GUARANTEE TRUST LIFE INSURANCE COMPANY
1275 Milwaukee Avenue, Glenview, Illinois, 60025

This Policy is issued to the Policyholder by Guarantee Trust Life Insurance Company (herein referred to as We, Us, Our) 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 Us and Policyholder.

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

READ YOUR POLICY CAREFULLY.

Secretary

President

Accident Medical Expense Benefits will be reduced when the Insured has Other Valid and Collectible Insurance. Refer to the Accident Medical Expense Benefit section in the Policy and the Policy Schedule.

ONE YEAR NON-RENEWABLE TERM

BLANKET ACCIDENT POLICY

NON-PARTICIPATING

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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:

1. transportation to a Hospital; or
2. 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 or from facility to facility.

Ambulatory Surgical Facility: A facility which meets licensing and other legal requirements and which:

1. Is equipped and operated to provide medical care and treatment by a Doctor;
2. Does not provide services or accommodations for overnight stays;
3. Has a medical staff that is supervised full time by a Doctor;
4. Has full-time services of a licensed registered nurse (R.N.) at all times when patients are in the facility;
5. Has at least one operating room and one recovery room and is equipped to support any surgery performed;
6. Has X-ray and laboratory diagnostic facilities;
7. Maintains a medical record for each patient; and
8. Has a written agreement with at least one Hospital for the immediate transfer of patients who develop complications or need confinement.

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.

Civil Union Partner: A person of the same or opposite sex as the Insured who has applied with the county clerk for a civil union with the Insured, received a certificate of civil union with the Insured from the county clerk and who has established a civil union with the Insured pursuant to the provisions of California law; provided that the civil union was not entered into prior to:

1. both parties attaining 18 years of age; or
2. the dissolution of a marriage or civil union or substantially similar legal relationship of one of the parties, and provided that the civil union is not between:
1. an ancestor and a descendent; or
2. siblings, whether the relationship is by the half or the whole blood or by adoption; or
3. an aunt or uncle and a niece or nephew, whether the relationship is by the half or the whole blood or by adoption; or
4. first cousins.

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. Activities which are not under the sponsorship or a supervision arrangement with the Policyholder are not covered activities.

Covered Charge: The Reasonable and Customary charge for a service or supply listed in this Policy 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 Person: A person who is eligible for coverage as an Insured; and

1. who has been accepted for coverage or has been automatically added; and
2. who has paid the required premium; and
3. whose coverage has become effective and has not terminated.

Designated Vehicle: A Motor 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 who 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 licensed medical 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 or her life or health would be in serious jeopardy; or
2. his or her 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:

1. 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; or
2. 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; or
3. 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; or
4. reliable evidence shows that the drug, device or medical care or treatment:
    a. is the subject of ongoing Phase I or Phase II clinical trials; or
    b. is the research, experimental study or investigational arm of on-going Phase III clinical trials; or
    c. 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
    d. reliable evidence shows 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:

1. published reports and articles in authoritative medical and scientific literature; or
2. written protocol or protocols by the treating facility studying substantially the same drug, device or medical care or treatment; or
3. 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, registered domestic partner, 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).

Heart or Circulatory Malfunction: means disease or illness of the heart or circulatory system.

Hospital: An institution licensed, accredited or certified by the State which:

1. is accredited by the Joint Commission on Accreditation of Healthcare Organizations; and
2. provides 24-hour nursing service by registered nurses (R.N.); and
3. mainly provides diagnostic and therapeutic care under the supervision of Doctors on an inpatient basis; and
4. maintains permanent surgical facilities or has an arrangement with another surgical facility supervised by a staff of one or more Doctors.

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

The term Hospital does not include a place, special ward, floor or other accommodation used for:

1. custodial or educational care; or
2. rest; or
3. the aged; or
4. 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:

1. is the proximate cause of, resulting in a covered loss; and
2. results in medical expense; and
3. occurs after the effective date of the Insured's coverage under this Policy; and
4. 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:

1. He or she is eligible for coverage under the Policy.
2. He or she has been accepted for coverage under the Policy, or has been automatically added.
3. Premium has been paid for him or her.
4. 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 on 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.

