GUARANTEE TRUST LIFE INSURANCE COMPANY

1275 Milwaukee Avenue
Glenview, Illinois 60025

This Policy is issued to the Policyholder by Guarantee Trust Life Insurance Company on the Policy Effective Date at 12:01 a.m. standard time at Policyholder's address. The Policyholder and Policy Effective Date are shown on the Schedule of Benefits.

This Policy is governed by the laws of the State where it is issued and is a legal contract between the Company and Policyholder.

The Company hereby insures Eligible Persons of the Policyholder for whom premium has been timely paid. Eligible Persons are defined on the Schedule of Benefits. Company agrees to pay benefits set forth in the Policy. Benefit payment is governed by the terms of this Policy.

READ YOUR POLICY CAREFULLY.

Secretary

President

ONE YEAR NON-RENEWABLE TERM

BLANKET ACCIDENT POLICY

NON-PARTICIPATING

AXXCV100

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DEFINITIONS

Accident: A sudden, unforeseeable, external event which results in an Injury.

Ambulance: A vehicle which is licensed solely as an ambulance by the local regulatory body to provide transportation to a Hospital or transportation from one Hospital to another when the Insured is unable to travel to receive medical care by any other means. Air ambulance charges are only eligible for transportation from the site of an Emergency to the nearest appropriate facility.

Benefit Period: The number of days following the date of an Injury during which Covered Charges must be incurred, subject to the Initial Treatment Period. The Benefit Period begins on the date of Injury and ends on the last day of the Benefit Period. The Benefit Period is shown on the Schedule of Benefits.

Company: Guarantee Trust Life Insurance Company, a mutual company. Also hereinafter referred to as We, Us and Our.

Covered Activity: Any activity which the Policyholder requires the Insured to attend, or any activity of the Policyholder's school, including field trips, which is under the sole control and supervision of the Policyholder, but not including activities which are under the sponsorship or supervision arrangement with any non-Policyholder group.

Covered Charge: A service or supply listed in this Policy and which is performed or given for the treatment of an Injury.

Covered Person: A person:

- Who is eligible for coverage as the Insured;
- Who has been accepted for coverage or has been automatically added;
- Who has paid the required premium; and
- Whose coverage has become effective and has not terminated.

Designated Vehicle: A vehicle designated by and under the direct supervision of the Policyholder and operated by a properly licensed adult driver which transports Insureds to and from Covered Activities.

Doctor: A legally qualified person licensed in the healing arts and practicing within the scope of his or her license and is not a Family Member.

Eligible Person: A member of the Policyholder's organization as defined on the Schedule of Benefits.

Emergency: An Injury for which the Insured seeks immediate medical treatment at the nearest available facility. The condition must be one which manifests itself by acute symptoms which are sufficiently severe (including severe pain) that without immediate medical care the Insured could reasonably expect that: (1) his life or health would be in serious jeopardy; (2) his bodily functions would be seriously impaired; or (3) a body organ or part would be seriously damaged.

Experimental/Investigational: A drug, device or medical care or treatment will be considered experimental/investigational if:

- the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;
- the informed consent document utilized with the drug, device, medical care or treatment states or indicates that the drug, device, medical care or treatment is part of a clinical trial, experimental phase or investigational phase or if such a consent document is required by law;
- the drug, device, medical care or treatment or the patient informed consent document utilized with the drug, device or medical care or treatment was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal or state law requires such review and approval;
- reliable evidence show that the drug, device or medical care or treatment is the subject of ongoing Phase I or Phase II clinical trials, is the research, experimental study or investigational arm of on-going Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its

toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment of diagnosis; or
- reliable evidence show that the prevailing opinion among experts regarding the drug, device or medical care or treatment is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment of diagnosis.

Reliable evidence means only: published reports and articles in authoritative medical and scientific literature; written protocol or protocols by the treating facility studying substantially the same drug, device or medical care or treatment; or the written informed consent used by the treating facility or other facility studying substantially the same drug, device or medical care or treatment. Covered Charges will be considered in accordance with the drug, device or medical care at the time the expense is incurred.

Family Member: A person who is related to the Insured in any of the following ways: spouse, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister), or child (includes legally adopted, step or foster child).

Hospital: An institution licensed, accredited or certified by the State which:
- is accredited by the Joint Commission on Accreditation of Healthcare Organizations;
- provides 24-hour nursing service by registered nurses (R.N.);
- mainly provides diagnostic and therapeutic care under the supervision of Doctors on an inpatient basis; and
- maintains permanent surgical facilities or has an arrangement with another surgical facility supervised by a staff of one or more Doctors.

Hospital also includes tax-supported institutions, which are not required to maintain surgical facilities.

Hospital does not include a place, special ward, floor or other accommodation used for: custodial or educational care; rest, the aged; a nursing home or an institution mainly rendering treatment or services for mental illness or substance abuse.

Hospital Confined/Hospital Confinement: Confinement in a Hospital for at least 18 consecutive hours by reason of an Injury for which benefits are payable.

Initial Treatment Period: The number of days following an Injury during which the Insured must seek initial treatment for an Injury. The Initial Treatment Period is shown on the Schedule of Benefits.

Injury: Bodily injury due to an Accident which:
- results directly and independently of disease, bodily infirmity or any other causes;
- solely, directly and independently of all other causes results in medical expense;
- occurs after the effective date of the Insured's coverage under this Policy; and
- occurs while this Policy is in force.

