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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AXXTC103

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 for those individuals who are 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 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 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.

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 the Insured must pay before We pay any benefits under this Policy. 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 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: An Eligible Person, as defined by the Policyholder, is shown on the Schedule.

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 ongoing 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.

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 the Insured.

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.

Sound Natural 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.

Urgent Care Center: A healthcare 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.

AOHDF105

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.

AXXCI101

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;
  - 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.

AXXSC104

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.

AXXADD400

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.

AXXBP201

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 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.
- Injury contributed to by the use of alcohol or drugs not prescribed by a Doctor.

AXXEX102

- Re-injury or complications of an Injury which occurred prior to the Policy's Effective Date.
- Services of an assistant surgeon or Doctor when surgery is performed.
- Dental treatment, except as specifically stated.
- Eyeglasses, contact lenses, routine eye exams or prescriptions therefor.
- Hernia, any type.
- Injury sustained fighting or brawling, except in self-defense.
- Suicide or attempted suicide while sane or insane.
- 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 caused by or contributed to by aggravation of a Pre-existing Condition.

AXXEX310

- 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

- Treatment in any Veteran's Administration or federal Hospital, except if there is a legal obligation to pay.
- Cosmetic surgery, except for reconstructive surgery on an injured part of the body.

AXXEX600

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.

AXXPP100

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 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.

Subrogation: When benefits are paid to or for the 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.

AXXCP101

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.

AXXGP100

SCHEDULE OF BENEFITS

POLICYHOLDER INFORMATION

Policy Number:	**SEE SIGNED APPLICATION**
Policyholder:	**SEE SIGNED APPLICATION**
Policy Effective Date:	**SEE SIGNED APPLICATION**
Policy Term:	**SEE SIGNED APPLICATION**
Eligible Persons:	Students who are enrolled and attending the Policyholder's School as Full-Time Students
Scope of Coverage:	Football Only Accident Coverage Student Accident Coverage 24-Hour-A-Day Accident Coverage
Insured's Effective Date:	The date premium is received by Us or Our representative but not prior to the opening day of School. For students who purchased coverage the previous school year, the effective date will be retroactive to the first day of school provided the new premium is paid within 7 days of the school term. Students participating in preschool practice or play for interscholastic sports sanctioned by the Ohio High School Athletic Association will be covered as of the date of actual premium payment but only while engaged in actual practice or game sessions.

AXXPI100

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

Loss of Life	$2,000
Loss of Both Hands	$10,000
Loss of Both Feet	$10,000
Loss of the Entire Sight of Both Eyes	$1,000
Loss of One Hand or One Foot	$1,000

AXXADDSOB201

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	30 days
Benefit Period	52 weeks
Primary Benefit Amount	$250

AXXSOB201

COVERED CHARGES

Treatment, services or supplies incurred for:
Hospital room and board and general nursing care, limited to a maximum of $150 per day.
Hospital miscellaneous expense during Hospital Confinement or for outpatient surgery under general anesthetic, limited to a maximum of $1,000.
Doctor's fees for surgery in accordance with the Surgical Schedule, using $80 per unit value. Includes suturing, cutting and reduction of fractures.
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 $25 for the first visit and $25 for each visit thereafter. Physical Therapy is limited to 3 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 $100; • No fracture or dislocation, up to a maximum benefit of $100; and • MRI/CAT scan, up to a maximum benefit of $125.
Ambulance expense, limited to a maximum of $100.
Dental treatment for Injury to Sound Natural Teeth, limited to $200 per tooth, up to a maximum of $600. Future dental treatment payable only if the preceding per tooth maximum has not been used within the Benefit Period, and then only upon approval of a Certificate of Future Dental Care which must be filed within the Benefit Period, up to a maximum benefit of $100.

AXXCCSOB101

LOW 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.
Hospital miscellaneous expense during Hospital Confinement or for outpatient surgery under general anesthetic, limited to a maximum of $2,000.
Doctor's fees for surgery in accordance with the Surgical Schedule, using $160 per unit value. Includes suturing, cutting and reduction of fractures.
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 $50 for the first visit and $50 for each visit thereafter. Physical Therapy is limited to 3 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 $200; • No fracture or dislocation, up to a maximum benefit of $200; and • MRI/CAT scan, up to a maximum benefit of $250.
Ambulance expense, limited to a maximum of $200.
Dental treatment for Injury to Sound Natural Teeth, limited to $400 per tooth, up to a maximum of $1,200. Future dental treatment payable only if the preceding per tooth maximum has not been used within the Benefit Period, and then only upon approval of a Certificate of Future Dental Care which must be filed within the Benefit Period, up to a maximum benefit of $200.

AXXCCSOB101

HIGH OPTION

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.

