



A Mutual Company Incorporated in 1909
Two East Gilman Street • PO Box 1191
Madison WI 53701-1191 • Phone 800-988-0826

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

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 as defined by the Policyholder, for whom premium has been timely paid. Eligible Persons are stated on the Schedule. Company agrees to pay benefits set forth in this Policy. Benefit payment is governed by the terms, conditions and limitations of this Policy.

READ YOUR POLICY CAREFULLY

Handwritten signature of Matthew J. Dew in black ink.

Secretary

Handwritten signature of Mark F. Solwend in black ink.

President

**ONE YEAR NON-RENEWABLE TERM
BLANKET POLICY PROVIDING
SICKNESS AND INJURY COVERAGE
NON-PARTICIPATING**

GPBCVOH100

NOTICE: IF YOU OR YOUR DEPENDENTS ARE COVERED BY MORE THAN ONE HEALTH CARE PLAN, YOU MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE THE INSURED TO FOLLOW ITS RULES OR USE SPECIFIC DOCTORS AND HOSPITALS, AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. YOU SHOULD READ ALL OF THE RULES VERY CAREFULLY, INCLUDING THE COORDINATION OF BENEFITS SECTION, AND COMPARE THEM WITH THE RULES OF ANY OTHER PLAN THAT COVER THE YOU OR THE YOUR DEPENDENTS.

GPBCVOH100

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GENERAL DEFINITIONS

The terms listed below, if used, have the meaning stated.

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

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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 or the Hospital cannot provide the needed care.

GGDFXX300

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

GGDFXX500

Complications of Pregnancy: A condition which:

- When pregnancy is not terminated, requires medical treatment and the diagnosis is distinct from pregnancy but is adversely affected by or is caused by pregnancy, such as: (a) acute nephritis; (b) nephrosis; (c) cardiac decompensation; (d) missed abortion; (e) eclampsia; (f) puerperal infection; (g) R.H. Factor problems; (h) severe loss of blood requiring transfusion; (i) and other similar medical and surgical conditions of comparable severity related to pregnancy; or
- When pregnancy is terminated: (a) non-elective cesarean section; (b) ectopic pregnancy that is terminated; and (c) spontaneous termination of pregnancy during a period of gestation in which a viable birth is not possible.

Complications of Pregnancy will **not** include:

- False labor;
- Occasional spotting;
- Doctor prescribed rest during the period of pregnancy;
- Morning Sickness;
- Preeclampsia; and
- Similar conditions associated with the management of a difficult pregnancy but which are not a separate Complication of Pregnancy.

Delivery by cesarean section is considered a Complication of Pregnancy if the cesarean section is non-elective. A cesarean section will be considered non-elective if the fetus or mother is determined to be in distress and is in immediate danger of death, Sickness or Injury if a cesarean section is not performed. A cesarean section beyond one performed in any previous pregnancy will also be considered non-elective if vaginal delivery is medically inappropriate, or a vaginal delivery is attempted but discontinued due to immediate danger of death, Sickness or Injury to the child or mother.

GGDFXX600

Covered Charge: The Reasonable and Customary Charge incurred for a service or supply which is performed or given under the direction of a Doctor for the Medically Necessary treatment of a Sickness or Injury. A Covered Charge is considered incurred on the date the treatment or service is rendered or the supply is furnished.

GGDFXX700

Covered Person: A person:

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

GGDFXX800

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.

GGDFXX1000

Emergency: A Sickness or Injury that manifests itself by such acute symptoms of sufficient severity, including severe pain, that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing the health of the individual or, with respect to a pregnant woman, the health of the woman of her unborn child, in serious jeopardy;

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- Serious impairment of any bodily organ or part.

Emergency Services: Covered Persons are encouraged to use the 9-1-1 system and any other telephone access system utilized to access pre-Hospital emergency services. Emergency services required by federal law include:

- a medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate an emergency medical condition; and
- such further medical examination and treatment to stabilize an emergency medical condition and are within the capability of the staff and facilities available at the Hospital, including any trauma and burn center of the Hospital.

GGDFOH1100

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 (FDA) and approval for marketing has not been given at the time the drug or device is furnished;
- The informed consent document utilized with the drug, device, medical care or treatment states or indicates that the drug, device, medical care or treatment is part of a clinical trial, experimental phase or investigational phase or if such a consent document is required by law;
- The drug, device, medical care or treatment or the patient informed consent document utilized with the drug, device or medical care or treatment was reviewed and approved by the treating facility's institutional review board or other body serving a similar function, or if federal or state law requires such review and approval;
- Reliable evidence show that the drug, device or medical care or treatment is the subject of ongoing Phase I or Phase II clinical trials, is the research, experimental study or investigational arm of on-going Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment of diagnosis; or
- Reliable evidence show that the prevailing opinion among experts regarding the drug, device or medical care or treatment is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment of diagnosis.

