Accidental Death and Dismemberment Certificate of Insurance

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

State of Tennessee

Voluntary Accidental Death and Dismemberment insurance plan

Effective January 1, 2024

POLICYHOLDER: State of Tennessee

POLICY NUMBER: 34295-G

Read Your Certificate Carefully

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

Legal Actions

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

Renée D. Montz

Secretary

President

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GENERAL INFORMATION

POLICYHOLDER: State of Tennessee **POLICY NO.:** 34295-G

POLICY EFFECTIVE DATE: January 1, 2014. This specifications page represents the plan in effect as of January 1, 2024.

POLICY ANNIVERSARY DATE: January 1 of each year beginning January 1, 2015

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

GROUP: The group is composed of all active employees of the policyholder and its associated employers working in the United States who meet the following eligibility criteria:

- Any person employed by the employer, who is regularly scheduled to work at least 30 hours per week;
- Any person who has received a seasonal appointment and who meets the requirements set forth in TCA 8-27-204(a)(3); and
- All other individuals cited in state statute or approved as an exception by the State Insurance Committee.

Note: Individuals in positions classified as temporary appointments or performing services on a contractual basis shall not be considered to be employees unless they otherwise meet the definition of an eligible employee as defined in the last bullet above.

WAITING PERIOD: **Active Employees regularly scheduled to work 30 hours a week or more:** The period commencing with the employee's date of hire and completion of one full calendar month of employment.

For newly hired employees, the effective date of coverage will be the first day of the month following the employee's date of hire and one full calendar month of employment.

Any person who has received a seasonal appointment and who meets the requirements set forth in TCA 8-27-204(a)(3): The period commencing 24 months from the employee's date of hire and ending on the 1st day of the month following the completion of the 24-month requirement and submission of a completed enrollment form to the Policyholder.**

**For seasonal employees meeting the requirements stated in TCA 8-27-204(a)(3), part-time to full-time employees, and emergency appointment to permanent employment employees; the effective date of coverage will be the first day of the month following gaining eligibility for coverage and submission of a completed enrollment form to the Policyholder.

ENROLLMENT PERIOD:

An employee may apply for coverage during the following enrollment periods:

Newly eligible employees: within the 30 day period beginning from the first day of eligibility.

Annual enrollment: A period of annual enrollment as determined by the policyholder's normal practices and procedures.

Enrollment Due to an Acquire Event or Loss of Eligibility for Other Coverage Event: Enrollments due to an Acquire Event or Loss of Eligibility for Other Coverage Event are enrollments outside of an initial enrollment or annual enrollment period. Without regard to the dates or circumstances on which an individual would otherwise be able to enroll in one of the Programs, current Employees and Dependents as defined are permitted to enroll in coverage under one or more of these Programs if the Employee or Dependent experiences one of the events stated in Section A or B below:

A. *Loss of Eligibility for Other Coverage.*

1. An Employee or Dependent, otherwise eligible to enroll in a specific benefit Program may be enrolled through this provision provided that they:
   a. Declined coverage in this voluntary AD&D benefit Program when it was previously offered during their initial eligibility period for employees and for dependents, or during a subsequent annual enrollment period;
   b. Had specific benefit coverage under any group AD&D insurance plan at the time a specific Program coverage was previously offered; **and**
   c. Experience a loss of eligibility for other specific life insurance coverage (voluntary AD&D) for reasons including the following (but not for a failure to pay premiums or termination for cause):
      i. Death;
      ii. Divorce;
      iii. Legal separation;
      iv. Cessation of dependent status;
      v. Termination of employment (voluntary and non-voluntary);
      vi. Employer's discontinuation of contribution to insurance coverage (total contribution, not partial);
      vii. Reduction in number of work hours of employment
2. If an Employee satisfies all three requirements of A.1. above, the Employee and all Dependents of the Employee are eligible for enrollment to the specific benefit Program (voluntary AD&D).
3. If a Dependent satisfies all three requirements of A.1. above, only that Dependent, the Employee, and other Dependents satisfying the requirements of A 1. above are eligible for enrollment to the specific benefit Program.
4. All enrollments due to a Loss of Eligibility for other Coverage Event must be submitted to and received by the Policyholder, Department of Finance and Administration, Division of Benefits Administration within **sixty (60) days** of the loss of eligibility for other coverage.
5. The effective date of coverage for an enrollment due to a Loss of Eligibility for Other Coverage shall be the first day of the first calendar month after the date the Policyholder receives the request for enrollment.
6. Substantiation of Loss of Coverage. If requesting enrollment based on a loss of eligibility for other coverage, the Employee must submit appropriate documentation to substantiate all of the following:
   a. That the Employee or Dependent was covered for voluntary AD&D by any other group life insurance plan at the time they declined the offer of specific coverage from This Program; and