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

Insured: An Eligible Person who has satisfied all of the following requirements:
- he or she is eligible for coverage under the Policy;
- he or she has been accepted for coverage under the Policy or has been automatically added;
- premium has been paid for him or her; and
- his or her coverage has become effective and has not terminated.

Insured Percent: The percentage of Covered Charges We pay for each Injury. The Insured Percent is shown in the Schedule of Benefits.

Intensive Care Unit: A specifically designed facility of the Hospital that provides the highest level of medical care; and which is restricted to those patients who are critically ill or injured. Such facility must be

separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient confinement. They must be permanently equipped with special life-saving equipment for the care of the critically ill or injured; and under constant and continuous observation by nursing staff assigned on a full-time basis, exclusively to the Intensive Care Unit. Intensive Care Unit does not mean any of these step-down units: progressive care; sub-acute intensive care; intermediate care units; private monitored rooms; observation units; or other facilities which do not meet the standards for Intensive Care.

Medically Necessary: A treatment, drug, device, procedure, supply or service that is necessary and appropriate for the diagnosis or treatment of Sickness or Injury in accordance with generally accepted standards of medical practice in the United States at the time it is provided. When specifically applied to Hospital confinement, it means that the diagnosis or treatment of symptoms or a condition cannot be safely provided on an outpatient basis.

A treatment, drug, device, procedure, supply or service shall not be considered as Medically Necessary if it:

- is Experimental/Investigational or for research purposes;
- is provided solely for education purposes or the convenience of the Insured the Insured's family, Doctor, Hospital or any other provider;
- exceeds in scope, duration, or intensity that level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment and where ongoing treatment is merely for maintenance or preventive care;
- could have been omitted without adversely affecting the person's condition or the quality of medical care;
- involves the use of a medical device, drug or substance not formally approved by the United States Food and Drug Administration;
- involves a service, supply or drug not considered reasonable and necessary by the Healthcare Financing Administration Medicare Coverage Issues Manual; or
- can be safely provided to the patient on a less cost-effective basis such as outpatient, by a different medical professional, or pursuant to a more conservative form of treatment.

We reserve the right to determine whether a service, supply or drug is Medically Necessary.

Mental or Nervous Disorder: Any condition or disease, regardless of its cause, listed in the most recent edition of the *International Classification of Diseases* as a Mental Disorder on the date the medical care or treatment is rendered to an Insured.

Orthopedic Appliances: Any supportive device or appliance used in treating an Insured's Injury.

Other Valid and Collectible Insurance or Plan: Any reimbursement for or recovery of any element of Covered Charges incurred available from any other source whatsoever, except gifts and donations, but including without limitation:

- any individual, group, blanket, or franchise policy of accident, disability or health insurance;
- any arrangement of benefits for members of a group, whether insured or uninsured;
- any prepaid service arrangement such as Blue Cross or Blue Shield; individual or group practice plans, or health maintenance organizations;
- any amount payable for Hospital, medical or other health services. Injury arising out of a motor vehicle accident to the extent such benefits are payable under any medical expense payment provision (by whatever terminology used including such benefits mandated by law) of any motor vehicle insurance policy;
- any amount payable for services or injuries or diseases related to the Insured's job to the extent that he actually received benefits under a Worker's Compensation Law. If the Insured enters into a settlement to give up his or her rights to recover future medical expenses that would have been payable except for that settlement;
- Social Security Disability Benefits, except that Other Valid and Collectible Insurance or Plan shall not include any increase in Social Security Disability Benefits payable to the Insured after he or she becomes disabled while insured hereunder; or
- any benefits payable under any program provided or sponsored solely or primarily by any governmental agency or subdivision or through operation of law or regulation.

Physical Therapy: Non-surgical physical or mechanical therapy, diathermy, ultrasonic therapy, heat treatment in any form, manipulation or massage.

Policyholder: The entity to which this Policy is issued.

Policy Year: The period of 12 months following the Policy's Effective Date.

Pre-existing Condition: A condition for which medical care, treatment, diagnosis or advice was received or recommended within the 12 months prior to the Insured Effective Date of coverage under this Policy.

Prescription Drugs: Drugs which may only be dispensed by written prescription under Federal law, and approved for general use by the Food and Drug Administration. The drugs must be dispensed by a licensed pharmacy provider for the Insured's outpatient use.

Reasonable and Customary Charges, Fees or Expenses: The most common charge for similar professional services, drugs, procedures, devices, supplies or treatment within the area in which the charge is incurred, so long as those charges are reasonable. The most common charge means the lesser of:

- the actual amount charged by the provider;
- the negotiated rate; or
- the charge which would have been made by the provider (Doctor, Hospital, etc) for a comparable service or supply made by other providers in the same Geographic Area as reasonably determined by us for the same service or supply.

"Geographic Area" means the three digit zip code in which the service, treatment, procedure, drugs or supplies are provided; or a greater area if necessary to obtain a representative cross-section of charge for a like treatment, service, procedure, device drug or supply.
Reasonable and Customary Charges, Fees or Expenses as used in this Policy to describe expense, will be considered to mean the payment system in effect at Policy issue as shown in the Schedule of Benefits.

Residence: The home and land or property on which the Insured's dwelling or home is located.

Teeth: Natural teeth, the major portion of the individual tooth which is present, regardless of fillings and caps; and is not carious, abscessed, or defective.