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

GGDFXX1200

Family Member: A person who is related to the Covered Person 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). A Family Member includes an individual who normally lives in the Covered Person's household.

GGDFXX1300

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 licensed registered nurses (R.N.);
- Mainly provides diagnostic and therapeutic care under the supervision of Doctors while Hospital Confined; 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 or Nervous Disorders or Serious Mental Disorders; or an institution mainly rendering treatment or services for substance abuse, except as specifically provided in the Policy.

GGDFOH1400

Hospital Confined/Hospital Confinement: Confinement in a Hospital for at least 18 consecutive hours for which a room and board charge is made by reason of a Sickness or Injury for which benefits are payable.

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Injury: Bodily injury due to an Accident which results solely, directly and independently of disease, bodily infirmity or any other causes.

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

GGDFXX1601

Insured: The Covered Person who is enrolled at the Policyholder's school.

GPBDFXX100

Medicaid: The Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965 as Then Constituted or Later Amended.

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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 educational purposes or the convenience of the patient, the patient'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 patient's condition or the quality of medical care;
- Involves treatment of or the use of a medical device, drug or substance not formally approved by the U.S. Food and Drug Administration (FDA);
- 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 more cost-effective basis such as out-patient, 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.

GGDFXX1700

Medicare: The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended.

GGDFXX3800

Mental or Nervous Disorder: Nervous, emotional and mental disease, illness, syndrome or dysfunction classified 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 a Covered Person. Does not include Serious Mental Disorders.

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Physiotherapy: Any form of the following administered by a Doctor:

- Physical or mechanical therapy;
- Diathermy;
- Ultra-sonic therapy;
- Heat treatment in any form; or
- Manipulation or massage.

GGDFXX4100

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

GGDFXX1910

Policyholder: The entity shown as the Policyholder on the Schedule.

GGDFXX2000

Prescription Drugs: Drugs which may only be dispensed by written prescription under Federal law, and approved for general use by the U.S. Food and Drug Administration (FDA). The drugs must be dispensed by a licensed pharmacy provider for out of Hospital use. Coverage for a Prescription Drug will not be excluded for a particular indication on the

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ground that the drug has not been approved by the FDA for that indication, if such drug is recognized for treatment of such indication in one of the standard reference compendia or in the medical literature as recommended by current American Medical Association (AMA) policies.

GGDFXX2200

Reasonable and Customary Charges, Fees or Expenses: An amount equal to the lesser of:

- The actual amount charged by the provider;
- The negotiated rate, if any; or
- The reasonable charge as determined by the Payment System software as shown in the Schedule.

GGDFXX2301

Serious Mental Disorders: Means the following terms as defined in the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association:

- schizophrenia;
- schizoaffective disorder;
- major depressive disorder;
- bipolar disorder;
- paranoia and other psychotic disorders;
- obsessive-compulsive disorder; and
- panic disorder.

Sickness: Illness, disease, and Complications of Pregnancy. All related conditions and recurrent symptoms of the same or a similar condition will be considered the same Sickness.

GGBDFOH101

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

GGDFXX2400

We, Ours and Us: The National Guardian Life Insurance Company.

Male pronouns whenever used include female pronouns.

GPDFXX100

CONDITIONS OF INSURANCE

ELIGIBILITY

An Eligible Person as defined by the Policyholder is stated on the Schedule.

We maintain the right to investigate student status and attendance records to verify that the Policy eligibility requirements have been met. If We discover that the Policy eligibility requirements have not been met, Our only obligation is refund of premium.

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Eligibility requirements must be met each time a premium is paid to continue coverage.

GGBCIXX200

EFFECTIVE DATE

Policyholder: The Policy shall be effective at 12:01 a.m. standard time on the Policy Effective Date shown on the Schedule.

GPBCIXX100

Insured: Coverage is effective as stated on the Schedule.

TERMINATION

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

Covered Person: Coverage will terminate at 12:01 a.m. standard time at the Covered Person's residence on the earliest of:

- The termination of the Policy;
- The date the Insured ceases to be an Eligible Person;
- The last day of the Term of Coverage for which premium is paid;
- The date a Covered Person enters full time active military service. Upon written request, We will refund any unearned pro-rata Premium with respect to such person.