Procedure	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 (e.g., 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

Notice Concerning Coverage Limitations and Exclusions Under the Ohio Life and Health Insurance Guaranty Association Act

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

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

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus. You should check with your insurance company representative to determine if you are only covered in part or not covered at all.

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

Ohio Life and Health Insurance Guaranty Association
1840 Mackenzie Drive
Columbus, Ohio 43220

Ohio Department of Insurance
50 W. Town Street
Third Floor, Suite 300
Columbus, Ohio 43215

The state law that provides for this safety-net coverage is called the Ohio Life and Health Insurance Guaranty Association Act. On the back of this page is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the guaranty association.

(please turn to back of page)

COVERAGE

Generally, individuals will be protected by the life and health insurance guaranty association if they live in Ohio and hold a life or health insurance contract, annuity contract, unallocated annuity contract, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this association if:

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

The association does **not** provide coverage for:

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

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the association is obligated to pay out: The association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the association will pay a maximum of $300,000 - no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall $300,000 limit, the association will not pay more than $100,000 in cash surrender values, $100,000 in health insurance benefits, $250,000 in present value of annuities, or $300,000 in life insurance death benefits - again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages.

Note to benefit plan trustees and other holders of unallocated annuities (GICs, DACs, etc.) covered by the act: For unallocated annuities that fund governmental retirement plans under subsection 401(k), 403(b) or 457 of the Internal Revenue Code, the limit is $250,000 in present value of annuity benefits including net cash surrender and net cash withdrawal per participating individual. In no event shall the association be liable to spend more than $300,000 in the aggregate per individual. For covered unallocated annuities that fund other plans, a special limit of $1,000,000 applies to each contractholder, regardless of the number of contracts held with the same company or number of persons covered. In all cases, of course, the contract limits also apply.

NOTICE OF GRIEVANCE PROCEDURES

If You are aggrieved by a claim decision of Guarantee Trust Life Insurance Company up to 4 levels of appeals may be pursued. Levels I, II, and III form the Internal Grievance Review process conducted by Us. The Level IV appeal is the Ohio External Review process. This Ohio External Review process is available for appeals regarding a denial of coverage due to lack of medical necessity and may be used after the completion of the internal appeal process.

LEVEL 1: You may request an appeal of an action or decision of within 90 days of the event giving rise to the appeal. The appeal request should be submitted in writing to Us at the address and telephone number listed on Your coverage identification card. The request for an appeal should include:

- a statement that this is a request for an appeal;
- the name and relationship of the person making the appeal;
- the reason for the appeal;
- any information that might help resolve the issue;
- the date of the service or claim; and
- if possible, a copy of the Explanation of Benefits.

We will review all materials, make a decision, and respond to You in writing within 30 days of receipt of the completed information needed to respond to the appeal.

LEVEL 2: If you are dissatisfied with the results of the Level 1 review of Your grievance, You, Your medical provider or Your personal representative, on Your behalf, may request a 2nd Level Grievance Review within 90 days of receiving the Level 1 decision.

The request for an appeal should include:

- a statement that this is a request for a Level 2 appeal and the date of the Level 1 determination;
- the name and relationship of the person making the appeal;
- the reason for the Level 2 appeal, including any substantive additional information not previously submitted

A decision will be made by a Supervisor within 30 calendar days after receiving your second level Grievance Review request. We will advise You of Our decision.

Level 3: If you are dissatisfied with the results of the Level 2 review of Your grievance, You, Your medical provider or Your personal representative, on Your behalf, may request a 3rd level Grievance Review within 90 days of receiving the Level 2 decision.

The request for an appeal should include:

- a statement that this is a request for a Level 3 appeal and the date of the Level 2 determination;
- the name and relationship of the person making the appeal;
- the reason for the Level 3 appeal, including any substantive additional information not previously submitted

A decision will be made by a Claim Manager and/or Vice-President of Claims within 30 calendar days after receiving your second level Grievance Review request. We will advise You of Our final decision.

Administrator Contact Information:

You may submit Your appeal request for formal Grievance Review to the following address:

Ms. Tina Tobias
Manager, Claims Department
Guarantee Trust Life Insurance Company
1275 Milwaukee Avenue
Glenview, IL 60025
800-338-7452

OHIO EXTERNAL REVIEW

GENERAL EXTERNAL REVIEW

You or Your authorized representative may request an external review of a coverage denial if both of the following are the case:

- We have denied, reduced, or terminated coverage for what would be a covered health care service except that We have determined that the health care service is not medically necessary.
- Except in the case of an expedited review, the proposed service, plus any ancillary services and follow-up care, will cost You more than five hundred dollars ($500) if the proposed service is not covered by Us.

If You have a terminal condition, We will follow the External Review for Experimental or Investigative Treatment procedures detailed in such section of these Procedures.