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CONDITIONS OF INSURANCE

ELIGIBILITY

Eligible Persons are eligible to enroll for coverage under this Policy.

EFFECTIVE DATE

Policyholder: This Policy shall be effective on the later of:
- The Effective Date shown on the application; or
- The date We approve the application.

The Effective Date is shown on the Schedule of Benefits.

Insured: Subject to receipt of premium, coverage is effective on the Effective Date shown on the Schedule of Benefits.

TERMINATION

Policyholder: This Policy is issued for the term stated on the Schedule of Benefits on the Effective Date of this Policy. If the Policyholder desires to continue coverage, We will issue a new Policy for a new Policy term, subject to then current underwriting requirements.

Insured: Football Only Coverage. Coverage will terminate at the earlier of:
- the date the Policy terminates;
- the date the Insured ceases to be a member of the Policyholder's football team;
- the last day of regularly scheduled football activity;
- the date the Insured ceases to be an Eligible Person; or
- the end of the period for which any applicable premium has been paid.

Insured: Student Accident Coverage. Coverage will terminate at the earlier of:
- the date the Policy terminates;
- the date the Insured ceases to be an Eligible Person; or
- the end of the period for which any applicable premium has been paid.

Insured: 24-Hour-A-Day Accident Coverage. Coverage will terminate at the earlier of:
- the date the Policy terminates;
- the date the Insured ceases to be an Eligible Person; or
- the end of the period for which any applicable premium has been paid.

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Insured: Other Accident Coverage: Coverage will terminate at the earlier of:
- the date the Policy terminates;
- the date the Insured ceases to be an Eligible Person; or
- the end of the period for which any applicable premium has been paid.

SCOPE OF ACCIDENT COVERAGE

Football Only Accident Coverage: If this option is shown on the enrollment form, an Insured will be covered for Injury which is incurred while the Insured is:

- Participating in football competitions which are officially authorized, sanctioned and scheduled by the Policyholder, and governed by the rules and regulations of the appropriate athletic/activities association. This includes related:
  - pre-competition activities;
  - practice sessions; and
  - sponsored team travel authorized, organized and supervised by the Policyholder; and
  - off season physical conditioning.
- Traveling directly and uninterruptedly to or from football competitions in a Designated Vehicle.

Student Accident Coverage: If this option is shown on the enrollment form, an Insured will be covered for Injury which is incurred while the Insured is:

- On the Policyholder's premises:
  - During the hours and on the days when Policyholder is in session, including one hour before and after; or
  - During the hours and on the days when Policyholder is not in session while the Insured is participating in or attending any Covered Activity.
- Away from the Policyholder's premises while participating in or attending any Covered Activity, or traveling to and from such activity in a Designated Vehicle, whether or not such Policyholder is in session.

  Traveling directly and uninterruptedly to or from the Insured's Residence to attend regular Policyholder sessions.

24-Hour-A-Day Accident Coverage: If this option is shown on the enrollment form, an Insured will be covered for Injury which is incurred on a 24-hour per day basis.

Other Accident Coverage: If this option is shown on the application, an Insured will be covered for Injury which is incurred as described in Scope of Coverage on the Schedule of Benefits.

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ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

If, within 365 days from the date of an Accident, Injury from such Accident results in a loss covered by this benefit, We will pay the benefit in the amount set opposite such loss, as shown on the Schedule of Benefits. If the Insured sustains more than one such loss as the result of one Accident, We will pay only one amount, the largest to which the Insured is entitled.

Loss of hand or foot means loss by severance at or above the wrist or ankle joint. Loss of sight means the total, permanent loss of sight of the eye. The loss of sight must be irrecoverable by natural, surgical or artificial means. Severance means the complete separation and dismemberment of the part from the body.

Benefit payment is subject to the definitions, limitations, exclusions and other provisions of this Policy.

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ACCIDENT MEDICAL EXPENSE BENEFITS

We will pay benefits, as defined and limited below, for Covered Charges incurred by an Insured due to Injury. A Covered Charge is the Reasonable and Customary charge for a service or supply which is performed or given under the direction of a Doctor for the Medically Necessary treatment of an Injury. A Covered Charge is considered incurred on the date the treatment or service is rendered or the supply is furnished.

Covered Charges are payable only for an Injury:

- for which the first treatment or service is incurred within the Initial Treatment Period; and
- for which expense for all treatment or service is incurred within the Benefit Period.

Covered Charges are shown on the Schedule of Benefits.

No Other Valid and Collectible Insurance or Plan

After the Deductible has been satisfied, We will pay the Insured Percent of incurred Covered Charges up to the Maximum Benefit Amount, Per Injury. Benefit payment is subject to the definitions, limitations, exclusions and other provisions of this Policy.

Other Valid and Collectible Insurance or Plan

After the Deductible has been satisfied, We will pay the Insured Percent of incurred Covered Charges which are in excess of the total benefits payable for the same Injury by any Other Valid and Collectible Insurance or Plan on a provision of service or on an expense incurred basis, up to the Maximum Benefit Amount, Per Injury. Benefit payment is subject to the definitions, limitations, exclusions and other provisions of this Policy.

If Other Valid and Collectible Insurance or Plan provides benefits on an excess coverage basis, benefits will be paid first by the company or services plan whose policy or service contract has been in effect for the longer period of time at the date of such Injury.