b. That the Employee experienced an event resulting in the Employee or Dependent's loss of eligibility for the specific coverage under the other group life insurance plan, and the date of the Employee or Dependent's loss of eligibility.

B. *Acquisition of New Dependents.*

1. When an Employee acquires a new Dependent by marriage, birth, adoption, placement for adoption or legal guardianship, custody or conservatorship, the Employee, Spouse, and any Dependent may be enrolled in the voluntary AD&D.
2. All enrollment applications based upon the acquisition of a new Dependent must be submitted to and received by the Policyholder, Department of Finance and Administration, Division of Benefits Administration within **thirty (30 days** of the acquisition date.
3. The effective date of coverage for an enrollment for acquiring a new Dependent Spouse, child pursuant to an order of guardianship, custody or conservatorship and new stepchild acquired by marriage shall be the first day of the first calendar month after the date the Policyholder receives the request for enrollment.
4. The effective date of coverage for an enrollment for acquiring a new child by birth, adoption, placement for adoption, shall be the date of the birth, adoption, or placement for adoption.
5. Substantiation of Acquiring a New Dependent. If requesting enrollment based on acquiring a new Dependent, the Employee must submit appropriate documentation as listed on the enrollment application to substantiate the following:
   a. The date of birth of a child; or
   b. The date of the adoption or the order placing the child in custody for adoption;
   c. The date of guardianship, custody or conservatorship specified by the order granting same; or
   d. Date of marriage.

PLAN OF INSURANCE

EMPLOYEE BENEFIT SCHEDULE

EMPLOYEE ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE:

Eligible Class	**Amount of AD&D Insurance:**
All eligible employees	An amount elected by the employee from the following options: $50,000, $60,000, $100,000, $250,000, $500,000

GENERAL PROVISIONS FOR INSURANCE

AGE REDUCTIONS:	None
EFFECT OF EMPLOYEE'S RETIREMENT:	All insurance terminates at retirement according to the provisions of the Termination section on page 6 of the Certificate.
CONTRIBUTORY/ NONCONTRIBUTORY:	All AD&D insurance is contributory insurance.

INCREASES AND DECREASES: All increases are subject to the actively at work requirement. Dependents insurance shall automatically increase or decrease as the employee's amount of insurance increases or decreases.

DEPENDENTS BENEFIT SCHEDULE

DEPENDENTS AD&D INSUANCE:

Employee's Family Consists of	Amount of AD&D Insurance
Spouse and Eligible Children	Spouse: 40% of employee's amount of insurance Each Child: 10% of employee's amount of insurance
Spouse and No Eligible Children	Spouse: 60% of employee's amount of insurance
No Spouse but Eligible Children	Each Child: 10% of employee's amount of insurance

GENERAL PROVISIONS FOR DEPENDENTS INSURANCE

CONTRIBUTORY/ NONCONTRIBUTORY: All dependents insurance is contributory insurance.

INCREASES AND DECREASES: Dependents insurance shall automatically increase or decrease as the employee's amount of insurance increases or decreases.

