National Guardian® Life Insurance Company

A Mutual Company Incorporated in 1909
PO Box 1191 • Madison, WI 53701-1191 • Phone 888-274-8050

BLANKET FIXED INDEMNITY BENEFIT POLICY

Underwritten by: National Guardian Life Insurance Company
Two East Gilman Street
P.O. Box 1191
Madison, WI 53701-1191

Administrator: Guarantee Trust Life Insurance Co.
1275 Milwaukee Ave.
Glenview, IL 60025
800-622-1993

This is a legal contract between us, NATIONAL GUARDIAN LIFE INSURANCE COMPANY, and Illinois Central College, (the Policyholder).

Policy Number: 12N-125-343 S

Policy Effective Date: August 15, 2014 Policy Anniversary/Termination Date: August 15, 2015

Policy Term: This policy will go into effect on the Policy Effective Date and will terminate on the Policy Termination Date. All periods of insurance for a Covered Person begin and end at 12:01 A.M. Standard Time at the Policyholder's address.

Scope of Coverage: In exchange for the payment of premiums, as described in PREMIUMS, we agree to pay benefits to all Eligible Persons covered for benefits for losses caused by:

a) Injury, directly and independently of disease or bodily infirmity; and

b) Sickness.

This coverage is subject to the exclusions, and to all of the other terms of the policy. The policy will be governed by the laws of Illinois.

Executed at Madison, Wisconsin on the Policy Effective Date.

Secretary *President*

THIS POLICY PROVIDES LIMITED ACCIDENT & SICKNESS COVERAGE. READ IT CAREFULLY.

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SCHEDULE OF BENEFITS

1. ELIGIBILITY

ELIGIBLE PERSONS ARE:

Eligible Class(es)	Description
1	Full-time students carrying 12 credit hours or more
2	Part-time students carrying 6 credit hours or more
3	Eligible Dependents

THE ELIGIBLE CLASS(ES) MAY BE AFFORDED THE FOLLOWING COVERAGES:

Coverage Description	Eligible Class(es)
24-Hour Accident & Sickness Coverage	1, 2 & 3 on a voluntary basis

2. COVERAGE PERIOD: Begins on August 15, 2014 and ends on August 15 of the next year.

3. COVERED SERVICES AND BENEFIT AMOUNTS:

Hospital Confinement Daily Income Benefit*

Daily benefit for non-critical care unit	$250 per day
Maximum benefit for non-critical care unit per Coverage Period	90 daily benefits
Daily benefit for critical care unit	$500 per day
Maximum benefit for critical care unit per Coverage Period	30 daily benefits

Doctors' Visits Benefit

Daily benefit for a new patient visit (1 daily benefit per Coverage Period)	$ 100 per day
Daily benefit or an established patient (6 daily benefits per Coverage Period)	$ 80 per day
Daily benefit for a consultation visit (1 daily benefit per Coverage Period)	$ 100 per day
Daily benefit for an emergency room (1 daily benefit per Coverage Period)	$ 75 per day

Diagnostic Laboratory Tests Benefit

Daily benefit for all laboratory tests (2 daily benefits per Coverage Period)	$ 60 per day

Diagnostic Radiology Tests Benefit

Daily benefit for a Magnetic Resonance Imaging (MRI) (1 daily benefit per Coverage Period)	$ 250 per day
Daily benefit for a Computerized Tomography (CT) Scan (1 daily benefit per Coverage Period)	$ 100 per day
Daily benefit for all other radiology tests (2 daily benefits per Coverage Period)	$ 60 per day

Diagnostic Cardiovascular Tests Benefit

Daily benefit for an echocardiogram (1 daily benefit per Coverage Period)	$ 60 per day
Daily benefit for an electrocardiogram (EKG or ECG) (1 daily benefit per Coverage Period)	$ 40 per day
Daily benefit for all other cardiovascular tests (1 daily benefit per Coverage Period)	$ 60 per day

Wellness Care Visits Benefit

Daily benefit for an annual physical (1 daily benefit per Coverage Period)	$ 100 per day
Daily benefit for a mammogram screening (1 daily benefit per Coverage Period)	$ 60 per day
Daily benefit for a cervical cancer screening (1 daily benefit per Coverage Period)	$ 40 per day