Maximum Benefit Amount: The maximum amount of benefits We will pay for any one Injury under the Accident Medical Expense Benefit. The Maximum Benefit Amount is shown on the Schedule of Benefits.

Medically Necessary: A treatment, drug, device, procedure, supply, or service that is necessary and appropriate for the diagnosis or treatment of an 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:

1. is Experimental/Investigational or for research purposes; or
2. is provided solely for education purposes or the convenience of the Insured, the Insured's family, Doctor, Hospital or any other provider; or
3. is merely for maintenance or preventive care; or
4. could have been omitted without adversely affecting the person's condition; or
5. involves the use of a medical device, drug, or substance not formally approved by the United States Food and Drug Administration; or
6. involves a service, supply, or drug not considered reasonable and necessary by the Healthcare Financing Administration Medicare Coverage Issues Manual.

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.

Motor Vehicle: Any registered motorized vehicle or conveyance with four or more wheels which is designated for travel on public roads or property and is not otherwise excluded.

Off-Season Physical Conditioning: School/team sanctioned and supervised off-season workouts and training for covered student athletes.

Orthopedic Appliances: Any supportive device or appliance used in treating the 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:

1. any individual, group, blanket, or franchise policy of accident, disability or health insurance; or
2. any arrangement of benefits for members of a group, whether insured or uninsured; or
3. any prepaid service arrangement such as Blue Cross or Blue Shield, individual or group practice plans, or health maintenance organizations; or
4. 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; or
5. 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 Workers' Compensation Law; or the settlement a Covered Person enters into to give up his or her rights to recover future medical expenses that would have been payable except for that settlement; or
6. 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
7. 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 by a Doctor 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 the Insured's outpatient use.

Primary Benefit Amount: The maximum amount of benefits We will pay for Covered Charges without regard to Other Valid and Collectible Insurance or Plan.

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

1. the actual amount charged by the provider; or
2. the negotiated rate; or
3. 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 Us for the same service or supply.

"Geographic Area" means the three-digit zip code prefix in which the service, treatment, procedure, drugs or supplies are provided.

Registered Domestic Partner: Registered domestic partner with the California Secretary of State.

Repetitive Motion Injury: Repetitive motion injuries are temporary or permanent injuries to muscles, nerves, ligaments, and tendons caused by doing the same motion over and over again.

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.

CONDITIONS OF INSURANCE

ELIGIBILITY

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

An Eligible Person, as shown on the Schedule of Benefits, is eligible to be insured on the Policy Effective Date, or the date he or she becomes eligible, if later. A person is insured under the Policy provided such person satisfies the eligibility requirements, becomes insured and remains insured under the terms of the Policy.

EFFECTIVE DATE

Policyholder: This Policy shall be effective, subject to the receipt of premium, on the later of:
1. the Effective Date shown on the application; or
2. 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.

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

Insured: All Sports Coverage. Coverage will terminate at the earlier of:
1. the date the Policy terminates; or
2. the date the Insured ceases to be a member of the Policyholder's sports teams; or
3. the last day of regularly scheduled sports activity in which the Insured participates; or
4. the date the Insured ceases to be an Eligible Person; or
5. the end of the period for which any applicable premium has been paid.

Insured: School-Time Student Accident Coverage. Coverage will terminate at the earlier of:
1. the date the Policy terminates; or
2. the date the Insured ceases to be an Eligible Person; or
3. 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:
1. the date the Policy terminates; or
2. the date the Insured ceases to be an Eligible Person; or
3. the end of the period for which any applicable premium has been paid; or
4. the last day of the period for which premium has been paid following the date a Dependent ceases to meet the definition of a Dependent.

Insured: Other Accident Coverage – as indicated on the application: Coverage will terminate at the earlier of:
1. the date the Policy terminates; or
2. the date the Insured ceases to be an Eligible Person; or
3. the end of the period for which any applicable premium has been paid.