Definitions

age

Your attained age as of September 1 each plan year, or for a newly eligible employee, your attained age on your date of eligibility.

associated employer

Any employer which is designated by the policyholder and agreed to by us to participate under the group policy. The policyholder represents any associated employer in all transactions pertaining to the group policy. The policyholder's acts or omissions and every notice given by us to the policyholder shall be binding on every associated employer.

contributory insurance

Insurance for which you are required to make premium contributions.

employee

An individual employed by the State or associated employer who:

(1) is regularly scheduled to work not less than thirty (30) hours per week; or
(2) has received a seasonal appointment and who meets the requirements set forth in TCA 8-27-204 (a)(3) and
(3) is deemed eligible by applicable state statute or approved as an exception by the State Insurance Committee.

Note: Individuals in positions classified as temporary appointments or performing services on a contractual basis shall not be considered to be employees unless they otherwise meet the definition of an eligible employee as defined in the last bullet above in this section.

If you are an eligible employee married to another eligible employee, then you cannot be insured as a spouse under the group policy. You can only obtain coverage as an employee.

employer

The Policyholder or any designated associated employer. These include Central State Government, State Higher Education and State Offline Agencies.

insured

A person who is eligible for and becomes insured under the terms of this certificate.

licensed physician

An individual who is licensed to practice medicine or treat illness in the state in which treatment is received. The physician cannot be you or your spouse, children, parents, grandparents, grandchildren, brothers or sisters, or the spouse of any such individuals.

non-work day

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

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

noncontributory insurance

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

policyholder

The owner of the group policy as shown on the specifications page attached to this certificate.

specifications page

The outline which summarizes your coverage under the Policyholder's plan of insurance.

waiting period

The period, if any, of continuous employment with the employer that the employee must satisfy prior to becoming eligible for coverage under this certificate. Any such waiting period is shown on the specifications page attached to this certificate.

we, our, us

Minnesota Life Insurance Company.

you, your, certificate holder

An insured employee.

General Information

What is your agreement with us?

This certificate summarizes the principal provisions of your accidental death and dismemberment insurance provided by the group policy. The provisions summarized in this certificate are subject in every respect to the group policy. Your application is deemed a part of this certificate.

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

This certificate is issued in consideration of your application and the payment of the required premium.

Can this certificate be amended?

Yes. Your consent is not required to amend this certificate. Any amendment will be without prejudice to any claim for benefits incurred prior to the effective date of the amendment.

Who is eligible for insurance?

You are eligible if you:

(1) are a member of the eligible group and of an eligible class identified in the specification page; and
(2) have satisfied the waiting period, if any; and
(3) meet the actively at work requirement described in the "What is the actively at work requirement?" provision of this section.

Are retired employees eligible for insurance?

No.

What is the actively at work requirement?

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

Employees not working due to illness or injury do not meet the actively at work requirement nor do employees receiving sick pay, short-term disability benefits or long-term disability benefits.

If the employee is not actively at work on the date coverage would otherwise begin, or on the date an increase in his or her amount of insurance would otherwise be effective, he or she will not be eligible for the coverage or increase until he or she returns to active work. However, if the absence is on a non-work day, coverage will not be delayed provided the employee was actively at work on the work day immediately preceding the non-work day.

Except as otherwise provided for in this certificate, an employee is eligible to continue to be insured only while he or she remains actively at work.

When does your insurance become effective?

Newly Eligible Employee – Employee Coverage.

If enrolled within 30 days of first becoming eligible, coverage will become effective on the first day of the month next following completion of one full calendar month of eligible employment, provided you are actively at work on the date your application is signed and on the date the coverage is to become effective.

If not actively at work on both of the above mentioned dates, coverage will not become effective until the first day of the month following your return to active work, provided it is within 180 days of when coverage would have otherwise become effective. If you do not return to active employment within 180 days, you must wait until the next annual enrollment period or an Acquire Event or Loss of Eligibility for Other Coverage Event to reapply for coverage.

The actively at work requirements also apply when your amount of coverage is being increased or when you are adding coverage.