GGBCIXX210

MEDICAL EXPENSE BENEFITS

We will pay benefits for Covered Charges incurred by the Covered Person due to Sickness or Injury. Covered Charges as shown on the Schedule are subject to:

- Deductible;
- Coordination of Benefits;
- Initial Treatment Period;
- Insured Percent;
- Benefit Period;
- The Policy Year Maximum Amount; and
- Definitions, limitations, exclusions and other provisions of the Policy.

The Deductible, Initial Treatment Period, Insured Percent, Benefit Period and Policy Year Maximum Amount are determined per Sickness or Injury.

GGCCXX100

Benefit Period: The period of time following the date of an Injury or the start of the first treatment of Sickness during which Covered Charges must be incurred, subject to the Initial Treatment Period. The Benefit Period begins on the date of Injury or the first treatment of Sickness and ends on the last day of the Benefit Period. The Benefit Period is shown on the Schedule.

GGCCXX200

Deductible: A dollar amount of Covered Charges a Covered Person must pay for each Sickness or Injury before We pay any benefits. The Deductible is shown in the Schedule.

GGBCCXX200

Initial Treatment Period: The period of time following an Injury during which a Covered Person must seek initial treatment for an Injury. The Initial Treatment Period is shown on the Schedule.

GGCCXX500

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

GGCCXX600

Policy Year Maximum Amount: The maximum amount of benefits We will pay for any one Sickness or Injury while a Covered Person is covered under this Policy during the Policy Year.

GGBCCXX400

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

If, within 100 days from the date of an Accident which occurs while coverage is in force, 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. If more than one such loss is sustained as the result of one Accident, We will pay only one amount, the largest to which the Covered Person is entitled.

Loss of hand or foot means loss by severance at or above the wrist or ankle joint. Loss of sight must be entire and irrecoverable. Any benefit payable under this part will be in addition to any benefit otherwise payable under this Policy.

This benefit is subject to all the terms, conditions and exclusions of this Policy.

GGADDXX100

GENERAL EXCLUSIONS

We won't pay benefits for:

- Treatment, services or supplies which:
 - Are not Medically Necessary;
 - Are not prescribed by a Doctor as necessary to treat a Sickness or Injury;
 - Are determined to be Experimental/Investigational in nature by Us;
 - Are received without charge or legal obligation to pay;
 - Would not routinely be paid in the absence of insurance;
 - Are received from any Family Member.

GGEXXX100

- Expenses incurred as a result of loss due to war, or any action of war, declared or undeclared; service in the armed forces of any country.
- Expenses incurred as a result of suicide or intentionally self-inflicted Injury while sane or insane.
- Injury or Sickness arising out of or in the course of employment or which is compensable under any Workers' Compensation or Occupational Disease Act or Law.
- Cosmetic surgery other than reconstructive surgery incidental to or following surgery resulting from trauma, infection, or other diseases of the involved part.
- Loss due to voluntarily using any drug, narcotic or controlled substance, unless as prescribed by a Doctor.
- Riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as a fare-paying passenger in an aircraft operated by a commercial scheduled airline.
- Any service or supply not specifically listed as a Covered Charge.

GGEXXX200

- Fighting or brawling.

GGEXXX3000

- Normal pregnancy and childbirth.

GGEXXX2900

- Treatment of alcoholism, or any form of substance abuse, except as specifically provided.
- Treatment of Mental or Nervous Disorders, except as specifically provided.

GGEXOH700

- Expenses incurred as a result of dental treatment, except as specifically stated.

GGEXXX800

- Eye examinations, contact lenses, eyeglasses, replacement of eyeglasses or prescription, therefore.

GGEXXX1000

- Treatment in any Veteran's Administration or federal Hospital, except if there is a legal obligation to pay.

GGEXXX1100

- Elective abortions.

GGEXXX2100

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

GGEXXX1901

- Treatment of hernia of any kind.

COORDINATION OF BENEFITS

I. Applicability

The Coordination of Benefits ("COB") provision applies when a person has health care coverage under more than one **Plan**. **Plan** is defined below.

The order of benefit determination rules govern the order in which each **Plan** will pay a claim for benefits. The **Plan** that pays first is called the **Primary plan**. The **Primary plan** must pay benefits in accordance with its policy terms without regard to the possibility that another **Plan** may cover some expenses. The **Plan** that pays after the **Primary plan** is the **Secondary plan**. The **Secondary plan** may reduce the benefits it pays so that payments from all **Plans** does not exceed 100% of the total **Allowable expense**.

