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 the Insured incurs the first Covered Charge related to an 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.

Deductible: A dollar amount of Covered Charges an Insured must pay before We pay any benefits. The Deductible is shown on the Schedule of Benefits.

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.

Durable Medical Equipment: A device which:

- is primarily and customarily used for medical purposes and is specially equipped with features and functions that are generally not required in the absence of Injury;
- is used exclusively by the Insured;
- is routinely used in a Hospital but can be used effectively in a non-medical facility;
- can be expected to make a meaningful contribution to the Insured's Injury; and
- is prescribed by a Doctor and the device is Medically Necessary for the Insured's rehabilitation.

Durable Medical Equipment does not include:

- comfort and convenience items;
- equipment that can be used by Family Members other than the Insured;
- health exercise equipment; and
- equipment that may increase the value of the Insured's Residence.

Such items that do not qualify as Durable Medical Equipment include, but are not limited to: modifications to the Insured's residence, property or automobiles, such as ramps, elevators, spas, air conditioners and vehicle hand controls; or corrective shoes, exercise and sports equipment.

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).

Full Time Student: A person who is enrolled in the Policyholder's school on a full-time basis as defined by the Policyholder. A person will cease to be a full time student on the date that person is no longer a full time student according to the records of the Policyholder's school.

The Company maintains its right to investigate student status and attendance records to verify that the Policy eligibility requirements have been made. If the Company discovers that the Policy eligibility requirements have not been met, Our only obligation is a refund of all premium paid, less any claims paid.

Home Health Agency: An agency which is licensed as a Home Health Agency by state or local government. It may offer the following services:

- part-time or periodic skilled nursing services by a registered nurse or licensed vocational nurse;
- part-time or periodic home health aide services which offer supportive services in the home under the supervision of a Registered Nurse or a physical, speech or occupational therapist;
- physical, occupational or speech therapy; and
- medical supplies, drugs and medicines prescribed by a Doctor and related pharmaceutical services, and laboratory services to the limit these charges or costs would be covered under the Policy if the Covered Person was Hospital Confined.

Home Health Care: Services by a Home Health Agency for the care and treatment of a Covered Person who is under the direct care and supervision of a Doctor but only if:

- services would have been covered in a medical facility if Home Health Care were not given; and

- a Home Health Care treatment plan is set up, in writing and approved by a Doctor.

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 an 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 an 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
- it 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 an 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's 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 an 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 reasonable 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.

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

Urgent Care Center: A health care facility, separate and distinct from a Hospital, providing immediate short term medical care for minor conditions without an appointment but where immediate medical care is necessary.

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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: All Sports 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 sports teams;
- the last day of regularly scheduled sports 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: 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.

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SCOPE OF ACCIDENT COVERAGE

All Sports Accident Coverage: If this option is shown on the application all Insureds will be covered for Injury which is incurred while the Insured is:

- Participating during the official season of the sport as a member of an interscholastic or intercollegiate athletic team of the Policyholder. Participation must be:
  - in a regularly scheduled and approved practice session or game of the Policyholder; and
  - under the supervision of proper adult authority of the Policyholder.
- Traveling directly and uninterruptedly to or from the above with other members of the team under the supervision of the proper adult authority of the Policyholder.

Student Accident Coverage: If this option is shown on the application all Insureds 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.

Other Accident Coverage: If this option is shown on the application all Insureds 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 must be entire and irrecoverable. Loss of a thumb and index fingers means loss by severance at or above the metacarpophalangeal joints, which are the joints between the fingers and the hand. Any benefit payable under this part will be in addition to any benefit otherwise payable under 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

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

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.

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OUT OF NETWORK OPTION

When Other Valid and Collectible Insurance or Plan denies benefits because the Insured failed to utilize an authorized medical vendor or chose not to utilize other Valid and Collectible Insurance or Plan for any reason, We will pay expense incurred that We would have paid had the Insured used the proper medical vendor. The Insured must provide Us with proof of such denial.

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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.
  - 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 received while traveling or flying by air, except as a fare paying passenger on a regularly scheduled commercial airline.
- Injury covered by Worker's Compensation or the Occupational Disease Law.
- Treatment of illness, disease or infections, except pyogenic infections or bacterial infections which result from the accidental ingestion of contaminated substances.
- Heat exhaustion.
- Treatment of Osgood-Schlatter's disease; appendicitis; osteomyelitis; pathological or stress fractures; congenital weakness; hernia; TMJ; fainting; headaches; boils; blisters; spondylolysis; osteochondritis; dissecans; poison ivy; bee stings; detached retina unless directly caused by Injury; or Mental or Nervous Disorders whether or not caused by Injury.
- Injury contributed to by the use of alcohol or drugs not prescribed by a Doctor.
- Injury caused by or contributed to aggravation or reinjury of a Pre-existing Condition.
- Suicide or attempted suicide while sane; or self-destruction or an attempt to self-destroy while insane.
- Expense incurred for the use of orthotics unless used exclusively to promote healing.
- Heart and/or circulatory malfunction resulting from participation in a Covered Activity.
- Repetitive motion Injuries, strains, hernia, tendinitis, and bursitis not related to a specific Injury.
- Any penalty imposed by Other Valid and Collectible Insurance or Plan for failure to follow plan procedures.