Termination of coverage will not affect a claim for a covered loss that occurred while the Insured's coverage was in force.

We have the right to terminate the coverage of any Insured who submits a fraudulent claim under the Policy.

SCOPE OF COVERAGE

Subject to the Eligibility, Effective Date, and Termination provisions, an Insured will be covered for Accidental Injury that occurs while insured as elected by the Policyholder and, if applicable, as elected on their enrollment form.

Football Only Accident Coverage: If this option is shown on the application an Insured will be covered for Injury which is incurred while the Insured is participating in football competitions, as described in Scope of Coverage on the Schedule of Benefits, which are officially authorized, sanctioned and scheduled by the Policyholder, and governed by the rules and regulations of the appropriate athletic/activities association or organization. This includes related:

1. pre-competition activities; and
2. practice sessions; and
3. Off Season Physical Conditioning; and
4. sponsored team travel authorized, organized, and supervised by the Policyholder.

Coverage is also provided while traveling directly and uninterruptedly to or from the location designated by the Policyholder for football competitions, in a Designated Vehicle.

All Sports Accident Coverage: If this option is shown on the application an Insured will be covered for Injury which is incurred while the Insured is participating in athletic competitions as described in Scope of Coverage on the Schedule of Benefits, which are officially authorized, sanctioned and scheduled by the Policyholder, and governed by the rules and regulations of the appropriate athletic/activities association or organization. This includes related:

1. pre-competition activities; and
2. practice sessions; and
3. Off Season Physical Conditioning; and
4. sponsored team travel authorized, organized, and supervised by the Policyholder;

Coverage is also provided while traveling directly and uninterruptedly to or from the location designated by the Policyholder for athletic competitions, in a Designated Vehicle.

School-Time Student Accident Coverage: If this option is shown on the application, an Insured will be covered for Injury which is incurred while the Insured is:

1. on the Policyholder's premises:
    a. during the hours and on the days when Policyholder is in session, including one hour before and after; or
    b. during the hours and on the days when Policyholder is not in session while the Insured is participating in or attending any Covered Activity.
2. 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.
3. 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 application, an Insured will be covered for Injury which is incurred on a 24-hour-per-day basis.

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

ACCIDENTAL DEATH, DISMEMBERMENT AND LOSS OF SIGHT BENEFIT

If Injury from an 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. Such loss must occur within 365 days of such Accident. 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.

ACCIDENT MEDICAL EXPENSE BENEFITS

Subject to the definitions, limitations, exclusions, and other provisions of the Policy, We will pay benefits, as defined and limited below, for Covered Charges incurred by the Insured due to Injury.

Covered Charges are payable only for an Injury:

1. for which the first treatment or service is incurred within the Initial Treatment Period; and
2. 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.

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 paid 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.

If Other Valid and Collectible Insurance or Plan provides benefits on an excess coverage basis, Our plan will pay first, if it has been in effect for the longer period of time at the date of such Injury.

For purposes of this Policy, the 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. Thereafter, subsequent claims received for the same Injury which are in excess of the Primary Benefit Amount, will be subject to the excess provision.

EXCLUSIONS

This Policy does not provide benefits for:

1. treatment, services, or supplies which:
    a. are not Medically Necessary; or
    b. are not prescribed by a Doctor as necessary to treat an Injury; or
    c. are determined to be Experimental/Investigational in nature; or
    d. are received without charge or legal obligation to pay; or
    e. are received from persons employed or retained by the Policyholder or any Family Member, unless otherwise specified; or
    f. are not specifically listed as Covered Charges in this Policy; or
2. intentionally self-inflicted Injury; or
3. Injury received while violating or attempting to violate any duly enacted law; or
4. Injury by acts of war, whether declared or not; or
5. Injury covered by Workers' Compensation or the Occupational Disease Law; or
6. heat exhaustion; or
7. hernia or slipped femoral capital epiphysis; or
8. Injury directly caused by fighting or brawling, except as an innocent victim; or
9. Injury directly caused by 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); or
10. Injury directly caused by participating in or practicing for interscholastic tackle football in grades 9 through 12, including travel, unless optional coverage has been purchased; or
11. Treatment of illness, disease or infections, except infections which result from an accidental Injury or infections which result from accidental, involuntary or unintentional ingestion of a contaminated substance.