II. Definitions

A. A **Plan** is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

(1) **Plan** includes: group and nongroup insurance contracts, health insuring corporation ("HIC") contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

(2) **Plan** does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; supplemental coverage as described in Revised Code sections 3923.37 and 1751.56; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate **Plan**. If a **Plan** has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate **Plan**.

B. **This plan** means, in a **COB** provision, the part of the contract providing the health care benefits to which the **COB** provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one **COB** provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another **COB** provision to coordinate other benefits.

C. The order of benefit determination rules determine whether **This plan** is a **Primary plan** or **Secondary plan** when the person has health care coverage under more than one **Plan**.

When **This plan** is primary, it determines payment for its benefits first before those of any other **Plan** without considering any other **Plan's** benefits. When **This plan** is secondary, it determines its benefits after those of another **Plan** and may reduce the benefits it pays so that all **Plan** benefits do not exceed 100% of the total **Allowable expense**.

D. **Allowable expense** is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any **Plan** covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an **Allowable expense** and a benefit paid. An expense that is not covered by any **Plan** covering the person is not an **Allowable expense**. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an **Allowable expense**.

The following are examples of expenses that are not **Allowable expenses**:

- (1) The difference between the cost of a semi-private hospital room and a private hospital room is not an **Allowable expense**, unless one of the **Plans** provides coverage for private hospital room expenses.
- (2) If a person is covered by 2 or more **Plans** that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an **Allowable expense**.
- (3) If a person is covered by 2 or more **Plans** that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an **Allowable expense**.
- (4) If a person is covered by one **Plan** that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another **Plan** that provides its benefits or services on the basis of negotiated fees, the **Primary plan's** payment arrangement shall be the **Allowable expense** for all **Plans** . However, if the provider has contracted with the **Secondary plan** to provide the benefit or service for a specific negotiated fee or payment amount that is different than the **Primary plan's** payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the **Allowable expense** used by the **Secondary plan** to determine its benefits.
- (5) The amount of any benefit reduction by the **Primary plan** because a covered person has failed to comply with the **Plan** provisions is not an **Allowable expense**. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

E. **Closed panel plan** is a **Plan** that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the **Plan**, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

F. **Custodial parent** is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

III. Order of Benefit Determination Rules

When a person is covered by two or more **Plans**, the rules for determining the order of benefit payments are as follows:

- A. The **Primary plan** pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other **Plan**.
- B.
 - (1) Except as provided in Paragraph (2), a **Plan** that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both **Plans** state that the complying plan is primary.
 - (2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the **Plan** provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a **Closed panel plan** to provide out-of-network benefits.
- C. A **Plan** may consider the benefits paid or provided by another **Plan** in calculating payment of its benefits only when it is secondary to that other **Plan**.
- D. Each **Plan** determines its order of benefits using the first of the following rules that apply:
 - (1) Non-Dependent or Dependent. The **Plan** that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the **Primary plan** and the **Plan** that covers the person as a dependent is the **Secondary plan** . However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the **Plan** covering the person as a dependent, and

primary to the **Plan** covering the person as other than a dependent (e.g. a retired employee), then the order of benefits between the two **Plans** is reversed so that the **Plan** covering the person as an employee, member, policyholder, subscriber or retiree is the **Secondary plan** and the other **Plan** is the **Primary plan**.

- (2) Dependent child covered under more than one plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one **Plan** the order of benefits is determined as follows:
- (a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:
- The **Plan** of the parent whose birthday falls earlier in the calendar year is the **Primary plan**;
or
 - if both parents have the same birthday, the **Plan** that has covered the parent the longest is the **Primary plan**.
 - However, if one spouse's plan has some other coordination rule (for example, a "gender rule" which says the father's plan is always primary), we will follow the rules of that plan.
- (b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
- (i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the **Plan** of that parent has actual knowledge of those terms, that **Plan** is primary. This rule applies to plan years commencing after the **Plan** is given notice of the court decree;
- (ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;
- (iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or
- (iv) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
- The **Plan** covering the **Custodial parent**;
 - The **Plan** covering the spouse of the **Custodial parent**;
 - The **Plan** covering the **non-custodial parent**; and then
 - The **Plan** covering the spouse of the **non-custodial parent** .
- (c) For a dependent child covered under more than one **Plan** of individuals who are not the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.
- (3) Active employee or retired or laid-off employee. The **Plan** that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the **Primary plan**. The **Plan** covering that same person as a retired or laid-off employee is the **Secondary plan**. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.
- (4) COBRA or state continuation coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another **Plan**, the **Plan** covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the **Primary plan** and the COBRA or state or

other federal continuation coverage is the **Secondary plan** . If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

- (5) Longer or shorter length of coverage. The **Plan** that covered the person as an employee, member, policyholder, subscriber or retiree longer is the **Primary plan** and the **Plan** that covered the person the shorter period of time is the **Secondary plan**.
- 6) If the preceding rules do not determine the order of benefits, the **Allowable expenses** shall be shared equally between the **Plans** meeting the definition of **Plan**. In addition, **This plan** will not pay more than it would have paid had it been the **Primary plan**.