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

Yes. The employer may continue your noncontributory insurance or allow you to continue your contributory insurance when you are absent from work due to sickness, injury, leave of absence, or temporary layoff.

Continuation of your insurance is subject to certain time limits and conditions as stated in the group policy. If you stop active work for any reason, you should discuss with the employer what arrangements may be made to continue your insurance.

Premiums

When and how often are premiums due?

Unless the policyholder and we have agreed to some other premium payment procedure, any premium contributions you are required to make for contributory insurance are to be paid by you to the policyholder on a monthly basis. We apply premiums consecutively to keep the insurance in force.

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

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

Accidental Death and Dismemberment Benefit

What does accidental death or dismemberment by accidental injury mean?

Accidental death or dismemberment by accidental injury means that an insured's death or dismemberment results, directly and independently of all other causes, from an accidental injury which is unintended, unexpected, and unforeseen. The bodily injury must be the sole cause of death or dismemberment.

The injury must occur while the insured's coverage is in force. The insured's death or dismemberment must occur within 180 days after the date of the injury.

What is the amount of the accidental death and dismemberment benefit?

The amount of the benefit shall be a percentage of the amount of insurance shown on the specifications page attached to the group policy. The percentage is determined by the type of loss as shown in the following table:

FOR LOSS OF	AMOUNT OF BENEFIT
Life	Full Amount of AD&D Insurance
Both Hands or Both Feet	Full Amount of AD&D Insurance
Sight of Both Eyes	Full Amount of AD&D Insurance
Speech and Hearing In Both Ears	Full amount of AD&D Insurance
One Hand and One Foot	Full Amount of AD&D Insurance
One Foot and Sight of One Eye	Full Amount of AD&D Insurance
One Hand and Sight of One Eye	Full Amount of AD&D Insurance
Quadriplegia	Full Amount of AD&D Insurance
Paraplegia	75% of Amount of AD&D Insurance
Speech or Hearing in Both Ears	50% of Amount of AD&D Insurance
Sight of One Eye	50% of Amount of AD&D Insurance
One Hand or One Foot	50% of Amount of AD&D Insurance
Hemiplegia	50% of Amount of AD&D Insurance
Thumb and Index Finger of One Hand	25% of Amount of AD&D Insurance

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

Quadriplegia means total and permanent paralysis of both upper limbs (from the shoulder down including total paralysis of both hands) and both lower limbs (from the waist down including total paralysis of both feet). Paraplegia means total and permanent paralysis of both lower limbs (from the waist down including total paralysis of both feet). Hemiplegia means total and permanent paralysis of both the upper limb (from the shoulder down including total paralysis of the hand) and lower limb (from the waist down including total paralysis of the foot) on one side of the body.

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

Benefits may be paid for more than one accidental loss but the total amount of AD&D insurance payable under this certificate for all of an insured's losses due to any one accident, not including any amount paid according to the terms of the Additional Benefits section of this certificate, will never exceed the full amount of AD&D insurance shown on the specifications page attached to this certificate.

What are the notice of claim and proof of loss requirements?

Written notice of injury on which a claim may be based must be given to us within 30 days after the accident. Proof of loss must be furnished to us within 90 days after the date of loss. However, failure to give such notice and proof within the time provided will not invalidate the claim if it is shown that notice and proof were given as soon as reasonably possible.

When we receive written notice of claim, we will send the claimant our claim forms if he or she needs them. If the claimant does not receive the forms within 15 days, we will accept his or her written description as proof of loss.

When will the accidental death or dismemberment benefit be payable?

We will pay the accidental death or dismemberment benefit upon receipt at our home office of written proof satisfactory to us that you died or suffered a covered dismemberment as a result of a covered accidental injury. All payments by us are payable from our home office.

To whom will we pay the accidental death or dismemberment benefit?

In the case of your accidental death, we will pay the accidental death benefit to the beneficiary or beneficiaries. All other benefits will be payable to you, if living, otherwise to your estate.