For purposes of this Policy, an Insured's entitlement to Other Valid and Collectible Insurance or Plan will be determined as if this Policy did not exist and shall not depend upon whether timely application for benefits from Other Valid and Collectible Insurance or Plan is made by or on behalf of the Insured.

Primary Benefit Amount: If a Primary Benefit Amount is shown in the Schedule of Benefits, We will pay the Covered Charges incurred for an Injury up to the Primary Benefit Amount. Such Covered Charges will be paid according to the terms of the Policy. Subsequent claims received for the same Injury which are in excess of the Primary Benefit Amount, will subject the entire claim to the excess provision. Benefit payment is subject to the definitions, limitations, exclusions and other provisions of the Policy.

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EXCLUSIONS

This Policy does not provide benefits for:

- Treatment, services or supplies which:
  - Are not Medically Necessary;
  - Are not prescribed by a Doctor as necessary to treat an Injury;
  - Are determined to be Experimental/Investigational in nature;
  - Are received without charge or legal obligation to pay;
  - Are received from persons employed or retained by the School or any Family Member, unless otherwise specified; or
  - Are not specifically listed as Covered Charges in this Policy.
- Intentionally self-inflicted Injury, violating or attempting to violate any duly enacted law. Injury by acts of war, whether declared or not.
- Injury covered by Worker's Compensation or the Occupational Disease Law.

AXXEX102

- Hernia or slipped femoral capital epiphysis.
- Injury sustained fighting or brawling, except as an innocent victim.
- Treatment of sickness or disease in any form, blisters, insect bites, frostbite, heat exhaustion or sunstroke.
- Treatment of vegetation or ptomaine poisoning or bacterial infections, except pyogenic infections due to accidental open cuts.

AXXEX300

- Injury sustained while operating, riding in or upon, mounting or alighting from, any two- or three- or four- wheeled recreational motor/engine driven vehicle or snowmobile or all-terrain vehicle (ATV).

AXXEX400

- Injury sustained while participating in or practicing for interscholastic tackle football in grades 9 through 12, including travel, unless optional coverage has been purchased.

AXXEX500

PREMIUM

Payment of Premium/Due Date: All premium, charges or fees (hereinafter "Premium") must be paid to Us at Our home office prior to the start of the term for which coverage is selected. In no event will coverage become effective prior to the date of enrollment and required premium are received at our home office or by the general agent.

Returned or Dishonored Payment: If a check in payment for the Premium is dishonored for insufficient funds, a reasonable service charge may be charged to You which will not exceed the maximum specified under state law. A dishonored check shall be considered a failure to pay Premium and coverage shall not take effect.

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CLAIM PROVISIONS

Notice of Claim: Written notice of claim must be given to the Company or its authorized representative within 60 days after a covered loss starts, or as soon thereafter as is reasonably possible. Notice should include information sufficient to identify the Insured.

Claim Forms: The company, upon receipt of written notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing Proofs of Loss. If such forms are not furnished within 15 days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of this Policy as to Proof of Loss upon submitting, within the time fixed in this Policy for filing Proof of Loss, written proof covering the occurrence, the character, and the extent of the loss for which claim is made.

Proof of Loss: Written Proof of Loss for Hospital Confinement must be given to Us or Our authorized representative within 90 days after release from the Hospital. Proof of any other covered loss must be given to Us or Our authorized representative not later than 90 days after the covered loss. If Proof of Loss is not given within 90 days, the claim will not be denied or reduced for that reason if that proof was given as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

Time of Payment of Claims: Benefits will be paid as soon as We receive proper proof of loss unless this Policy provides for periodic payment. When this Policy provides for periodic payment, the benefits will accrue and will be paid monthly subject to proper proof of loss.

Payment of Claims: Benefits payable under this Policy for loss of life will be paid to the Insured's next of kin and the provisions respecting such payment set out herein and effective at the time of payment. Any other payable benefits remaining unpaid at the time of the Insured's death may, at Our option, be paid to the Insured's next of kin or to the Insured's estate. All other benefits will be payable to the medical services provider.

If any indemnity of this Policy shall be payable to the estate of the Insured or to an Insured who is a minor or otherwise not competent to give a valid release, the Company may pay such indemnity to his parent, guardian or other person actually supporting him. Any payment made by the Company in good faith pursuant to this provision shall fully discharge the Company to the extent of such payment.

Subject to any written direction of the Insured or of the legal or natural guardian of the Insured, if the Insured is a minor or otherwise incompetent to make such a direction, all or a portion of any indemnities provided by this Policy as a result of medical, surgical, dental, hospital or nursing service will be paid directly to the hospital or person rendering such services; but it is not requested that the services be rendered by a particular Hospital or person.

Physical Examination and Autopsy: The Company, at its own expense, shall have the right and opportunity to examine the Insured as it may reasonably require while a claim is pending. The Company, at its own expense, may also have the right to make an autopsy in the case of death, where it is not prohibited by law.

Legal Actions: A legal action may not be brought to recover on this Policy within 60 days after written Proof of Loss has been given as required. No such action may be brought after 3 years from the time written proof was required to be given.

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GENERAL PROVISIONS

Entire Contract; Changes: This Policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid until approved by an executive officer of the Company and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or waive any of its provisions.

Failure by Company to enforce any Policy provision shall not waive, modify or render such provision unenforceable at any other time; at any given time; or under any given set of circumstances, whether the circumstances are or are not the same.