IV. Effect on the Benefits of this Plan

- A. When **This plan** is secondary, it may reduce its benefits so that the total benefits paid or provided by all **Plans** during a plan year are not more than the total **Allowable expenses**. In determining the amount to be paid for any claim, the **Secondary plan** will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any **Allowable expense** under its **Plan** that is unpaid by the **Primary plan** . The **Secondary plan** may then reduce its payment by the amount so that, when combined with the amount paid by the **Primary plan** , the total benefits paid or provided by all **Plans** for the claim do not exceed the total **Allowable expense** for that claim. In addition, the **Secondary plan** shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.
- B. If a covered person is enrolled in two or more **Closed panel plans** and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one **Closed panel plan**, **COB** shall not apply between that **Plan** and other **Closed panel plans** .

V. Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these **COB** rules and to determine benefits payable under **This plan** and other **Plans** . [Organization responsible for **COB** administration] may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under **This plan** and other **Plans** covering the person claiming benefits. [Organization responsible for **COB** administration] need not tell, or get the consent of, any person to do this. Each person claiming benefits under **This plan** must give [Organization responsible for **COB** administration] any facts it needs to apply those rules and determine benefits payable.

VI. Facility of Payment

A payment made under another **Plan** may include an amount that should have been paid under **This plan** . If it does, [Organization responsible for **COB** administration] may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under **This plan** . [Organization responsible for **COB** administration] will not have to pay that amount again. The term " payment made " includes providing benefits in the form of services, in which case " payment made " means the reasonable cash value of the benefits provided in the form of services.

VII. Right of Recovery

If the amount of the payments made Us is more than it should have paid under this **COB** provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid, or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made " includes the reasonable cash value of any benefits provided in the form of services.

VIII. Coordination Disputes

If you believe that we have not paid a claim properly, you should first attempt to resolve the problem by contacting Us. If you are still not satisfied, you may call the Ohio Department of Insurance for instructions on filing a consumer complaint. Call 1-800-686-1526, or visit the Department's website at: <http://insurance.ohio.gov>.

CLAIM PROVISIONS

Notice of Claim: Written Notice of Claim must be given to Us or Our 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 Covered Person.

GGCPXX100

Claim Forms: Upon Our receipt of written Notice of Claim, We will furnish to the claimant such forms as are usually furnished by Us 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.

GGCPXX200

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

GGCPXX300

Time of Payment of Claims: Benefits for any loss, other than loss for which this Policy provides any periodic payment, will be paid immediately upon, or within 30 days after, receipt of due written Proof of Loss. When this Policy provides for periodic payment, the benefits will accrue and will be paid monthly subject to proper proof of loss.

We will pay or deny the claim not later than 30 days after receipt of the claim. If We deny a claim, We will notify the provider and the Covered Person. The notice shall state, with specificity, why We denied the claim. However, if We determine that reasonable supporting documentation is needed to establish Our responsibility to make payment, We shall pay or deny the claim not later than 45 days after receipt of the claim. Not later than 30 days after receipt of the claim, We shall notify all relevant external sources that the supporting documentation is needed.

The number of days that elapse between Our last request for supporting documentation within the 30 day period and Our receipt of all of the supporting documentation that was requested shall not be counted for purposes of determining Our compliance with the time period of not more than 45 days for payment or denial of a claim. If We request additional supporting documentation after receiving the initially requested documentation, the number of days that elapse between making the request and receiving the additional supporting documentation shall be counted for purposes of determining Our compliance with the time period of not more than 45 days.

If, however, after receiving initially requested documentation, We need additional supporting documentation pertaining to a Covered Person's Pre-existing Condition which was unknown to Us at the time of Our initial request for documentation, We subsequently request this additional supporting documentation, the number of days that elapse between making the request and receiving the additional documentation shall not be counted for purposes of determining Our compliance with the time period of not more than 45 days.

If We deny a claim, We shall notify the provider and the Covered Person. The notice shall state, with specificity, why We denied the claim.