AXXEX101

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 the Company or its authorized representative within 60 days after release from the Hospital. Proof of any other covered loss must be given to the Company or its authorized representative not later than 90 days after the covered loss. If proof of loss is not given within 60 days, the claim will not be denied or reduced for that reason if that proof was given as soon as reasonably possible.

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 Insured or the medical services provider if We have received a valid assignment by the Insured.

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 may, at the Company option, and unless the Company is requested in writing not later than the time for filing proofs of loss, 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.

Subrogation: When benefits are paid to or for an Insured under the terms of this Policy, We shall be subrogated, unless otherwise prohibited by law, to the rights of recovery of such Insured against any person who might be acknowledgedly liable or found legally liable by a Court of competent jurisdiction for the Injury that necessitated the hospitalization or the medical or surgical treatment for which benefits were paid. Such subrogation rights shall extend only to the recovery by the Company of the benefits it has paid for such hospitalization and treatment and the Company shall pay fees and costs associated with such recovery.

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.

Company has full, exclusive and discretionary authority to determine all questions arising in connection with the Policy, including its interpretation.

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.

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SCHEDULE OF BENEFITS

POLICYHOLDER INFORMATION

Policy Number:	254-00T-001 B
Policyholder:	Billings Public Schools
Policy Effective Date:	August 15, 2018
Policy Term:	August 15, 2018 to August 15, 2019
Eligible Persons:	Students who are enrolled and attending the Policyholder's School as Full-Time Students
Scope of Coverage:	All Sports Accident Coverage Student Accident Coverage Other Accident Coverage: Pre-competition activities and off-season physical conditioning.
Insured's Effective Date:	The date premium is received by Us or Our representative but not prior to the opening day of School except in the case of All Sports Accident Coverage and Other Accident Coverage, in which case coverage will begin on the first official day of practice.

AXXPI100

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

Loss of Life	$5,000
Loss of Both Hands	$5,000
Loss of Both Feet	$5,000
Loss of the Entire Sight of Both Eyes	$5,000
Loss of One Hand and One Foot	$5,000
Loss of One Hand and the Sight of One Eye	$5,000
Loss of One Foot and the Sight of One Eye	$5,000
Loss of One Hand or One Foot	$2,500
Loss of the Entire Sight of One Eye	$2,500
Loss of Thumb and Index Finger of the Same Hand	$1,250
Policy Year Aggregate Loss of Life Maximum	$0

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ACCIDENT MEDICAL EXPENSE BENEFITS

Maximum Benefit Amount, Per Injury	$25,000
Deductible, Per Injury	$0
Insured Percent	100%
Payment System Percentile	90th
Initial Treatment Period	60 days
Benefit Period	52 weeks
Primary Benefit Amount	$0

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COVERED CHARGES

Treatment, services or supplies incurred for:
Hospital room and board and general nursing care, up to the semi-private room rate, limited to a maximum of $235 per day.
Intensive Care, limited to a maximum of $235 per day.
Hospital miscellaneous expense, limited to a maximum of $900.
Doctor's fees for surgery, limited to a maximum of $1,000.
Anesthesia services.
Doctors visits, inpatient and outpatient, limited to a maximum of $40 each visit.
Hospital Emergency care, limited to a maximum of $60.
X-ray and laboratory services, limited to a maximum of $500.
Home Health Care.
Ambulance expense, limited to a maximum of $300.
Urgent Care Center expense.
Orthopedic Appliances, limited to a maximum of $250.
Durable Medical Equipment, limited to a maximum of $250.
Prescription Drugs.
Dental treatment for Injury to Sound Natural Teeth, limited to $100 per tooth, up to a maximum of $300.
Physical Therapy and/or treatment of the spine by manual or mechanical means unless related to surgery which is performed under general anesthesia, limited to $25 per visit, up to a maximum of 14 visits**.**
Registered Nurse expense.
Assistant surgeon expense.

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NOTICE OF
PROTECTION PROVIDED BY
MONTANA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a **brief summary** of the Montana Life and Health Insurance Guaranty Association (the Association) and the protection it provides for policyholders. This safety net was created under Montana law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Montana law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 in cash surrender or withdrawal values

- Health Insurance
  - $500,000 in hospital, medical and surgical insurance benefits
  - $300,000 in disability income insurance benefits
  - $300,000 in long-term care insurance benefits
  - $100,000 in other types of health insurance benefits

- Annuities
  - $250,000 in withdrawal and cash values

The maximum amount of protection is $300,000 in benefits with respect to any one life regardless of the number of policies or contracts, except with respect to hospital, medical, and surgical insurance benefits.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Montana law.

To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association's web site at www.mtlifega.org or contact:

Montana Life and Health Insurance
Guaranty Association
PO Box 951
Oconomowoc, WI 53066-0951
877-678-1048 or administrator@mtlifega.org

Montana Department of Insurance
State Auditor's Office
840 Helena Ave.
Helena, MT 59601
406-444-2040

Insurance companies and agents are not allowed by Montana law to use the existence of the Association or its coverage to 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 Montana law, then Montana law will control.