Incontestability: All statements made in an application by the Policyholder are, in the absence of fraud, representations and not warranties. No statement shall be used to contest this Policy, the validity of coverage or reduce benefits, unless it is in writing, signed by the Policyholder, and a copy of such statement is furnished to the Policyholder.

Insurance Class: Policyholder may set forth in its application Insurance Classes of Eligible Persons. The Policyholder shall notify Company when a change of Insurance Class occurs for an Insured.

Clerical Error: If a clerical error is made so that an otherwise Eligible Person's coverage does not become effective, coverage may be in effect if: (a) the Policyholder makes a written request for coverage on a form approved by the Company; and (b) any premium not paid because of the error is paid in full from the effective date of coverage. 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, the Policyholder shall reimburse Company for the overpayment.

Information and Records: The Policyholder shall provide Company information necessary to administer coverage under the Policy. Information is required when an Eligible Person becomes covered, when changes in amounts of coverage occur, and when an Insured's coverage terminates.

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

Conformity With State Statutes: 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.

Certificate of Insurance: Where required by law, We will send to the Insured an individual certificate. The certificate will outline the insurance coverage under the Policy and to whom benefits are payable.

ACAGP100

INDEPENDENT MEDICAL REVIEW SYSTEM

DEFINITIONS

Disputed Health Care Service: Any health care service eligible for coverage and payment that has been denied, modified, or delayed by Our decision, or by one of Our contracting Doctors, in whole or in part due to a finding that the service is not Medically Necessary or the service is Experimental and Investigational.

"We," "Our" or "Us": Guarantee Trust Life Insurance Company

INDEPENDENT MEDICAL REVIEW

In the event benefits are denied, modified or delayed based on Our determination that health care services are not Medically Necessary or that services are Experimental and Investigational, the insured has the right to request an Independent Medical Review of these Disputed Health Care Services. The California Department of Insurance will contract with one or more independent medical review organizations to conduct Independent Medical Reviews. The California Department of Insurance will have the final authority in deciding whether the Disputed Health Care Services are or are not Medically Necessary or Experimental and Investigational.

REQUESTING AN INDEPENDENT MEDICAL REVIEW

If benefits are denied, modified or health care services are delayed based on Medical Necessity or Experimental and Investigational, We shall provide the insured with a one-page application form and an addressed envelope, which the insured may return to the California Department of Insurance to initiate an Independent Medical Review.

An insured may apply to the California Department of Insurance for an Independent Medical Review involving a Disputed Health Care Service when all of the following conditions are met:

1. (A) The insured's Doctor has recommended a health care service as Medically Necessary; or
   (B) The insured has received urgent care or emergency services that a Doctor determined was Medically Necessary; or
   (C) The insured, in the absence of a Doctor's recommendation under (A) or the receipt of urgent care or emergency services by a Doctor under (B), has been seen by a contracting Doctor for the diagnosis or treatment of the medical condition for which the insured seeks independent review. We shall expedite access to a contracting Doctor upon request of an insured. The contracting Doctor need not recommend the Disputed Health Care Service as a condition for the insured to be eligible for an Independent Medical Review.
2. The Disputed Health Care Service has been denied, modified, or delayed by Us, or by one of Our contracting Doctors, based in whole or in part on a decision that the health care service is not Medically Necessary; or
3. The Disputed Health Care Service has been denied by Us, or by one of Our contracting Doctors, based in whole or in part on a decision that the health care service is Experimental or Investigational.
4. The insured has filed a grievance with Us or Our contracting Doctor, and the disputed decision is upheld or the grievance remains unresolved after 30 days. The insured shall not be required to participate in Our grievance process for more than 30 days. In the case of a grievance that requires expedited review, the insured shall not be required to participate in the Our grievance process for more than three days.

The insured may apply for an Independent Medical Review within 6 months of any of the qualifying periods or events noted above. The Commissioner of Insurance may extend the application deadline beyond 6 months if the circumstances of a case warrant the extension.

If the California Department of Insurance finds that an Insured's grievance involving a Disputed Health Care Service does not qualify for an Independent Medical Review, the Insured's request for review shall be treated as a request for the California Department of Insurance to review the grievance.

CASE REVIEW PROCEDURE

Once the California Department of Insurance receives the insured's application for an Independent Medical Review, it shall review the application and any supporting documentation and base its decision on the following criteria:

1. The insured's specific needs; and
2. Peer-reviewed scientific and medical evidence regarding the effectiveness of the Disputed Health Care Service;
3. Nationally recognized professional standards;
4. Expert opinion;
5. Generally accepted standards of medical practice; or
6. Treatments that are likely to provide a benefit to a patient for conditions for which other treatments are not clinically efficacious.

If the Independent Medical Review is being performed on the basis that the Disputed Health Care Services are Experimental or Investigational, the California Department of Insurance will base its decision on the relevant medical and scientific evidence including, but not limited to the following:

1. Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;
2. Peer-reviewed literature, biomedical compendia and other medical literature that meet the criteria of the National Institutes of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline and MEDLARS data base health Services Technology Assessment Research (HSTAR);
3. Medical journals recognized by the Secretary of Health and Human Services, under Section 1861(t)(2) of the Social Security Act;
4. The following standard reference compendia: The American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluation, the American Dental Association Accepted Dental Therapeutics and The United States Pharmacopoeia-Drug Information;
5. Findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including the Federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Health Care Financing Administration, Congressional Office of Technology Assessment, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services;
6. Peer-reviewed abstracts accepted for presentation at major medical association meetings.