Therapeutic and Rehabilitative Care Visits Benefit

Daily benefit for physical, speech & occupational therapies (5 daily benefits per Coverage Period)	$ 100 per day
Daily benefit for acupuncture (2 daily benefits per Coverage Period)	$ 25 per day

Ambulance Transportation Benefit

Daily benefit for a trip in an ambulance (1 daily benefit per Coverage Period)	$ 100 per day

Emergency Room (ER) Visits Benefit

Daily benefit for an ER visit for the treatment of a Sickness (1 daily benefit per Coverage Period)	$ 150 per day
Daily benefit for an ER visit for the treatment of an Injury (2 daily benefits per Coverage Period)	$ 600 per day

Surgery Benefit

Per surgery benefit maximum	
Daily benefit per surgery performed as an Inpatient	$ 500 per day
Maximum benefit/number of surgeries per Coverage Period	1
Daily benefit per surgery performed as an Outpatient	$ 250 per day
Maximum benefit/number of surgeries per Coverage Period	1

Administration of Anesthesia Benefit

Daily benefit per administration amount	
For surgery performed as an Inpatient (1 daily benefit per Coverage Period)	$ 100 per day
For surgery performed as an Outpatient (1 daily benefit per Coverage Period)	$ 50 per day

Durable Medical Equipment Benefit

Daily benefit per purchase and/or rental	$ 50 per day
Maximum for all purchases and/or rentals benefit per Coverage Period	2 daily benefits

Outpatient Facility Visits Benefit

Per visit amount (5 daily benefits per Coverage Period)	$ 75 per day

Private-duty Nursing Care and Home Health Care Benefit

Daily benefit per session/visit	$ 50 per day
Maximum benefit for all sessions/visits per Coverage Period	3 daily benefits

Hospital Admission Benefit

Daily benefit per Hospital admission amount	$1,000 per day
Maximum benefit per Coverage Period	1 daily hospital admission

Additional Accident Benefit

Maximum benefit per Coverage Period	$ 5,000
Maximum number of Accidents per Coverage Period	3
Covered services:	
Daily benefit for Inpatient Hospital confinement	$ 100 per day
Daily benefit for Hospital admission	$ 500 per day
Daily benefit for Inpatient surgery and anesthesiologist	$ 750 per day
Daily benefit for an emergency room visit	$ 600 per day
Daily benefit for a trip in an ambulance	$ 500 per day
Daily benefits for Outpatient surgery and anesthesiologist	$ 300 per day
Daily benefit for an Outpatient Doctor's visit	$ 75 per day
Daily benefits for Outpatient diagnostic pathology and radiology tests	$ 60 per day

OTHER BENEFITS

Accidental Death & Dismemberment Benefit

Principal Sum	$ 50,000

4. INDIVIDUAL EFFECTIVE DATE: the following will apply to the noted classes of Eligible Persons.

5. PREMIUM SCHEDULE:

Eligible Class(es)	**Initial Annual Premiums**
Class 1 & 2 - Covered Person Only	$ 829
Class 1, 2 & 3 - Covered Person with one Eligible Dependent	$ 1,621
Class 1, 2 & 3 - Covered Person with Eligible Dependents (Family)	$ 2,603

GENERAL DEFINITIONS

"Accident" means an unforeseeable event that causes Injury to a Covered Person.

“Activities” means any activity which the School requires the Covered Person to attend, or any activity of the School which is under the sole control and supervision of School authorities, but not including activities which are under joint sponsorship or supervision arrangement with any non School group.

“Coverage Period” means the period of time described on the Schedule of Benefits.

"Covered Person" means any Eligible Person and any Eligible Dependent for whom coverage is in effect under the policy.

“Critical Care Unit" means a pre-designated and fixed medical/surgical care area within a Hospital that:

a) is utilized exclusively for the treatment of patients who are there because of their acute and critical condition;

b) provides continuous 24-hour monitoring of each patient's vital physiological responses;

c) has emergency lifesaving equipment and supplies that are immediately accessible;

d) is staffed with nurses specially trained for duty in such an area;

e) is not primarily a post-operative or post-anesthesia area.