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 receipt of the required premium at Our home office, or by Our 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.

Change to Premium: We may change the required premium at any time when any change affecting the rates is made to the Policy. Such change in the Policy will not take effect until any additional required premium is received by Us, except as otherwise agreed to in writing by Policyholder and Us.

Grace Period: A grace period of 31 days will be granted for the payment of premiums accruing after the first premium, during which grace period the Policy shall continue in force, but the Policyholder shall be liable to the insurer for the payment of the premium accruing for the period the policy continues in force.

CLAIM PROVISIONS

Notice of Claim: Written notice of claim must be given to the insurer within 60 days after the occurrence or commencement of any loss covered by the Policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the claimant to the insurer at 1275 Milwaukee Ave., Glenview, Illinois, 60025, or to any authorized agent of the insurer, with information sufficient to identify the Covered Person, shall be deemed notice to the insurer

Claim Forms: The insurer, upon receipt of a 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 the Policy for filing Proofs of Loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

Proofs of Loss: Written proof of loss must be furnished to the insurer, in case of claim for loss for which this Policy provides any periodic payment contingent upon continuing loss, within 90 days after the termination of the period for which the insurer is liable, and in case of claim for any other loss, within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the Insured, later than one year from the time proof is otherwise required.

Time of Payment of Claim: Indemnities payable under this Policy for any loss other than loss for which this Policy provides periodic payments will be paid as they accrue immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnity for loss for which this Policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of the period of liability will be paid immediately upon receipt of due written proof.

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 insurer at its own expense shall have the right and opportunity to examine the person of any individual whose injury or sickness is the basis of claim when and as often as it may reasonably require during the Pendency of a claim hereunder and to make an autopsy in case of death, where it is not forbidden by law.

Legal Actions: No action at law or in equity shall be brought to recover on this Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this certificate. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished

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.

Time Limit on Certain Defenses: After this policy has been in force for a period of three years, no statements of the policyholder contained in the application, and no statement relating to insurability made by any person eligible for coverage under the policy shall be used to deny a claim or in contesting the validity of the insurance with respect to which such statement was made after the insurance has been in force prior to the contest for a period

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 Us when a change of Insurance Class occurs for the 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:

1. the Policyholder makes a written request for coverage on a form approved by Us; and
2. any premium not paid because of the error is paid in full from the effective date of coverage.

We reserve 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 Us for the overpayment.

Information and Records: The Policyholder shall provide Us 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 the Insured's coverage terminates.

Non-Participating: The Policy is non-participating. It does not share in Our profits or surplus earnings.

Conformity With State Statutes: Any provision of this Policy, which, on its effective date, is in conflict with the statutes of the state in which this Policy was delivered or issued for delivery is hereby amended to conform to the minimum requirements of such statute.

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.

INDEPENDENT MEDICAL REVIEW SYSTEM

DEFINITIONS

Coverage Decision: The approval or denial of health care services by a disability insurer, or by one of its contracting entities, substantially based on a finding that the provision of a particular service is included or excluded as a covered benefit under the terms and conditions of the disability insurance contract. A coverage decision does not encompass a disability insurer or contracting provider decision regarding a disputed health care service.

Disputed Health Care Service: Any health care service eligible for coverage and payment under a disability insurance contract that has been denied, modified, or delayed by a decision of the insurer, or by one of its contracting providers, in whole or in part due to a finding that the service is not medically necessary. A decision regarding a disputed health care service relates to the practice of medicine and is not a coverage decision. A disputed health care service does not include services provided by a group or individual policy of vision- or dental-only coverage, except to the extent that (1) the service involves the practice of medicine, or (2) is provided pursuant to a contract with a disability insurer that covers hospital, medical, or surgical benefits. If an insurer, or one of its contracting providers, issues a decision denying, modifying, or delaying health care services, based in whole or in part on a finding that the proposed health care services are not a covered benefit under the contract that applies to the insured, the statement of decision shall clearly specify the provision in the contract that excludes that coverage.