The California Department of Insurance will makes its determination in writing within 30 days of the receipt of the application for review and supporting documentation. If the Disputed Health Care Service has not been provided and the insured's Doctor or the California Department of Insurance certifies in writing that an imminent and serious threat to the health of the insured may exist, the analyses and determinations of the California Department of Insurance shall be expedited and rendered within three days of the receipt of the information. "Imminent and serious threat", include, but is not limited to, serious pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of the health of the insured.

Subject to the approval of the California Department of Insurance, the deadlines for analyses and determinations involving both regular and expedited reviews may be extended by the Commissioner of Insurance for up to three days in extraordinary circumstances or for good cause.

GGIMRCA100 (Rev. 5/02)

IMPORTANT NOTICE

If you have any complaints regarding this insurance, You may contact the following:

GUARANTEE TRUST LIFE INSURANCE COMPANY
1275 Milwaukee Avenue
Glenview, Illinois 60025
800-338-7452

If you continue to remain unsatisfied, You may contact the California Department of Insurance with any complaint. To contact the Department of Insurance, You may write or call them at:

California Department of Insurance
Consumer Services Division
300 S. Spring St., South Tower
Los Angeles, CA 90013
800-927-HELP

CANOTE

SCHEDULE OF BENEFITS

POLICYHOLDER INFORMATION

Policy Number:	**See Attached Application**
Policyholder:	**See Attached Application**
Policy Effective Date:	**See Attached Application**
Policy Term:	**See Attached Application**
Eligible Persons:	Students who are enrolled and attending the Policyholder's School as Full-Time Students.

Scope of Coverage:

24-Hour-A-Day Accident Coverage

Student Accident Coverage

Football Only Accident Coverage, limited to Senior High Football:
- Including Grade 9 if playing or practicing with Grade 10 or above;
- Spring Practice; and
- Regular Season including Spring Practice

Other Accident Coverage

The following coverages may be offered to the district provided the district distributes the Voluntary Student Accident Coverage materials to the parents/guardians of the students in the district and acceptance of a proper system of written waivers of student insurance. These coverages are designed to assist compliance with California Education Code where applicable:

INTERSCHOLASTIC SPORTS OVERSIGHT COVERAGE: We cover injuries to the district's interscholastic athletes who: 1. did not purchase student accident insurance because the district personnel failed to provide the Student Accident Insurance Plan to the injured athletes as required by the California Education Code 2. did not file a waiver of student insurance, and 3. participated in interscholastic athletics without coverage. Benefits are paid under the "Low Option" plan schedule up to a maximum of $1,500.

NON-COMPETING PARTICIPANTS COVERAGE: Students will be covered while traveling in school-provided vehicles to and from athletic events for which they have been designated by the school district to directly assist in the noncompetitive activities associated with the events, e.g. members of school bands, cheerleaders, pompom girls and team managers. Benefits are paid under the "High Option" plan schedule up to a maximum of $1,500.

ONE-DAY FIELD TRIP COVERAGE: We cover accidents which occur while your students are participating in school-sponsored and directly supervised one-day field trips. A field trip is when the school district is fully responsible for the students while they are participating in the trip. Benefits are paid under the "High Option" plan schedule up to a maximum of $1,500.

Other Accident Coverage

The following coverages are available to the district for an additional premium.

ELEMENTARY COMPETITORS COVERAGE - We will cover students who participate in school sponsored and supervised interscholastic sports. No coverage is provided for tackle football. Coverage includes interscholastic sports contests, including school furnished transportation in a Designated Vehicle to practice and contests. Benefits are payable under the "Low Option" plan to a maximum of $1,500.

	POWDER PUFF FOOTBALL - Benefits are payable under the "Low Option" plan, up to the $25,000 maximum. All participants must be covered. TRAVEL ACCIDENT COVERAGE - This is a per trip coverage for school district sponsored trips on a twenty-four hour basis. Benefits are payable under the "Low Option" plan to a maximum of $25,000. Rider GR-738-CAL. INTERSCHOLASTIC TACKLE FOOTBALL "TRY-OUT" COVERAGE Covers injuries caused by accidents during practice for high school Interscholastic football. Also covers injuries caused by accidents occurring while traveling in a Designated Vehicle to and from practice. Coverage commences the first official day of practice, terminating Fourteen (14) days later. Benefits are payable under the "Low Option" plan up to $1,500 per Injury. No premium refunds are permitted except as specifically stated.
Insured's Effective Date:	The date premium is received by Us or Our Representative, but not prior to the first day of school. Coverage can pre-date the official first day of school for students who are participating in pre-school practice for interscholastic sports. In such cases coverage will be effective as of the date of premium receipt but only while participating in actual practice sessions. Football Only Accident Coverage begins on the first day of scheduled football practice, provided the list of players to be insured is submitted to Us or Our Representative, within three days after the date of the first practice, but not prior to the first official date of practice. Coverage for additional players is effective subject to receipt of premium the day AFTER the postmark on the return envelope. Coverage continues through the date of the last official game of the current season, including playoffs.