“Doctor" means any duly licensed practitioner who is recognized by the law of the state in which treatment is received as qualified to perform the service for which claim is made.

"Eligible Dependents" means:

a) the Insured's lawful spouse; or

b) a person with whom the Insured forms a civil union according to Illinois law; and

c) the Insured's eligible children who are less than age 26; and

d) an unmarried child of the Insured from age 26 until age 30 provided that child:

1) is a resident of Illinois; and

2) served as a member of the active or reserve components of any of the branches of the Armed Forces of the United States; and

3) has received a release or discharge other than a dishonorable discharge.

To be eligible for coverage under this subsection d), the Eligible Dependent must submit a form approved by the Illinois Department of Veterans' Affairs stating the date on which the dependent was released from service.

Eligible children include natural children, stepchildren, foster children, legally adopted children, children of adopting parents pending finalization of adoption procedures, children for whom coverage has been court-ordered and otherwise eligible children who are born or brought into a civil union that has been established according to Illinois law.

"Hospital" means an institution operated by law for the care and treatment of injured or sick persons; has organized facilities for diagnosis and surgery or has a contract with another hospital for these services; and has 24-hour nursing service. Hospital excludes any institution that is primarily a rest home, nursing home, convalescent home, a home for the aged, a facility for treatment of alcoholism or drug addiction, or a facility for treatment of mental disorders.

"Injury" means accidental bodily Injury of a Covered Person:

a) caused by an Accident; and

b) that results directly and independently of Sickness, disease, or bodily infirmity in loss covered by the policy.

All Injuries sustained in one Accident, including all related conditions and recurring symptoms of the Injuries, will be considered one Injury.

"Inpatient" means a Covered Person who is admitted to a Hospital on an inpatient basis and who is provided at least one day's room and board by a Hospital.

"Insured" means an Eligible Person for whom coverage is in effect under the policy.

"Medically Necessary" means the service or supply is:

a) provided for the diagnosis, treatment, cure or relief of a health condition, Sickness, Injury or its symptoms; and

b) necessary for and appropriate to the diagnosis or treatment according to the attending medical care provider.

"Outpatient" means a Covered Person who receives covered services while other than an Inpatient at a Hospital.

“School” means any facility under the management of the Policyholder which operates for the purpose of educating its students.

"Sickness" means Sickness or disease of a Covered Person that:

a) is treated by a Doctor while the person is covered under the policy; and

b) results directly and independently of all other causes in loss covered by the policy.

INDIVIDUAL INSURING PROVISIONS

Eligible Persons **-** The persons eligible for coverage are all persons within the classifications described in the Schedule of Benefits.

Enrollment Period - Eligible Persons may enroll during the school year. Such persons are eligible for coverage under the policy subject to the particular types and amounts of insurance as specified in the enrollment form.

When Coverage Begins **-** Any Eligible Person will automatically become an Insured with respect to the coverage under the policy at 12:01 A.M. on the latest of the following dates:

a) the Policy Effective Date; or

b) the date the person comes within a classification of Eligible Persons, or

c) the date that a completed enrollment form (if any) and the required premium payment for such person's coverage are received by the Administrator; or

d) as provided on the Schedule of Benefits.

When Coverage Ends **-** Coverage with respect to any Insured will end at 12:01 A.M. on the earliest of the following dates:

a) the date the policy is terminated; or

b) the premium due date, if the required premium is not paid within 31 days following such premium due date; or

c) the date such person ceases to come within any classification of Eligible Persons; or

d) the Coverage Expiration Date contained in the applicable COVERAGE DESCRIPTION

In the event an Insured enters the armed forces, unearned premium will be returned, but the amount returned will only be for the number of full months of the unexpired term of coverage, less any administrative fees.

Coverage ending will not affect a claim for: (1) a covered accidental death or dismemberment loss due to an Accident that occurred while coverage was in effect as to the Insured; and (2) a covered expense due to an Injury occurring or Sickness commencing while coverage was in effect as to the Insured provided (a) such expense was incurred while coverage was in effect as to the Insured; and (b) treatment is rendered within 52 weeks of the Injury or the onset of Sickness.

Dependent Coverage **-** An Insured for whom Accident and Sickness coverage is in force under the policy may also make application to cover his or her Eligible Dependents.