You should designate a beneficiary or beneficiaries when you first enroll under the plan. You can change your beneficiary designation at any time, provided all of the following are true:

(1) your coverage is in force; and
(2) we have written consent of all irrevocable beneficiaries.

A beneficiary designation must be made in writing, or in any other method agreeable between us and the policyholder and made available under the plan. Any beneficiary designation shall take effect as of the date it is signed, but will not affect any payment we make or action we take before receiving the designation.

You may also choose to name a beneficiary that you cannot change without the beneficiary's consent. This is called an irrevocable beneficiary.

If there is more than one beneficiary, each will receive an equal share, unless you have requested another method in your beneficiary designation. To receive the death benefit, a beneficiary must be living at the time of your death. In the event a beneficiary is not living at the time of your death,

that beneficiary's portion of the death benefit shall be equally distributed to the remaining surviving beneficiaries. In the event of the simultaneous deaths of you and a beneficiary, the death benefit will be paid as if you survived the beneficiary.

If there is no eligible beneficiary, or if you do not name one, we will pay the death benefit to:

(1) your lawful spouse, if living; otherwise
(2) your natural or legally adopted child (children) in equal shares, if living; otherwise
(3) your parents in equal shares, if living; otherwise
(4) the personal representative of your estate.

A request to add or change a beneficiary must be made in writing, or in any other method agreeable between us and the policyholder and made available under the plan. A change will take effect as of the date it is signed, but will not affect any payment we make or action we take before receiving your request.

Additional Benefits

Unless stated otherwise, additional benefits are payable to the same person or persons who receive the AD&D benefits. Additional benefits are paid in addition to any AD&D benefits described in the Accidental Death and Dismemberment section, unless otherwise stated. All provisions of this certificate, including but not limited to the exclusions and requirements listed under the "What does accidental death or dismemberment by accidental injury mean?" section, shall apply to these additional benefits**.**

Adaptive Home and Vehicle Benefit

What is the adaptive home and vehicle benefit?

If an insured suffers a loss other than loss of life and a benefit is payable under the AD&D benefit, we will pay for an insured's principal residence to be made accessible and/or an insured's private automobile to be made drivable or rideable. These one-time alteration expenses must be incurred within two years from the date of the accident. An insured's benefit will be the lesser of:

(1) 10% of his or her amount of AD&D insurance; or
(2) $10,000; or
(3) the actual alteration expense.

The Adaptive Home and Vehicle Benefit will be payable only if:

(1) such home alterations are made by a person or persons with experience in such alterations and recommended by a recognized organization associated with the injury;
(2) such vehicle modifications are carried out by a person or persons with experience in such matters and approved by the Motor Vehicle Department.

Coma Benefit

What is the coma benefit?

If an insured lapses into a coma as a result of and within 365 days of a covered accidental injury, and such coma has lasted for a minimum of 31 days, we will pay a monthly benefit equal to the lesser of:

(1) 1% of the insured's amount of AD&D insurance; or
(2) 1% of the difference between the insured's amount of AD&D insurance and the amount of any benefits paid under the loss schedule for the same accident. (if the full amount of AD&D insurance has been paid, no benefit is payable under this section).

This benefit will be paid monthly until the earliest of the following:

(1) the date the insured recovers such that he or she is no longer in a coma as defined herein; or
(2) the date of the insured's death. If an accidental death payment is due under this certificate, the amount of such payment will be reduced by the amount of AD&D insurance paid under this coma provision; or
(3) 100 monthly benefits have been paid.

Coma means a state of profound unconsciousness with no evidence of appropriate responses to stimulation. The insured must be confined in a medical facility and diagnosed as comatose by a licensed physician.

Repatriation Benefit

What is the repatriation benefit?