AXXPI100

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

Loss of Life	$5,000
Loss of Both Hands	$10,000
Loss of Both Feet	$10,000
Loss of the Entire Sight of Both Eyes	$10,000
Loss of One Hand or One Foot	$5,000
Loss of One Hand and Entire Sight of One Eye	$10,000
Loss of One Foot and the Entire Sight of One Eye	$10,000

AXXADDSOB100

ACCIDENT MEDICAL EXPENSE BENEFITS

Maximum Benefit Amount, Per Injury, 24-Hour-A-Day Coverage, Up To	$50,000
Maximum Benefit Amount, Per Injury, School-Time Coverage,	
High Option, Up To	$50,000
Low Option, Up To	$25,000
Maximum Benefit Amount, Per Injury, Optional Football Only Coverage, Up To	$25,000
Initial Treatment Period	120 days
Benefit Period	52 weeks
Primary Benefit Amount	$500

AXXSOB200

COVERED CHARGES

Treatment, services or supplies incurred for:
Hospital room and board and general nursing care, up to the semi-private room rate.
Intensive Care, limited to a maximum of $1,200 per day.
Hospital miscellaneous expense during Hospital Confinement or for outpatient surgery under general anesthetic, such as the cost of the operating room, laboratory tests, x-ray examinations, anesthesia, drugs (excluding take-home drugs) or medicines, therapeutic services and supplies, limited to a maximum of $3,000.
Doctor's fees for surgery, in accordance with the Surgical Schedule, using $270 per unit value.
Assistant surgeon expense, limited to 25% of the surgeon's fee.
Anesthesia services, limited to 25% of the surgical fee.
Doctor's visits, including Physical Therapy, limited to 1 visit per day and does not apply when related to surgery, up to $120 for the first visit and $60 for each visit thereafter. Physical Therapy is limited to 9 visits.
Hospital Emergency care, limited to a maximum of $300.
Outpatient imaging procedures, including x-rays and interpretation for: • Fracture or dislocation, up to a maximum benefit of $500; • No fracture or dislocation, up to a maximum benefit of $100; and • MRI/CAT scan, up to a maximum benefit of $900.
Ambulance expense.
Orthopedic Appliances, including braces and crutches, up to a maximum benefit of $100.
Casts, non-surgical, up to a maximum benefit of $100.
Eyeglass replacement expense for broken eyeglasses or lenses resulting from an Injury requiring medical treatment, up to a maximum benefit of $150.
Prescription Drugs.
Dental treatment for Injury to Teeth, limited to $300 per tooth.
Re-aggravation or re-injury of a Pre-existing Condition, limited to a maximum of $500.
Extended dental expense for: Examination, diagnoses and x-ray; restorative treatment; endodontics; and oral surgery (not to include periodontics or orthodontics); up to $250 for dental prostheses toward the cost of a bridge, partial denture or denture, or for replacement in kind of previous dental repairs. If during the Benefit Period, the Insured's dentist certifies that treatment must be deferred, We will pay up to a maximum of $100 in lieu of all other dental benefits.

HIGH OPTION

COVERED CHARGES

Treatment, services or supplies incurred for:
Hospital room and board and general nursing care, limited to a maximum of $300 per day.
Intensive Care, limited to a maximum of $600 per day.
Hospital miscellaneous expense during Hospital Confinement or for outpatient surgery under general anesthetic, such as the cost of the operating room, laboratory tests, x-ray examinations, anesthesia, drugs (excluding take-home drugs) or medicines, therapeutic services and supplies, limited to a maximum of $1,500.
Doctor's fees for surgery, in accordance with the Surgical Schedule, using $175 per unit value.
Assistant surgeon expense, limited to 25% of the surgeon's fee.
Anesthesia services, limited to 25% of the surgical fee.
Doctor's visits, including Physical Therapy, limited to 1 visit per day and does not apply when related to surgery, up to $60 for the first visit and $30 for each visit thereafter. Physical Therapy is limited to 9 visits.
Hospital Emergency care, limited to a maximum of $150.
Outpatient imaging procedures, including x-rays and interpretation for: • Fracture or dislocation, up to a maximum benefit of $250; • No fracture or dislocation, up to a maximum benefit of $50; and • MRI/CAT scan, up to a maximum benefit of $500.
Ambulance expense, limited to a maximum of $250.
Orthopedic Appliances, including braces and crutches, up to a maximum benefit of $50.
Casts, non-surgical, up to a maximum benefit of $50.
Eyeglass replacement expense for broken eyeglasses or lenses resulting from an Injury requiring medical treatment, up to a maximum benefit of $100.
Prescription Drugs, limited to a maximum of $50.
Dental treatment for Injury to Teeth, limited to $150 per tooth.
Re-aggravation or re-injury of a Pre-existing Condition, limited to a maximum of $500.
Extended dental expense for: Examination, diagnoses and x-ray; restorative treatment; endodontics; and oral surgery (not to include periodontics or orthodontics); up to $250 for dental prostheses toward the cost of a bridge, partial denture or denture, or for replacement in kind of previous dental repairs. If during the Benefit Period, the Insured's dentist certifies that treatment must be deferred, We will pay up to a maximum of $100 in lieu of all other dental benefits.

SURGICAL SCHEDULE

For any surgical operation or procedure not specifically named or excluded, We will pay an amount which shall be determined on the basis of the gravity and severity of the unnamed operation as compared to the below named operations, using the 1974 Revision of the May 10, 1969 Relative Value Studies published by the California Medical Association.