GGCPOH400

Payment of Claims: Unless instructed by You otherwise, benefits payable under this Policy for loss of life are payable to the first surviving classes of the Covered Person: spouse; child or children; mother or father; sisters or brothers; or estate. All other benefits will be payable to the Covered Person or the medical services provider if We have received a valid assignment by the Covered Person.

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

NGP-2002

Subject to any written direction of the Covered Person or of the legal or natural guardian of the Covered Person, if the Covered Person is a minor or otherwise incompetent to make such a direction, all or a portion of any indemnities provided by the Policy as a result of medical, surgical, dental, hospital or nursing service may, at Our option, and unless We are 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.

GGCPXX510

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

GGCPXX600

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.

GGCPXX700

Subrogation: When benefits are paid to or for a Covered Person under the terms of the Policy, We shall be subrogated, unless otherwise prohibited by law, to the rights of recovery of such Covered Person against any person who might be acknowledged 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 Our recovery of the benefits We have paid for such hospitalization and treatment and We shall pay fees and costs associated with such recovery.

GGCPXX800

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 Our authorized representative.

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 the Policyholder 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.

GGPPXX100

GENERAL PROVISIONS

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

Failure by Us 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.

We have full, exclusive and discretionary authority to determine all questions arising in connection with the Policy, including its interpretation, notwithstanding the opportunity for an external review of a coverage denial.
GGGPOH100

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 the 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.

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

Workers' Compensation: This Policy is not in lieu of and does not affect any requirement for coverage by Workers' Compensation Insurance.
GPGPXX100

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 Us ; 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 Us for the overpayment.

Information and Records: We shall have the right to inspect, at reasonable times, any of the Policyholder's records for the Policy. The Policyholder shall provide Us with information necessary to administer coverage and set premium under the Policy. Information is required when an eligible person becomes covered, when changes in amounts of coverage occur, and when a Covered Person's coverage terminates.
GGGPXX200

SCHEDULE

POLICYHOLDER INFORMATION

Policy Number:	SEE SIGNED APPLICATION
Policyholder:	SEE SIGNED APPLICATION
Policy Effective Date:	SEE SIGNED APPLICATION
Policy Term:	SEE SIGNED APPLICATION
Term(s) of Coverage:	SEE SIGNED APPLICATION
Eligible Person:	<p>Students who are enrolled and attending the Policyholder as full-time students. Full-time student status is determined by the Policyholder.</p> <p>For Senior High Football Coverage- 2013 season only (Grades 10-12 including grade 9 if playing with grades 10-12), only the students who purchase the additional Optional Senior High School Football Coverage will be eligible for coverage under this plan for Injury sustained while participating in the practice or play of interscholastic senior high school football or travel connected therewith.</p>
Insured's Effective Date:	<p>Coverage must be purchased within 75 days of the beginning of each school year or within 75 days of initial enrollment into the district as a new student. Exceptions will only be made for those students who become ineligible under another plan of creditable coverage.</p> <p>Coverage will be effective as of the day after receipt of premium except in the case of interscholastic sports sanctioned by the Ohio High School Athletic Association which will be covered as of the date of actual premium payment but only while engaged in actual practice or game sessions.</p> <p>For students who purchased coverage the previous school year, there will be no interruption in coverage provided the new premium is paid within 14 days of the opening day of the school year.</p>

GPBSOBXX100

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

Loss of Life	\$2,000
Loss of Both Hands, Both Feet or Sight of Both Eyes	\$10,000
Loss of One Hand and One Foot	\$10,000
Loss of One Hand and the Sight of One Eye.....	\$10,000
Loss of One Foot and the Sight of One Eye	\$10,000
Loss of One Hand or One Foot or the Sight of One Eye	\$1,000

GGSOBXX200

MEDICAL EXPENSE BENEFITS

Policy Year Aggregate Maximum Amount Per Injury or Sickness	\$25,000
Except, Injury sustained as the result of operating, riding in or upon, entering into or mounting, alighting from or being struck by any conveyance or vehicle propelled by an engine or motor is limited to traveling directly and uninterrupted to or from the Insured's residence to attend regular sessions at the Policyholder's school, up to a maximum amount of	
	\$750
Deductible, Per Injury or Sickness	\$0
Insured Percent	100% of Reasonable and Customary Expense Subject to any allocated amounts stated in the Covered Charges
Initial Payment	\$250
After making the Initial Payment, benefits will coordinate with any other valid and collectible insurance.	
Payment System Percentile	90 th
Initial Treatment Period	30 days
Benefit Period	52 weeks