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

INDEPENDENT MEDICAL REVIEW

All insured grievances involving a disputed health care service are eligible for review under the Independent Medical Review System if the requirements are met. If the California Department of Insurance finds that an insured grievance involving a disputed health care service does not meet the requirements for review under the Independent Medical Review System, the insured request for review shall be treated as a request for the California Department of Insurance to review the grievance. All other insured grievances, including grievances involving coverage decisions, remain eligible for review by the alifornia Department of Insurance.

In any case in which an insured or provider asserts that a decision to deny, modify, or delay health care services was based, in whole or in part, on consideration of medical necessity, the California Department of Insuracne shall have the final authority to determine whether the grievance is more properly resolved pursuant to an Independent Medical Review

REQUESTING AN INDEPENDENT MEDICAL REVIEW

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

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

(1) (A) The insured's provider has recommended a health care service as medically necessary, or

(B) The insured has received urgent care or emergency services that a provider determined was medically necessary, or

(C) The insured, in the absence of a provider recommendation under subparagraph (A) or the receipt of urgent care or emergency services by a provider under subparagraph (B), has been seen by a contracting provider for the diagnosis or treatment of the medical condition for which the insured seeks independent review. The insurer shall expedite access to a

contracting provider upon request of an insured. The contracting provider need not recommend the disputed health care service as a condition for the insured to be eligible for an independent review.

(2) The disputed health care service has been denied, modified, or delayed by the insurer, or by one of its contracting providers, based in whole or in part on a decision that the health care service is not medically necessary.

(3) The insured has filed a grievance with the insurer or its contracting provider, and the disputed decision is upheld or the grievance remains unresolved after 30 days. The insured shall not be required to participate in the insurer's grievance process for more than 30 days. In the case of a grievance that requires expedited review, the insured shall not be required to participate in the insurer's grievance process for more than three days.

The Insured may apply to the California Department of Insurance for an Independent Medical Review of a decision to deny, modify, or delay health care services, based in whole or in part on a finding that the disputed health care services are not medically necessary, within six (6) months of any of the qualifying periods or events under subdivision (1). The Commissioner of the California Department of Insurance may extend the application deadline beyond six (6) months if the circumstances of a case warrant the extension.

The Insured shall pay no application or processing fees of any kind.

As part of its notification to the insured regarding a disposition of the insured's grievance that denies, modifies, or delays health care services, the insurer shall provide the Insured with a one- or two-page application form approved by the California Department of Insurance, and an addressed envelope, which the Insured may return to initiate an Independent Medical Review. The insurer shall include on the form any information required by the California Department of Insurance to facilitate the completion of the Independent Medical Review, such as the insured's diagnosis or condition, the nature of the disputed health care service sought by the insured, a means to identify the insured's case, and any other material information. The form shall also include the following:

(1) Notice that a decision not to participate in the independent review process may cause the insured to forfeit any statutory right to pursue legal action against the insurer regarding the disputed health care service.

(2) A statement indicating the insured's consent to obtain any necessary medical records from the insurer, any of its contracting providers, and any noncontracting provider the insured may have consulted on the matter, to be signed by the insured.

(3) Notice of the insured's right to provide information or documentation, either directly or through the insured's provider, regarding any of the following:

(A) A provider recommendation indicating that the disputed health care service is medically necessary for the insured's medical condition.

(B) Medical information or justification that a disputed health care service, on an urgent care or emergency basis, was medically necessary for the insured's medical condition.

(C) Reasonable information supporting the insured's position that the disputed health care service is or was medically necessary for the insured's medical condition, including all information provided to the insured by the insurer or any of its contracting providers, still in the possession of the insured, concerning an insurer or provider decision regarding disputed health care services, and a copy of any materials the insured submitted to the insurer, still in the possession of the insured, in support of the grievance, as well as any additional material that the insured believes is relevant.