Enrollment Period: - An Eligible Person may enroll Eligible Dependents on the date that such person enrolls for coverage. An Insured's legal spouse may be enrolled within 31 days of the date they were legally married. An Insured's newborn or adopted child may be enrolled within 31 days after the date of birth or placement for adoption.

When Coverage Begins - An Eligible Dependent's coverage will begin at 12:01 A.M. on the latest of the following dates:

a) the effective date of the Insured's coverage; or

b) the date the dependent meets the eligibility requirements; or

c) the date that a completed enrollment form (if any) and the required premium payment for dependent coverage are received by the Administrator; or

d) as provided on the Schedule of Benefits.

When Coverage Ends - Coverage with respect to any covered dependent will end at 12:01 A.M. on the earliest of the following dates:

a) the date the Insured is no longer covered under the policy; or

b) the premium due date, if the required premium for the dependent coverage is not paid within 31 days following such premium due date; or

c) the date such dependent ceases to meet the dependent eligibility requirements. However, coverage will continue for any dependent child who reaches the age limit and is both:
   1) totally incapable of self-sustaining employment due to a physical or mental disability; and

2) chiefly dependent on the Insured for support and maintenance.

The Insured must give the Administrator proof of the child's incapacity and dependency within 31 days of the child reaching the age limit. We may require proof again from time to time but not more often than once a year after the 2 years that follow the child reaching the age limit.

Premium will be refunded in full or pro-rated if it is later determined that the dependent is not eligible for coverage or if the enrollment form and/or subsequent renewal forms (if any) contained inaccurate or misleading information.

In the event a covered dependent enters the armed forces, unearned premium will be returned, but the amount returned will only be for the number of full months of the unexpired term of coverage, less any administrative fees.

Newborn Child Coverage - A child of the Insured born while Sickness coverage under the policy is in force as to the Insured is provided coverage, subject to the particular Coverages and amounts of insurance as specified in the Schedule of Benefits, for covered services rendered for Injury and Sickness (including covered services that are necessary to care and treat congenital defects, birth abnormality and premature birth), as well as those for routine newborn care for the first 31 days. The child is covered from the moment of birth until the 31st day of age. A notice of birth and the additional premium, if any, must be submitted to the Administrator within 31 days of the birth in order to continue coverage for Injury and Sickness beyond the initial 31-day period.

Adopted Children Coverage - A minor child who, due to a court order or placement for adoption, comes under the charge, care and control of the Insured while Sickness coverage under the policy is in force as to the Insured is provided coverage, subject to the particular Coverages and amounts of insurance as specified in the Schedule of Benefits, for covered services rendered for Injury and Sickness. The coverage provided to such child will be the same as provided for other members of the Insured's family. Such child is covered from the earlier of the date of the court order or the date of placement in the Insured's home. However, coverage begins at the moment of birth if court order or placement for adoption, application for coverage and payment of premium occurs within 31 days after the child's birth. Coverage for such child will continue unless the court order or placement is revoked.

Coverage ending will not affect a claim for: (1) a covered accidental death or dismemberment loss due to an Accident that occurred while coverage was in effect as to the covered dependent; and (2) a covered expense due to an Injury occurring or Sickness commencing while coverage was in effect as to the covered dependent provided (a) such expense was incurred while coverage was in effect as to the covered dependent; and (b) treatment is rendered within 52 weeks of the Injury or the onset of Sickness.

EXTENSION OF BENEFITS

If coverage under the policy ends while the Covered Person is totally disabled due to Injury or Sickness, we will pay benefits for covered services occurring after the date coverage under the policy ends as long as they meet the following requirements:

a) the covered service must be rendered due to the same Injury or Sickness causing the Covered Person to be totally disabled on the date coverage ends; and

b) the covered service must occur within 90 days after the date the Covered Person's coverage under the policy ends; and

c) coverage must not have ended as a result of the Covered Person's or, in the case of a dependent child, the child's parent's voluntary termination of the coverage.

This extension of benefits terminates at the end of the 90-day period specified above.

As used in this section, "totally disabled" means:

a) with respect to a Covered Person who would otherwise be employed, the complete inability to perform all of the substantial and material duties of such person's occupation; and

b) with respect to a Covered Person who is not otherwise gainfully employed, confinement as an Inpatient in a Hospital.