	Unit Value
Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and /or Extremities (Including hands and feet); 2.6 cm to 7.5 cm (12002)	0.65
Open treatment of nasal fracture; uncomplicated (21325)	2.7
Closed treatment of clavicular fracture; with manipulation (23505)	1.8
Closed treatment of humeral shaft fracture; with manipulation, with or without skeletal traction (24505)	3.3
Closed treatment of distal radial fracture (eg, Colles or Smith type) or epiphyseal separation, with or without fracture of ulnar styloid; with manipulation (25605)	2.7
Closed treatment of metacarpal fracture, single; with manipulation, each bone (26605)	1.6
Closed treatment of phalangeal shaft fracture, proximal or middle phalanx, finger or thumb; without manipulation, each (26720)	0.75
Closed treatment of femoral shaft fracture, with manipulation, with or without skin or skeletal traction (27502)	4.75
Closed treatment of tibial shaft fracture (with or without fibular fracture); with manipulation, with or without skeletal traction (27752)	4.0
Closed treatment of fracture great toe, phalanx or phalanges; with manipulation (28495)	0.7
Arthroscopy, knee, surgical, with meniscectomy (medial OR lateral, including any meniscal shaving) (29881)	10.0
Arthroscopically aided anterior cruciate ligament repair/ augmentation or reconstruction (29888)	17.0
Open treatment of acromioclavicular dislocation, acute or chronic; (23550)	8.0
Crainiectomy or craniotomy, exploratory; infratentorial (posterior fossa) (61305)	23.0
Repair, extensor tendon, finger, primary or secondary: with free graft (includes obtaining graft) each tendon (26420)	4.2
Open treatment and/or reduction of vertebral fracture(s) and/or dislocation(s), posterior approach, one fractured vertebrae or dislocated segment; lumbar (22325)	15.0

GGSOBXX500

NOTICE OF PROTECTION PROVIDED BY CALIFORNIA LIFE AND HEALTH INSURANCE GUARANTEE ASSOCIATION

This notice provides a brief summary regarding the protections provided to policyholders by the California Life and Health Insurance Guarantee Association ("the Association"). The purpose of the Association is to assure that policyholders will be protected, within certain limits, in the unlikely event that a member insurer of the Association becomes financially unable to meet its obligations. Insurance companies licensed in California to sell life insurance, health insurance, annuities and structured settlement annuities are members of the Association. The protection provided by the Association is not unlimited and is not a substitute for consumers' care in selecting insurers. This protection was created under California law, which determines who and what is covered and the amounts of coverage.

Below is a brief summary of the coverages, exclusions and limits provided by the Association. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations or the rights or obligations of the Association.

COVERAGE

● Persons Covered

Generally, an individual is covered by the Association if the insurer was a member of the Association *and* the individual lives in California at the time the insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payees or assignees, whether or not they live in California.

● Amounts of Coverage

The basic coverage protections provided by the Association are as follows.

● Life Insurance, Annuities and Structured Settlement Annuities

For life insurance policies, annuities and structured settlement annuities, the Association will provide the following:

- Life Insurance
  80% of death benefits but not to exceed $300,000
  80% of cash surrender or withdrawal values but not to exceed $100,000

- Annuities and Structured Settlement Annuities
  80% of the present value of annuity benefits, including net cash withdrawal and net cash surrender values but not to exceed $250,000

The maximum amount of protection provided by the Association to an individual, for *all* life insurance, annuities and structured settlement annuities is $300,000, regardless of the number of policies or contracts covering the individual.

● Health Insurance

The maximum amount of protection provided by the Association to an individual, as of July 1, 2016, is $546,741. This amount will increase or decrease based upon changes in the health care cost component of the consumer price index to the date on which an insurer becomes an insolvent insurer. Changes to this amount will be posted on the Association's website www.califega.org.

COVERAGE LIMITATIONS AND EXCLUSIONS FROM COVERAGE

The Association may not provide coverage for this policy. Coverage by the Association generally requires residency in California. You should not rely on coverage by the Association in selecting an insurance company or in selecting an insurance policy.

The following policies and persons are among those that are excluded from Association coverage:

- A policy or contract issued by an insurer that was not authorized to do business in California when it issued the policy or contract
- A policy issued by a health care service plan (HMO), a hospital or medical service organization, a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society
- If the person is provided coverage by the guaranty association of another state
- Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which do not guaranty annuity benefits to an individual
- Employer and association plans, to the extent they are self-funded or uninsured
- A policy or contract providing any health care benefits under Medicare Part C or Part D
- An annuity issued by an organization that is only licensed to issue charitable gift annuities
- 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 certain investment elements of a variable life insurance policy or a variable annuity contract
- Any policy of reinsurance unless an assumption certificate was issued
- Interest rate yields (including implied yields) that exceed limits that are specified in Insurance Code Section 1067.02(b)(2)(C)

NOTICES

Insurance companies or their agents are required by law to give or send you this notice. Policyholders with additional questions should first contact their insurer or agent. To learn more about coverages provided by the Association, please visit the Association's website at www.califega.org, or contact either of the following:

California Life and Health Insurance
Guarantee Association
P.O. Box 16860
Beverly Hills, CA 90209-3319
(323) 782-0182

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street
Los Angeles, CA 90013
(800) 927-4357

Insurance companies and agents are not allowed by California law to use the existence of the Association or its coverage to solicit, induce or encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and California law, then California law will control.