A request for a General External Review will not be granted in any of the following circumstances:

- You have failed to exhaust Our internal review process.
- You have previously been afforded an external review for the same denial of coverage, and no new clinical information has been submitted to Us.

We will deny a request for a General External Review if it is requested later than 60 days after notice has been sent regarding a final determination of the internal appeal process. A General External Review may be requested by You, an authorized person, Your provider, or a health care facility rendering health care service to You. You may request a review without the approval of the provider or the health care facility rendering the health care service. The provider or health care facility may not request a review without Your prior consent.

A General External Review must be requested in writing, except that if You have a condition that requires Expedited Review, the review may be requested orally or by electronic means. When an oral or electronic request for review is made, written confirmation of the request must be submitted to Us not later than 5 days after the request is made.

A request for a General External Review must be accompanied by written certification from Your provider or the health care facility rendering the health care service to You that the proposed service, plus any ancillary services and follow-up care, will cost You more than $500 dollars if the proposed service is not covered.

Except in the case of an expedited review, the independent review organization will issue a written decision not later than 30 days after the filing of the request. The independent review organization will send a copy of its decision to Us and to You. If Your provider or the health care facility rendering health care services to You requested the review, the independent review organization will also send a copy of its decision to Your provider or the health care facility.

We will provide any coverage determined by the independent review organization's decision to be Medically Necessary, subject to the other terms, limitations, and conditions of the insured's policy or certificate.

EXTERNAL REVIEW OF DENIAL OF EXPERIMENTAL OR INVESTIGATIVE TREATMENT FOR TERMINAL CONDITIONS

You or Your authorized representative may request an external review of a coverage denial if all of the following are the case:

- You have a terminal condition that, according to the current diagnosis of Your physician, has a high probability of causing death within 2 years.
- You request a review not later than 60 days after notice from Us regarding a final determination of the internal appeal process.
- Your physician certifies that You have a terminal condition as described above and any of the following situations are applicable:
  - Standard therapies have not been effective in improving Your condition.
  - Standard therapies are not medically appropriate for You.
  - There is no standard therapy covered by Us that is more beneficial than therapy recommended by your physician.

- Your physician has recommended a drug, device, procedure, or other therapy that the physician certifies, in writing, is likely to be more beneficial to You, in the physician's opinion, than standard therapies, or You have requested a therapy that has been found in a preponderance of peer-reviewed published studies to be associated with effective clinical outcomes for the same condition.
- You have been denied coverage by Us for a drug, device, procedure, or other therapy recommended or requested, and has exhausted Our internal review process.
- The drug, device, procedure, or other therapy, for which coverage has been denied, would be a covered health care service except for Our determination that the drug, device, procedure, or other therapy is experimental or investigational.

A review must be requested in writing, except that if Your physician determines that a therapy would be significantly less effective if not promptly initiated, the review may be requested orally or by electronic means. When an oral or electronic request for review is made, written confirmation of the request must be submitted to Us not later than 5 days after the oral or written request is submitted.

When You meet the criteria set forth above You have the opportunity to have Our decision to deny coverage reviewed under this Process. You will be notified of that opportunity within 30 business days after We deny coverage.

Except in the case of an expedited review, the independent review organization will issue a written decision not later than 30 days after the filing of the request. The independent review organization will send a copy of its decision to Us and to You. If Your provider or the health care facility rendering health care services to You requested the review, the independent review organization will also send a copy of its decision to Your provider or the health care facility.

The independent review organization will provide Us with the opinions of a panel of up to 3 experts. We will make the experts' opinions available to You and Your physician, upon request.

The opinion of the majority of the experts on the panel is binding on Us with respect to You. We will provide any coverage determined by the independent review organization's decision to be Medically Necessary, subject to the terms, limitations, and conditions of Your policy or certificate. If the opinions of the experts on the panel are evenly divided as to whether the therapy should be covered, Our final decision will be in favor of coverage. If less than a majority of the experts on the panel recommend coverage of the therapy, We may, in Our discretion, cover the therapy.

If Our initial denial of coverage for a therapy recommended or requested is based upon an external, independent review of that therapy meeting the requirements as stated above, this review process shall not be a basis for requiring a second external, independent review of the recommended or requested therapy.

At any time during the external, independent review process, We may elect to cover the recommended or requested health care service and terminate the review. We will notify You and all other parties involved by mail or, with consent or approval, by electronic means.

EXPEDITED REVIEW

For an expedited review, Your provider must certify that Your condition could, in the absence of immediate medical attention, result in any of the following:

- Placing the health of You or, with respect to a pregnant woman, the health of the unborn child, in serious jeopardy;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part.

The independent review organization will issue a written decision not later than seven days after the filing of the request for an Expedited Review.