If, as a result of a covered accident, an insured dies at least 75 miles from his or her principal residence, an additional accidental death benefit shall be paid for the preparation and transportation of the body to a mortuary. The additional benefit shall be the lesser of the actual cost of such preparation and transportation or $5,000. The benefit will be paid to the person who has or who will incur such cost, as evidenced to the satisfaction of us. This may or may not be the beneficiary for the rest of the accidental death proceeds. We may at our sole discretion pay benefits directly to the facility handling the preparation and/or transportation. All determinations and payments by us will be final and fully release and discharge us from any further liability under this repatriation benefit.

Exclusions

What are the exclusions under this certificate?

In no event will we pay the accidental death or dismemberment benefit where the insured's death or dismemberment results from or is caused directly or indirectly by any of the following:

(1) any disease or infirmity of mind or body, and any medical or surgical treatment thereof; or
(2) suicide or attempted suicide, while sane or insane; or
(3) any intentionally self-inflicted injury; or
(4) war, declared or undeclared war, whether or not you are a member of any armed force; or
(5) commission of, participation in, or any attempt to commit an assault or felony; or
(6) being under the influence of any narcotic, hallucinogen, barbiturate, gas or fumes, poison or any other controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as now or hereafter amended, unless as prescribed by the insured's licensed physician.
Conviction is not necessary for a determination of being under the influence; or
(7) intoxication as defined by the laws of the jurisdiction in which the accident occurred. Conviction is not necessary for a determination of being intoxicated; or
(8) active participation in a riot. "Riot" means all forms of public violence, disorder, or disturbance of the public peace, by three or more persons assembled together, whether with or without a common intent and whether or not damage to person or property or unlawful act is the intent or the consequence of such disorder.

Family Coverage

If you have dependents, you may elect AD&D coverage for your eligible dependents as described below. All provisions of the policy applicable to an "insured," including but not limited to references in the Exclusions and Additional Benefits sections shall apply to a dependent insured hereunder.

What members of your family are eligible for this benefit?

The following members of your family are eligible for insurance under this supplement:

A. A legally married spouse; or
B. A child from birth to the last day of the month in which such child turns age 26 who meets at least one of the following criteria without consideration of factors such as financial dependency, marital status, enrollment in school, or residency:
    1. employee's natural (biological) child, or
    2. employee's adopted child (including a child placed for adoption in anticipation of adoption); or
C. An employee or spouse's stepchild under the age of 26; or
D. A person under age 26 who is placed with the Employee by a valid order of guardianship, custody, or conservatorship (or legally equivalent order) by a court of competent jurisdiction ("placement order"), subject to Employee's signed attestation upon enrollment, and upon request to demonstrate thereafter that the dependent meets requirements to continue coverage until age 26; or
E. Dependents over the age of 26 years who meet at least one of the criteria in B or C in this section and who are incapacitated (mentally or physically incapable of earning a living regardless of age, provided the dependent is incapable of self-sustaining employment). This provision applies only when the incapacity existed before the dependent's 26th birthday and they were already insured under this plan. The child must meet the requirements for dependent eligibility listed in this section. A request to continue coverage due to incapacity must be provided to the Policyholder, Department of Finance and Administration, Division of Benefits Administration prior to the dependent's 26th birthday. Annual proof may also be required. Approval is subject to review by us. Coverage will not continue and will not be reinstated once the dependent is no longer incapacitated.

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

Any dependent child who subsequent to the effective date of your child life insurance, meets the requirements of this provision will become insured on the date he or she so qualifies.

When does insurance on a dependent become effective?

Newly Eligible Employee – Spouse/Child Coverage

If enrolled within 30 days of you first becoming an eligible employee, coverage will be effective on the first day of the month next following completion of one full calendar month of eligible employment, unless:

(1) you are not actively at work on such date; or
(2) your spouse is unable to engage in normal activities because he or she is:
    (a) medically confined on the date the insurance would otherwise take effect; or
    (b) regularly treated by a home health care agency under a plan of treatment established and approved by a physician; or
    (c) receiving or entitled to receive disability or sick pay income from any source.