GGSOBXX300

COVERED CHARGES

Treatment, services or supplies incurred for:
Hospital room and board, and general nursing care, up to the semi-private room rate, limited to a maximum of \$150 per day .
Hospital miscellaneous expense, limited to a maximum of \$1,000.
Doctor fees for surgery, limited to the Surgical Schedule, using a \$80 factor. For a fracture that does not require a reduction, the benefit will be 50% of the Surgical Schedule. Coverage is <u>not</u> provided for services of an assistant surgeon or doctor when surgery is performed.
Anesthesia services, limited to 20% of the surgical fee.
Doctor visits, non-surgical, inpatient and outpatient, including physical therapy, limited to a maximum of \$25 each visit. Physical therapy is limited to 3 visits.
Hospital emergency care expense, limited to a maximum of \$150.
Outpatient imaging procedures Including x-ray and interpretation up to a maximum of \$100.
Outpatient imaging procedures other than x-rays up to a maximum of \$125.
Ambulance expense, limited to a maximum of \$100.
Dental treatment for Injury to Sound Natural Teeth, limited to \$200 per tooth. 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.

GGSOBOH400

COVERED CHARGES - DOUBLE BENEFITS

Treatment, services or supplies incurred for:
Hospital room and board, and general nursing care, up to the semi-private room rate, limited to a maximum of \$300 per day.
Hospital miscellaneous expense, limited to a maximum of \$2,000.
Doctor fees for surgery, limited to the Surgical Schedule, using a \$160 factor. For a fracture that does not require a reduction, the benefit will be 50% of the Surgical Schedule. Coverage is <u>not</u> provided for services of an assistant surgeon or doctor when surgery is performed.
Anesthesia services, limited to 20% of the surgical fee.
Doctor visits, non-surgical, inpatient and outpatient, including physical therapy, limited to a maximum of \$50 each visit. Physical therapy is limited to 3 visits.
Hospital emergency care expense, limited to a maximum of \$300.
Outpatient imaging procedures Including x-ray and interpretation up to a maximum of \$200.
Outpatient imaging procedures other than x-rays up to a maximum of \$250.
Ambulance expense, limited to a maximum of \$200.
Dental treatment for Injury to Sound Natural Teeth, limited to \$400 per tooth. 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.

GGSOBOH400

MANDATED BENEFITS – DO NOT DOUBLE

PAID THE SAME AS ANY OTHER SICKNESS

<ul style="list-style-type: none"> • Emergency Service expenses.
<ul style="list-style-type: none"> • Treatment of alcoholism on an outpatient, inpatient and intermediate basis, up to a maximum benefit of \$550 per Policy Year.
<ul style="list-style-type: none"> • Mammograms for a female Covered Person, payable up to 130% of the Medicare reimbursement rate, at the following intervals: <ul style="list-style-type: none"> one screening mammography ages 35 to 39, inclusive; one mammogram every 2 years or annually if a Doctor has determined that the woman has risk factors to breast cancer, ages 40 to 49, inclusive; and a mammogram every year age 50 to 64, inclusive.
<ul style="list-style-type: none"> • Cytologic screening for the presence of cervical cancer.
<ul style="list-style-type: none"> • Coverage for the costs of any routine patient care administered to a Covered Person participating in any stage of an eligible cancer clinical trial. Eligible cancer clinical trial means a cancer clinical trial that meets all of the following conditions: <ol style="list-style-type: none"> 1. A purpose of the trial is to test whether the intervention potentially improves the trial participant's health outcomes. 2. The treatment provided as part of the trial is given with the intention of improving the trial participant's health outcomes. 3. The trial has a therapeutic intent and is not designed exclusively to test toxicity or disease pathophysiology. 4. The trial does one of the following: <ol style="list-style-type: none"> a. Tests how to administer a health care service, item or drug for the treatment of cancer; b. Tests responses to a health care service, item or drug for the treatment of cancer; c. Compares the effectiveness of a health care service, item, or drug for the treatment of cancer with that of other health care services, items or drugs for the treatment of cancer; d. Studies new uses of a health care service, item, or drug for the treatment of cancer. 5. The trial is approved by one of the following entities: <ol style="list-style-type: none"> a. The National Institute of Health or one of its cooperative groups or centers under the U.S. Department of Health and Human Services; b. The U.S. Food and Drug Administration; c. The U.S. Department of Defense; or d. The U.S. Department of Veterans' Affairs.
<ul style="list-style-type: none"> • Serious Mental Disorders.

GGSBOH400

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.

