted prior to legal adoption and the Child is removed from placement. However, You must notify Us in writing within 60 days of such placement for adoption or entry of an order and pay the required additional premium, if any, in order to have Coverage for the adopted Child continue beyond such 60 day period.

B. **SECTION 5 -- BENEFITS** is amended by adding the following Covered Benefit:

Surgical and nonsurgical treatment of musculoskeletal disorders affecting any bone or joint in the face, neck or head, including temporomandibular joint (TMJ) disorder and craniomandibular disorder when such treatment is administered or prescribed by a Doctor or a dentist. The Indemnity Benefits are payable on the same basis as any other covered musculoskeletal disorder of the body as shown on the Schedule of Benefits. Coverage includes Medically Necessary diagnosis and treatment of these conditions whether they are the result of accident, trauma, congenital defect, developmental defect, or pathology.

C. **SECTION 6– EXCLUSIONS AND LIMITATIONS FROM COVERAGE**, the following change is hereby made:

1. Item #40 pertaining to treatment, services or supplies as the result of prognathism, retrognathism, micrognathism is deleted in its entirety.
2. Item #41 pertaining to TMJ is deleted in its entirety.

D. **SECTION 7– TERMINATION**, the following change is hereby made:

Item a., in the 2nd paragraph, under **Termination of a Dependent's Coverage** is deleted and replaced with the following:

- a. Medical proof, in writing, of such incapacity must be given to Us after the date on which the Dependent Child attains a limiting age.

E. **SECTION 8 – GENERAL PROVISIONS**, the following changes are hereby made:

1. The following is added to the **Recovery of Overpayments** provision:

Except in cases of fraud committed by a health care provider, We may exercise recoupment from a provider only during the 18 month period after the date We paid the claim submitted by the provider. If We exercise recoupment, We will give the provider a written or electronic statement specifying the basis for the recoupment. The statement will provide the following information: (1) The amount of the recoupment; (2) The Covered Person's name to whom the recoupment applies; (3) The patient identification number; (4) The date of service; (5)

The service or services on which the recoupment is based; (6) The pending claims being recouped or future claims that will be recouped; and (7) The specific reasons for the recoupment.

For the purpose of this provision, the following definition applies:

Recoupment: Any action or attempt by Us to recover or collect payments already made to the provider with respect to a claim by: (1) Reducing other payments currently owed to the provider; (2) Withholding or setting off the amount against current or future payments to the provider; (3) Demanding payment back from a provider for a claim already paid; or (4) Any other manner that reduces or affects the future claim payments to the provider.

2. The provisions captioned **Arbitration and Arbitration Action** are deleted in their entirety.
3. The **Appeal** provision is deleted and replaced with the following:

Appeal

Under ERISA or state law, You have certain administrative appeal rights. If You disagree with any Benefit determination made by Us or Our authorized administrator, You must complete all administrative appeals to which You are entitled before You may demand Legal Action.

4. The **Ambiguities** provision is deleted and replaced with the following:

Ambiguities

Any terms or conditions specified in the Policy that are determined to be ambiguous or in conflict with state or federal laws shall be considered separately and shall not void or affect the legality of the remaining terms and conditions that are included in the Policy.

5. The following provision is added:

Legal Action

No action at law or in equity may be brought to recover Benefits on the Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of the Policy. No such action may be brought after the expiration of 3 years after the time written proof of loss is required to be furnished.

This Amendatory Endorsement is endorsed and made part of the Policy/Certificate as of its Effective Date.

Nothing in this Amendatory Endorsement shall be held to vary, alter, waive or extend any of the terms, conditions, agreements, provisions or limitations of the Policy, other than as stated above.

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.



Larry R. Graber
President



Adam C. Vandervoort
Secretary

SERFF Tracking Number: ICCI-127879267 State: Arkansas
 Filing Company: Madison National Life Insurance Company, Inc. State Tracking Number:
 Company Tracking Number: MNL LMB POL 0112
 TOI: H14G Group Health - Hospital Indemnity Sub-TOI: H14G.000 Health - Hospital Indemnity
 Product Name: MNL LMB POL 0112
 Project Name/Number: MNL LMB POL 0112/MNL LMB POL 0112

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification Comments: Attachment: Cert of Comp. with Rule 19 MNL LMB 0112.pdf	Approved-Closed	07/06/2012

	Item Status:	Status Date:
Satisfied - Item: Application Comments: See form schedule tab	Approved-Closed	07/06/2012

	Item Status:	Status Date:
Satisfied - Item: MNL Authorization Letter 2012 Comments: Attachment: ICC Authorization letter Madison Nat 2012.pdf	Approved-Closed	07/06/2012

**Certificate of Compliance with
Arkansas Rule and Regulation 19**

Insurer: Madison National Life Insurance Company, Inc.

Form Number(s): MNL LMB POL 0112, MNL LMB CERT 0112, MNL LMB ER APP 0112, MNL LMB EE APP 0112, MNL LMB ACC 0112, MNL LMB ADD 0112, MNL LMB CCR 0112, MNL LMB DEN 0112, MNL LMB LIF 0112, MNL LMB VIS 0112, MNL LMB WDI 0112, MNL LMB AEHBA 0112, MNL LMB AE AR 0112

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirement of Rule and Regulation 19.



Signature of Company Officer

Larry R. Graber

Name

President

Title

July 5, 2012

Date



Madison National Life

January 1, 2012

Mr. Brian Camling
President
Insurance Compliance Consultants, Inc.
3925 East State Street, Suite 200
Rockford, IL 61108

Dear Mr. Camling:

Please accept this letter as written confirmation that Insurance Compliance Consultants, Inc., has authority to file the attached form(s) or a state specific variation of it, and to act on behalf of Madison National Life Insurance Company, Inc. regarding such filings, in all jurisdictions where this form(s) or a state specific variation of it is being filed. Madison National may withdraw this authorization at any time, by giving notice to Insurance Compliance Consultants.

Sincerely,

A handwritten signature in cursive script that reads "Larry R. Graber". The signature is written in black ink and is positioned above the printed name.

Larry Graber