If either of the above apply, coverage will not become effective until you are actively at work and your spouse resumes his or her normal activities; provided both requirements are met within 180 days of when coverage would have otherwise become effective. If not met within 180 days, you must wait until the next annual enrollment period or an Acquire Event or Loss of Eligibility for Other Coverage Event to reapply for coverage. The actively at work requirements also apply when your amount of coverage is being increased or when you are adding coverage.

Newly Eligible Spouse/Child Due to Marriage

If after becoming an eligible employee you are married, you have 30 days from the date of marriage to enroll your newly eligible spouse. Coverage will become effective on the date you enroll, unless:

(1) you are not actively at work on such date; or
(2) your spouse is unable to engage in normal activities because he or she is:

(a) medically confined on the date the insurance would otherwise take effect; or
(b) regularly treated by a home health care agency under a plan of treatment established and approved by a physician; or
(c) receiving or entitled to receive disability or sick pay income from any source.

If either of the above apply, coverage will not become effective until you are actively at work and your spouse resumes his or her normal activities; provided both requirements are met within 180 days of when coverage would have otherwise become effective. If not met within 180 days, you must wait until the next annual enrollment period or an Acquire Event or Loss of Eligibility for Other Coverage Event to reapply for coverage.

What is the amount of the accidental death and dismemberment benefit for each insured dependent?

The amount of insurance for a dependent is shown on the specifications page. The Accidental Death and Dismemberment section found earlier in this policy describes the amount of benefits, which are based on the insured's amount of insurance.

When will the accidental death or dismemberment benefit be payable?

We will pay the accidental death or dismemberment benefit upon receipt at our home office of written proof satisfactory to us that an insured dependent died or suffered dismemberment as a result of an accidental injury. All payments by us are payable from our home office.

To whom will we pay a dependents accidental death or dismemberment benefit?

A dependents accidental death or dismemberment benefit will be paid to you, if living, otherwise to your estate.

Termination

When does your insurance end?

Your insurance ends on the earliest of the following:

(1) the date the group policy ends; or
(2) the date you no longer meet the eligibility requirements as described below:

- for all Central State Government employees: An insured employee shall remain covered until the end of the month in which he or she ceases to meet the eligibility requirements.
- for all employees of state higher education or state offline agencies: An insured employee shall remain covered until the end of the month following the month in which he or she ceases to meet the eligibility requirements.

(3) the date the group policy is amended so you are no longer eligible; or
(4) 31 days (the grace period) after the due date of any unpaid premium if the premium remains unpaid at that time; or
(5) the last day for which premium contributions have been paid following your written request to cease participation under this certificate.

When does your dependent's coverage terminate?

Your dependent's coverage terminates on the earliest of the following:

(1) the last day of the month in which dependent no longer meets the eligibility requirements; or
(2) 31 days (the grace period) after the due date of any unpaid premium if the premium remains unpaid at that time; or
(3) the last day for which premium contributions have been made following your written request that insurance your dependents be terminated; or
(4) the date you are no longer covered under the group policy.

Can your coverage be reinstated after termination?

Yes. When your coverage terminates because you are no longer eligible, an you become eligible again with your previous employer within 30 days after the date your coverage under this certificate terminated, your coverage may be reinstated.

Additional Information

Do we have the right to obtain independent medical verification?

Yes. We retain the right to have an insured medically examined at our expense whenever a claim is pending and, where not forbidden by law, we reserve the right to have an autopsy performed in the case of death.

What if an insured's age has been misstated?

If an insured's age has been misstated, the accidental death or dismemberment benefit payable will be that amount to which the insured is entitled based on his or her correct age.

A premium adjustment will be made to the premium you pay for the insured's noncontributory insurance and to the premium an insured pays for contributory insurance, if

any, so that the actual premium required at the insured's correct age is paid.

When does an insured's insurance become incontestable?

Except for fraud or the non-payment of premiums, after the insured's insurance has been in force during his or her lifetime for two years from the effective date of his or her coverage, we cannot contest the insured's coverage. However, if there has been an increase in the amount of insurance for which the insured was required to apply, then, to the extent of the increase, any loss which occurs within two years of the effective date of the increase will be contestable.