COVERAGE DESCRIPTIONS

Unless otherwise stated, we will pay benefits for a covered loss only once, even if coverage was provided under more than one Coverage Description.

24-HOUR ACCIDENT AND SICKNESS COVERAGE

Effective Term: This coverage will begin with respect to an Covered Person on: the date described in the applicable provision titled When Coverage Begins (in the section titled INDIVIDUAL INSURING PROVISIONS). It ends on the Coverage Expiration Date.

Coverage Expiration Date: The date described in the applicable provision titled When Coverage Ends in the section titled INDIVIDUAL INSURING PROVISIONS.

Description of Hazards: The hazards against which insurance is provided while the policy and this Coverage are in force are the Injuries to or Sickness of the Covered Person 24 hours a day excluding practice or play in Intercollegiate tackle football. All Covered Expenses incurred as a result of the same or related cause (including any complications) shall be considered as resulting from one Injury or Sickness.

DESCRIPTION OF BENEFITS

The following provisions describe the benefits we will pay for covered services. We will pay benefits for a covered service only once, even if the service could be included under more than one benefit description, unless otherwise indicated.

Hospital Confinement Daily Income Benefit

We will pay the applicable Daily Benefit shown on the Schedule of Benefits when a Covered Person is confined as an Inpatient in a Hospital if:

a) the Hospital confinement is Medically Necessary; and

b) the Covered Person is under a Doctor's care; and

c) the Hospital confinement begins while the Covered Person is covered under the policy.

Payment of the applicable Daily Benefit will start on the first day of Hospital confinement and will continue for a period not to exceed the maximum benefit, as shown on the Schedule of Benefits.

Doctors' Visits Benefit

We will pay the applicable benefit amount shown on the Schedule of Benefits when a Covered Person visits a Doctor if the visit is:

a) Medically Necessary; or

b) for a medical consultation made by a Doctor whose advice or opinion is being requested by another Doctor; and

c) made while the Covered Person is not an Inpatient in a Hospital; and

d) made while such person is covered under the policy.

We will not pay benefits for more than one Doctor visit per day for each Covered Person. Benefits for Doctors' visits will be paid up to the maximum benefit, as shown on the Schedule of Benefits.

Diagnostic Laboratory Tests Benefit

We will pay the applicable benefit amount shown on the Schedule of Benefits when diagnostic laboratory tests are performed on a Covered Person if the test is:

a) Medically Necessary; and

b) performed while the Covered Person is not an Inpatient in a Hospital; and

c) performed while such person is covered under the policy.

All diagnostic laboratory tests performed on a Covered Person at the same visit will be counted as one visit. We will not pay benefits for more than one visit for diagnostic laboratory tests per day for each Covered Person. Benefits for diagnostic laboratory tests will be paid up to the maximum benefit, as shown on the Schedule of Benefits.

Diagnostic Radiology Tests Benefit

We will pay the applicable benefit amount shown on the Schedule of Benefits when diagnostic radiology tests are performed on a Covered Person if the test is:

a) Medically Necessary; and

b) performed while the Covered Person is not an Inpatient in a Hospital; and

c) performed while such person is covered under the policy.

Benefits for diagnostic radiology tests will be paid up to the maximum benefit, as shown on the Schedule of Benefits.

Diagnostic Cardiovascular Tests Benefit

We will pay the applicable benefit amount shown on the Schedule of Benefits when diagnostic cardiovascular tests are performed on a Covered Person if the test is:

a) Medically Necessary; and

b) performed while the Covered Person is not an Inpatient in a Hospital; and

c) performed while such person is covered under the policy.

All diagnostic cardiovascular tests performed on a Covered Person at the same visit will be counted as one visit. We will not pay benefits for more than one visit for diagnostic cardiovascular tests per day for each Covered Person. Benefits for diagnostic cardiovascular tests will be paid up to the maximum benefit, as shown on the Schedule of Benefits.

Wellness Care Visits Benefit

We will pay the applicable benefit amount shown on the Schedule of Benefits when a Covered Person visits a Doctor for wellness care if the visit is:

a) made while the Covered Person is not an Inpatient in a Hospital; and

b) made while such person is covered under the policy.