	<u>Unit Value</u>
Appendectomy	5.8
Cholecystectomy	8.2
Colectomy Partial with Anastomosis	12.0
Repair, simple wounds, recent, 2.5 cm to 7.5 cm	0.65
Dilation and curettement of cervical stump	2.3
Excision of Hydrocele, unilateral	4.6
Excision of Pilonidal Cyst or Sinus, Simple	0.25
Exploratory Laparotomy	6.5
Gastrotomy with Exploration of Foreign Body Removal	7.8
Hemorrhoidectomy, External, Complete	3.7
Hemorrhoidectomy, Internal and External, Complex or Extensive	6.5
Incision and Drainage, Sebaceous Cyst, One Lesion	0.25
Inguinal Herniorrhaphy	5.6
Pneumonostomy, with Open Drainage of Pulmonary Abscess	8.5
Splenectomy	10.0
Submucous Resection, Nasal Septum	5.0
Tonsillectomy	2.7
Fractured Humerus, shaft, simple closed reduction	3.3
Total Gastrectomy, including Intestinal Anastomosis	16.5
Vaginal Hysterectomy	9.9
Arthrotomy, knee with exploration, drainage or removal of foreign body	7.2
Fracture, Femur shaft, simple closed reduction	5.3
Fracture metacarpal, one, simple closed reduction	1.6
Craniotomy, decompression, orbital, unilateral	14.5

GGSOBXX500

NOTICE OF GRIEVANCE PROCEDURES

If You are aggrieved by a claim decision of Guarantee Trust Life, up to 4 levels of appeals may be pursued. Levels I, II, and III form the internal appeals 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.

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.



PRIVACY NOTICE

At National Guardian Life Insurance Company (NGL) we know the importance of the right to privacy. That's why protecting the information that personally identifies each and every one of our valued insurance customers is high priority, and a matter we take very seriously.

Our primary goal is, and will continue to be, providing competitive, fairly priced, and exceptional quality insurance products to meet the short-term and long-term financial needs of our customers. From life and health insurance to credit life and credit disability insurance, getting people the protection they need is not just a job to us. It is a privilege.

While the personal, financial and medical information shared with us (from applying for coverage, to filing a claim) is the cornerstone to providing the high-quality insurance protection and service our customers have come to know and expect, be assured that information, unique to our insurance customers, is kept secure, confidential and used expressly for the purpose of conducting our insurance relationship with them. Remember, protecting our customer's privacy is not only our priority...it's a promise.

The following is a summary of our privacy policy and practices. It tells you about the kinds of personally identifiable information we collect, disclose or share with others.

INFORMATION WE COLLECT AND SOURCES OF INFORMATION

In order for NGL to provide and administer the insurance products we offer, we collect personal information about the customer. Some of the information we collect is "nonpublic". The nonpublic personal information we collect is obtained from the following sources:

- Information we receive on the application for insurance or other forms (*such as name, address, telephone number, age, social security number, and beneficiary designation.*)
- Information about our customer's transactions with us and our affiliates (*such as the type of insurance product purchased, the premium paid, the method of purchase, and payment history.*)
- Information we receive from third party reports, (*such as consumer-reporting/credit agencies, motor vehicle records, and medical information. All medical information we receive is subject to the Medical Confidentiality rules described below.*)

INFORMATION WE DISCLOSE

NGL does not disclose any nonpublic personal information about our customers or former customers to anyone, except as permitted or required by law.

We may also disclose all of the information we collect, as described above, with the following:

- Affiliates – We may share information with our affiliates. Our affiliates offer products and services that may complement insurance purchases and we believe may be of interest to our customers.
- Service Providers – We may share information with companies engaged to perform services on our behalf, such as third party administrators and vendors hired to effect, administer or enforce a transaction a customer requests or authorizes; to develop or maintain computer software; or to perform market research.
- Joint Marketing – We may share information with companies that perform marketing services on our behalf or to other financial institutions with which we have a joint marketing agreement.

MEDICAL CONFIDENTIALITY

All medical information is kept confidential. We will not use or share, internally or with third-parties, our customer's medical information except for the purposes of:

- Underwriting;
- Administering the policy or claim;
- As permitted or required by law; or
- As authorized by the customer.

SECURITY AND CONFIDENTIALITY OF CUSTOMER INFORMATION

We restrict access to nonpublic personal information about our customers to those employees (or people working on our behalf under confidentiality agreements) who need to know the information in order to provide products and services. We also maintain physical, electronic, and procedural safeguards that comply with federal regulations to guard all nonpublic personal information. To file a complaint with us, contact our Administrator's Consumer Affairs Department at Guarantee Trust Life Insurance Company (GTL):

Guarantee Trust Life Insurance Company
1275 Milwaukee Avenue
Glenview, Illinois 60025
1-800-338-7452