Any statements the insured makes in his or her application will, in the absence of fraud, be considered representations and not warranties. Also, any statement an insured makes will not be used to void his or her insurance, or defend against a claim, unless the statement is contained in the application.

Who is the owner of this coverage?

You, the employee, are the owner of the certificate. Only the owner has the right to exercise ownership rights under the certificate, including but not limited to naming or changing a beneficiary, changing the amount of insurance or terminating the coverage.

Can a change of ownership for a certificate be requested?

No.

Is the policyholder required to maintain records?

Yes. The Policyholder is required to maintain adequate records of any information necessary for us to administer this certificate and shall provide access to such records when required for us to administer the policy.

If a clerical error is made in keeping records on the insurance under the group policy, it will not affect otherwise valid insurance. A clerical error does not continue insurance which is otherwise stopped, make insurance effective when it should not have been or change the amount of insurance provided by the provisions of the policy. If an error causes a change in premium payment, a fair adjustment will be made.

Will the provisions of this certificate conform with state law?

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

Notice

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

NOTICE CONCERNING COVERAGE UNDER THE TENNESSEE LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Insurance companies and health maintenance organizations (HMOs) licensed in this state to write life insurance, annuities or health insurance are members of the Tennessee Life and Health Insurance Guaranty Association. The purpose of this Association is to provide a safety-net of coverage, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however. And, as noted below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The state law that provides for this safety-net coverage is called the Tennessee Life and Health Insurance Guaranty Association Act. The following is a brief summary of this law's coverage's, exclusions and limits. **This summary does not cover all provisions of the law or describe all of the conditions and limitations relating to coverage. This summary does not in any way change anyone's rights or obligations under the act or the rights or obligations of the Guaranty Association.**

COVERAGE

Generally, individuals will be protected by the Life and Health Insurance Guaranty Association if they live in this state and hold a life or health insurance contract, HMO contract, or an annuity, or if they are insured under a group insurance contract, issued by an insurer authorized to conduct business in Tennessee. Health insurance includes disability and long term care policies. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are **not** protected by this Guaranty Association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who outside that state);
- the insurer was not authorized to do business in this state;
- their policy was issued by a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does **not** provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed an average rate;
- dividends;
- credits given in connection with the administration of a policy by a group contractholder;
- employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- unallocated annuity contracts (which give rights to group contractholders, not individuals).

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the Guaranty Association is obligated to pay out. The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. For any one insured life, the Guaranty Association guarantees payments up to a stated maximum no matter how many policies and contracts there were with the same company, even if they provided different types of coverage. These aggregate limits per life are as follows:

- $300,000 for policies and contracts of all types, except as described in the next point;
- $500,000 for basic hospital, medical and surgical insurance, and major medical insurance issued by companies that become insolvent after January 1,2010.

With these overall limits, the Guaranty Association cannot guarantee payment of benefits greater than the following:

- life insurance death benefits - $300,000
- life insurance cash surrender value - $100,000
- present value of annuity benefits for companies insolvent before July 1, 2009 - $100,000
- present value of annuity benefits for companies insolvent after June 30, 2009 - $250,000
- health insurance benefits for companies declared insolvent before January 1, 2010 - $100,000
- health insurance benefits for companies declared insolvent on or after January 1, 2010:
  - $100,000 for limited benefits and supplemental health coverages
  - $300,000 for disability and long term care insurance
  - $500,000 for basic hospital, medical and surgical insurance, or major medical insurance

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

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

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

Tennessee Life and Health Insurance Guaranty Association
PO Box 190434
Nashville, TN 37219
Website: www.tnlifega.org

Tennessee Department of Commerce and Insurance
500 James Robertson Parkway
Nashville, TN 37243

Tennessee Notice

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

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

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

Telephone: (651) 665-3500

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

ACCIDENTAL DEATH AND DISMEMBERMENT CERTIFICATE OF INSURANCE