We will not pay benefits for more than one wellness care visit per day for each Covered Person. Benefits for wellness care visits will be paid up to the maximum benefit, as shown on the Schedule of Benefits.

Additional Definitions - Wherever used in this benefit:

"Wellness care" means medical examinations and procedures that are preventative in nature and not for the treatment of an Injury or Sickness.

Therapeutic and Rehabilitative Care Visits Benefit

We will pay the applicable benefit amount shown on the Schedule of Benefits when a Covered Person visits a Doctor for therapeutic and rehabilitative care if the visit is:

a) Medically Necessary; and

b) made while the Covered Person is not an Inpatient in a Hospital; and

c) made while such person is covered under the policy.

We will not pay benefits for more than one therapeutic and rehabilitative care visit per day for each Covered Person. Benefits for therapeutic and rehabilitative care visits will be paid up to the maximum benefit, as shown on the Schedule of Benefits.

Additional Definitions - Wherever used in this benefit:

“Therapeutic and rehabilitative care" means:

a) physical, speech and occupational therapies (including: applying physical agents to produce therapeutic changes to biologic tissue; applying clinical skills to improve function; wound care management to promote healing; and conducting performance tests and measurements); and

b) acupuncture.

Ambulance Transportation Benefit

We will pay the applicable benefit amount shown on the Schedule of Benefits when a Covered Person travels to a Hospital in an ambulance if:

a) the trip is Medically Necessary; and

b) emergency care is required for the Covered Person's Injury or Sickness; and

c) the trip occurs while such person is covered under the policy

We will not pay benefits for more than one ambulance trip per day for each Covered Person. Benefits for ambulance transportation will be paid up to the maximum benefit, as shown on the Schedule of Benefits.

Additional Definitions - Wherever used in this benefit:

"Ambulance" means a ground or air vehicle that:

a) is utilized exclusively for the transport of patients who require medical attention because of their acute and/or critical condition; and

b) has emergency life saving equipment and supplies that are immediately accessible; and

c) is staffed with medical personnel specially trained for duty in such a vehicle; and

d) is not primarily a vehicle used to convey the general public.

"Emergency care" means bona fide emergency services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in:

a) placing the patient's health in serious jeopardy; or

b) serious impairment to bodily functions; or

c) serious dysfunction of any bodily organ or part.

Emergency Room Visits Benefit

We will pay the applicable benefit amount shown on the Schedule of Benefits when a Covered Person visits a Doctor in an emergency room if:

a) the visit is Medically Necessary; and

b) the visit occurs while such person is covered under the policy

We will not pay benefits for more than one visit to the emergency room per day for each Covered Person. Benefits for visits to the emergency room will be paid up to the maximum benefit, as shown on the Schedule of Benefits.

Additional Definitions - Wherever used in this benefit:

"Emergency room" means a pre-designated and fixed medical/surgical care area within a Hospital that:

a) treats patients on other than an Inpatient basis; and

b) is utilized exclusively for the diagnosis and treatment of such patients' acute and/or critical conditions; and

c) has emergency life saving equipment and supplies that are immediately accessible; and

d) is staffed with medical personnel specially trained for duty in such an area; and

e) is not primarily a clinic, Doctor's office or free-standing surgical facility.

Surgery Benefit

We will pay the applicable benefit shown on the Schedule of Benefits when surgery is performed on a Covered Person if the surgery is:

a) Medically Necessary; and

b) performed by a Doctor; and

c) performed while such person is covered under the policy.

Benefits for surgeries performed while the Covered Person is an Inpatient differ from those for surgeries performed while the Covered Person is an Outpatient, as shown on the Schedule of Benefits.

Benefits for any one surgery will not exceed the applicable per surgery benefit limit, as shown on the Schedule of Benefits. All surgeries performed on a Covered Person during the same visit will be counted as one surgery. We will not pay benefits for more than one surgery per day for each Covered Person. Benefits for all surgeries are subject to any applicable maximum benefit shown on the Schedule of Benefits.

Additional Definitions - Wherever used in this benefit:

“Surgery” means a procedure that is classified as a surgery in the Current Procedural Terminology (CPT®) coding system.