(4) A section designed to collect information on the insured's ethnicity, race, and primary language spoken that includes both of the following:

(A) A statement of intent indicating that the information is used for statistics only, in order to ensure that all insureds get the best care possible.

(B) A statement indicating that providing this information is optional and will not affect the independent medical review process in any way.

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

Upon notice from the California Department of Insurance that the Insured has applied for an Independent Medical Review, the insurer or its contracting providers, shall provide to the independent medical review organization designated by the California Department of Insurance a copy of all of the following documents within three (3) business days of the insurer's receipt of the California Department of Insurance's notice of a request by an insured for an independent review:

(1) (A) A copy of all of the insured's medical records in the possession of the insurer or its contracting providers relevant to each of the following:

(i) The insured's medical condition.

(ii) The health care services being provided by the insurer and its contracting providers for the condition.

(iii) The disputed health care services requested by the insured for the condition.

(B) Any newly developed or discovered relevant medical records in the possession of the insurer or its contracting providers after the initial documents are provided to the independent medical review organization shall be forwarded immediately to the independent medical review organization. The insurer shall concurrently provide a copy of medical records required by this subparagraph to the insured or the insured's provider, if authorized by the insured, unless the offer of medical records is declined or otherwise prohibited by law. The confidentiality of all medical record information shall be maintained pursuant to applicable state and federal laws.

(2) A copy of all information provided to the insured by the insurer and any of its contracting providers concerning insurer and provider decisions regarding the insured's condition and care, and a copy of any materials the insured or the insured's provider submitted to the insurer and to the insurer's contracting providers in support of the insured's request for disputed health care services. This documentation shall include the written response to the insured's grievance. The confidentiality of any insured medical information shall be maintained pursuant to applicable state and federal laws.

(3) A copy of any other relevant documents or information used by the insurer or its contracting providers in determining whether disputed health care services should have been provided, and any statements by the insurer and its contracting providers explaining the reasons for the decision to deny, modify, or delay disputed health care services on the basis of medical necessity. The insurer shall concurrently provide a copy of documents required by this paragraph, except for any information found by the commissioner to be legally privileged information, to the insured and the insured's provider. The California Department of Insurance and the independent medical review organization shall maintain the confidentiality of any information found by the commissioner to be the proprietary information of the insurer.

CASE REVIEW PROCEDURE

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

1. The insured's specific needs; and
2. Peer-reviewed scientific and medical evidence regarding the effectiveness of the Disputed Health Care Service;

3. Nationally recognized professional standards;
4. Expert opinion;
5. Generally accepted standards of medical practice; or
6. Treatments that are likely to provide a benefit to a patient for conditions for which other treatments are not clinically efficacious.

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

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

The California Department of Insurance will makes its determination in writing within 30 days of the receipt of the application for review and supporting documentation.

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

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

SCHEDULE OF BENEFITS

POLICYHOLDER INFORMATION

Policy Number:	**See Attached Application**
Policyholder:	**See Attached Application**
Policy Effective Date:	**See Attached Application**
Policy Term:	**See Attached Application**
Eligible Persons:	Students who are enrolled and attending the Policyholder's School as full-time students.
Scope of Coverage:	**24-Hour-A-Day Accident Coverage** **School Time Student Accident Coverage** **All Sports Accident Coverage,** all interscholastic sports, except Senior High Football Grades 10-12 (including Grade 9 if playing or practicing with Grade 10 or above) **Football Only Accident Coverage**, limited to Senior High Football: - Including Grade 9 if playing or practicing with Grade 10 or above; - Spring Practice; and - Regular Season including Spring Practice **Other Accident Coverage** The following coverages may be offered to the district provided the district distributes the Voluntary Student Accident Coverage materials to the parents/guardians of the students in the district and acceptance of a proper system of written waivers of student insurance. These coverages are designed to assist compliance with California Education Code where applicable: <u>INTERSCHOLASTIC SPORTS OVERSIGHT COVERAGE:</u> We cover injuries to the district's interscholastic athletes who: 1. did not purchase student accident insurance because the district personnel failed to provide the Student Accident Insurance Plan to the injured athletes as required by the California Education Code 2. did not file a waiver of student insurance, and 3. participated in interscholastic athletics without coverage. Benefits are paid under the "Low Option" plan schedule up to a maximum of $1,500. <u>NON-COMPETING PARTICIPANTS COVERAGE:</u> Students will be covered while traveling in school-provided vehicles to and from athletic events for which they have been designated by the school district to directly assist in the noncompetitive activities associated with the events, e.g. members of school bands, cheerleaders, pompom girls and team managers. Benefits are paid under the "High Option" plan schedule up to a maximum of $1,500. <u>ONE-DAY FIELD TRIP COVERAGE:</u> We cover accidents which occur while your students are participating in school-sponsored and directly supervised one-day field trips. A field trip is when the school district is fully responsible for the students while they are participating in the trip. Benefits are paid under the "High Option" plan schedule up to a maximum of $1,500.