Administration of Anesthesia Benefit

We will pay the applicable benefit amount shown on the Schedule of Benefits when a Covered Person is administered

anesthesia, if the administration of anesthesia is:

a) Medically Necessary; and

b) performed by a Doctor; and

c) performed while such person is covered under the policy; and

d) billed directly by the provider and not as a service of a Hospital; and

e) performed in conjunction with a surgery covered under the policy.

Benefits for anesthesia administered while the Covered Person is an Inpatient differ from those for anesthesia administered while the Covered Person is an Outpatient, as shown on the Schedule of Benefits.

Benefits for the administration of anesthesia will be paid up to the applicable maximum benefit, as shown on the Schedule of Benefits.

Durable Medical Equipment Benefit

We will pay the applicable benefit amount shown on the Schedule of Benefits when a Covered Person purchases or rents durable medical equipment if the equipment is:

a) Medically Necessary; and

b) prescribed while the Covered Person is not confined in a Hospital or nursing home; and

c) purchased or rented while such person is covered under the policy.

We will not pay benefits for more than one purchase and/or rental of durable medical equipment per day for each Covered Person. Benefits for durable medical equipment will be paid up to the applicable maximum benefit, as shown on the Schedule of Benefits.

Additional Definitions - Wherever used in this benefit:

"Durable medical equipment" means equipment that can withstand repeated use, is primarily for medical purposes, and is appropriate for use in the home. Durable medical equipment includes: air fluidized beds; blood glucose monitors; bone growth stimulators; canes (except white canes for the blind); commode chairs; crutches; home oxygen equipment and supplies; hospital beds; infusion pumps; lymphedema pumps/pneumatic compression devices; nebulizers; patient lifts; power operated vehicles or scooters; suction pumps; traction equipment; transcutaneous electronic nerve stimulators; ventilators or respiratory assist devices; walkers; and wheelchairs, but does not include medical supplies of an expendable nature, such as bandages, rubber gloves and irrigating kits.

Outpatient Facility Visits Benefit

We will pay the applicable benefit amount shown on the Schedule of Benefits when a Covered Person visits an Outpatient facility for a covered service if:

a) the visit is Medically Necessary; and

b) the visit occurs in an Outpatient setting; and

c) the visit occurs while the Covered Person is covered under the policy.

Only visits for those covered services listed on the Schedule of Benefits are eligible for an Outpatient Facilities Visit Benefit. All covered services received by a Covered Person at the same Outpatient facility visit will be counted as one visit. We will not pay benefits for more than one visit to an Outpatient facility per day for each Covered Person. Benefits for Outpatient facility visits will be paid up to the applicable maximum benefit, as shown on the Schedule of Benefits. This benefit is payable in addition to any other benefit payable under the policy.

Additional Definitions – Wherever used in this benefit:

"Outpatient facility" means either:

a) an urgent care facility; or

b) a free-standing, duly licensed, pre-designated and fixed medical/surgical care center that:

1) cares for patients on other than an Inpatient basis; and

2) is utilized exclusively for the diagnosis and/or treatment of such patients' like conditions; and

3) is staffed with medical personnel specially trained for duty in such facility; and

4) is not primarily a student health center, clinic or, as described below, an emergency room.

"Emergency room" means a pre-designated and fixed medical/surgical care area within a Hospital that:

a) treats patients on other than an Inpatient basis; and

b) is utilized exclusively for the diagnosis and treatment of such patients' acute and/or critical conditions; and

c) has emergency life saving equipment and supplies that are immediately accessible; and

d) is staffed with medical personnel specially trained for duty in such an area.

"Urgent care facility" means a free-standing, pre-designated and fixed medical/surgical care facility that:

a) treats patients on other than an Inpatient basis; and

b) is utilized exclusively for the diagnosis and treatment of such patients' acute and/or critical conditions; and

c) has emergency life saving equipment and supplies that are immediately accessible; and

d) is staffed with medical personnel specially trained for duty in such a facility.