	Other Accident Coverage The following coverages are available to the district for an additional premium. ELEMENTARY COMPETITORS COVERAGE - We will cover students who participate in school sponsored and supervised interscholastic sports. No coverage is provided for tackle football. Coverage includes interscholastic sports contests, including school furnished transportation in a Designated Vehicle to practice and contests. Benefits are payable under the "Low Option" plan to a maximum of $1,500. POWDER PUFF FOOTBALL - Benefits are payable under the "Low Option" plan, up to the $25,000 maximum. All participants must be covered. TRAVEL ACCIDENT COVERAGE - This is a per trip coverage for school district sponsored trips on a twenty-four hour basis. Benefits are payable under the "Low Option" plan to a maximum of $25,000. Rider GR-738-CAL. INTERSCHOLASTIC TACKLE FOOTBALL "TRY-OUT" COVERAGE Covers injuries caused by accidents during practice for high school Interscholastic football. Also covers injuries caused by accidents occurring while traveling in a Designated Vehicle to and from practice. Coverage commences the first official day of practice, terminating Fourteen (14) days later. Benefits are payable under the "Low Option" plan up to $1,500 per Injury.
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 Football Only Accident Coverage, in which case coverage will begin on the first official day of practice.

ACCIDENTAL DEATH, DISMEMBERMENT AND LOSS OF SIGHT BENEFIT

The losses listed below are payable per Covered Person per Accident, unless specified otherwise in the Policy.

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

ACCIDENT MEDICAL EXPENSE BENEFITS

Maximum Benefit Amount, Per Injury **Football Only Accident Coverage** – High and Low Option: **School-Time Student Accident Coverage**, including Sports Accident Coverage – High Option: **School-Time Student Accident Coverage**, including Sports Accident Coverage – Low Option: **24-Hour-A-Day Accident Coverage**, including Sports Accident Coverage – High and Low Option:	 $25,000 $50,000 $25,000 $50,000
Insured Percent	100%
Payment System Percentile	90th
Initial Treatment Period	120 days
Benefit Period	52 weeks
Primary Benefit Amount	$500

COVERED CHARGES HIGH OPTION

Treatment, services, or supplies incurred for:
• Hospital room and board and general nursing care, up to the semi-private room rate.
• Intensive Care, limited to a maximum of $1,200 per day.
• Inpatient and Outpatient Hospital miscellaneous expense, such as the cost of the operating room, laboratory tests, x-ray examinations, anesthesia, drugs (excluding take-home drugs) or medicines, therapeutic services and supplies, limited to a maximum of $3,000.
• Doctor's fees for surgery, in accordance with the Surgical Schedule, using $270 per unit value.
• Anesthesia services, limited to 25% of the surgical schedule allowance.
• Assistant surgeon expense, limited to 25% of the surgical schedule allowance.
• Non-surgical Doctors' visits, including Physical Therapy, limited to 1 visit per day, up to $120 for the first visit and $60 for each visit thereafter. Physical Therapy is limited to a maximum of 9 visits.
• Hospital Emergency care, limited to a maximum of $300.

• Outpatient imaging procedures, including x-rays and interpretation for:
  • Fracture or dislocation, up to a maximum benefit of $500; and
  • No fracture or dislocation, up to a maximum benefit of $100; and
  • MRI/CAT scan, up to a maximum benefit of $900.

• Ambulance expense.
• Orthopedic Appliances, including braces and crutches, up to a maximum benefit of $100.
• Casts, non-surgical, up to a maximum benefit of $100.
• Replacement expense for broken eyeglasses, lenses and contact lenses resulting from an Injury requiring medical treatment, limited to a maximum of $150.
• Prescription Drugs.
• Dental treatment for Injury to Sound Natural Teeth, limited to $300 per tooth.
• Re-aggravation or re-injury of a Pre-existing Condition, limited to a maximum of $500.
• Optional Extended dental expense for: (a) examination, (b) diagnoses and x-ray; (c) restorative treatment; (d) endodontics; and (e) oral surgery (not to include periodontics or orthodontics); up to $250 for dental prostheses toward the cost of a bridge, partial denture, or denture, or for replacement in kind of previous dental repairs. If, during the Benefit Period, the Insured's dentist certifies that treatment must be deferred, We will pay up to a maximum of $100 in lieu of all other dental benefits.

COVERED CHARGES LOW OPTION

Treatment, services, or supplies incurred for:
• Hospital room and board and general nursing care, limited to a maximum of $300 per day.
• Intensive Care, limited to a maximum of $600 per day.
• Inpatient and Outpatient Hospital miscellaneous expense, such as the cost of the operating room, laboratory tests, x-ray examinations, anesthesia, drugs (excluding take-home drugs) or medicines, therapeutic services and supplies, limited to a maximum of $1,500.
• Doctor's fees for surgery, in accordance with the Surgical Schedule, using $175 per unit value.
• Anesthesia services, limited to 25% of the surgical schedule allowance.
• Assistant surgeon expense, limited to 25% of the surgical schedule allowance.
• Non-surgical Doctors' visits, including Physical Therapy, limited to 1 visit per day, up to $60 for the first visit and $30 for each visit thereafter. Physical Therapy is limited to a maximum of 9 visits.
• Hospital Emergency care, limited to a maximum of $150.

• Outpatient imaging procedures, including x-rays and interpretation for:
  • Fracture or dislocation, up to a maximum benefit of $250; and
  • No fracture or dislocation, up to a maximum benefit of $50; and
  • MRI/CAT scan, up to a maximum benefit of $500.

• Ambulance expense, limited to a maximum of $250.
• Orthopedic Appliances, including braces and crutches, up to a maximum benefit of $50.
• Casts, non-surgical, up to a maximum benefit of $50.
• Replacement expense for broken eyeglasses, lenses and contact lenses resulting from an Injury requiring medical treatment, limited to a maximum of $100.
• Prescription Drugs, limited to a maximum of $50.
• Dental treatment for Injury to Sound Natural Teeth, limited to $150 per tooth.
• Re-aggravation or re-injury of a Pre-existing Condition, limited to a maximum of $500.
• Optional Extended dental expense for: (a) examination, (b) diagnoses and x-ray; (c) restorative treatment; (d) endodontics; and (e) oral surgery (not to include periodontics or orthodontics); up to $250 for dental prostheses toward the cost of a bridge, partial denture, or denture, or for replacement in kind of previous dental repairs. If, during the Benefit Period, the Insured's dentist certifies that treatment must be deferred, We will pay up to a maximum of $100 in lieu of all other dental benefits.

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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 OF PROTECTION PROVIDED BY CALIFORNIA LIFE AND HEALTH INSURANCE GUARANTEE ASSOCIATION

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

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

COVERAGE

● Persons Covered

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

● Amounts of Coverage

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

● Life Insurance, Annuities and Structured Settlement Annuities

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

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

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

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

● Health Insurance

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

COVERAGE LIMITATIONS AND EXCLUSIONS FROM COVERAGE

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

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

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

NOTICES

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

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

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

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