Private-duty Nursing Care and Home Health Care Benefit
We will pay the applicable benefit amount shown on the Schedule of Benefits when a Covered Person receives private-duty nursing care or home health care if:

a) for private-duty nursing care, the session is:

1) Medically Necessary; and

2) received while the Covered Person is confined as an Inpatient in a Hospital; and

3) received while such person is covered under the policy; or

b) for home health care, the visit is:

1) prescribed by a Doctor; and

2) received while the Covered Person is not confined in a Hospital or nursing home; and

3) received while such person is covered under the policy.

We will not pay benefits for more than one private-duty nursing care session per day for each Covered Person. All home health care services performed for a Covered Person at the same visit will be counted as one visit. We will not pay benefits for more than one home health care visit per day for each Covered Person. We will not pay benefits for both a private-duty nursing care session and a home health care visit on the same day. Benefits for private-duty nursing care and home health care will be paid up to the applicable maximum benefit, as shown on the Schedule of Benefits.

Additional Definitions - Wherever used in this benefit:

“Home health care" means the following services when provided by a licensed home health agency under a treatment plan prescribed by a Doctor:

a) professional nursing services provided by a registered graduate nurse (R.N.) or a licensed practical/vocational nurse (L.P.N. or L.V.N.).

b) physical, speech or occupational therapy services provided by a physical, speech or occupational therapist, respectively.

c) supportive services provided by a home health aide under the supervision of an R.N., or a physical, speech or occupational therapist.

“Private-duty nursing care" means nursing care provided by an R.N. who is not an employee of the Hospital where the care is rendered and which is billed directly by the provider and not as an Inpatient service of the Hospital.

"Session" means a period of at least 3 consecutive hours of nursing care.

Hospital Admission Benefit

We will pay the applicable benefit amount shown on the Schedule of Benefits when a Covered Person is admitted to a Hospital as an Inpatient if:

a) the Hospital admission is Medically Necessary; and

b) the Covered Person is under a Doctor's care; and

c) the Hospital admission occurs while the Covered Person is covered under the policy

Benefits for Hospital admissions will be paid up to the applicable maximum benefit, as shown on the Schedule of Benefits.

Additional Definitions - Wherever used in this benefit:

“Hospital admission” means each separate time a Covered Person is admitted to a Hospital as an Inpatient.

Additional Accident Benefit

We will pay the applicable benefit amount shown on the Schedule of Benefits when a Covered Person receives covered services for an Injury sustained in an Accident if:

a) the Accident occurs while the Covered Person is covered under the policy:

b) the initial covered service is received within 24 hours after the time of the Accident that caused the Injury;

c) the covered service is Medically Necessary; and

d) the covered service is received within 96 hours after the time of the Accident causing the Injury and while the Covered Person is covered under the policy.

Only those services listed on the Schedule of Benefits are eligible for an Additional Accident Benefit. Benefits will be paid up to the applicable maximum benefit, as shown on the Schedule of Benefits. No benefits are payable for any

accident that exceeds the Maximum Number of Accidents shown on the Schedule of Benefits. This benefit is payable in addition to any other benefit payable under the policy.

Additional Definitions - Wherever used in this benefit:

"Ambulance" means a ground or air vehicle that:

a) is utilized exclusively for the transport of patients who require medical attention because of their acute and/or critical condition; and

b) has emergency life saving equipment and supplies that are immediately accessible; and

c) is staffed with medical personnel specially trained for duty in such a vehicle; and

d) is not primarily a vehicle used to convey the general public.

"Emergency room" means a pre-designated and fixed medical/surgical care area within a Hospital that:

a) treats patients on other than an Inpatient basis; and

b) is utilized exclusively for the diagnosis and treatment of such patients' acute and/or critical conditions; and

c) has emergency life saving equipment and supplies that are immediately accessible; and

d) is staffed with medical personnel specially trained for duty in such an area; and

e) is not primarily a clinic, Doctor's office or free-standing surgical facility.

“Hospital admission” means each separate time a Covered Person is admitted to a Hospital as an Inpatient.

“Surgery” means a procedure that is classified as a surgery in the Current Procedural Terminology (CPT®) coding system.

Additional Exclusions - In addition to those items listed in the EXCLUSIONS section of the policy, this benefit is also not payable for a loss due to sickness, disease, bodily or mental infirmity or medical or surgical treatment thereof, or bacterial or viral infection regardless of how contracted. This does not include bacterial infection that is the natural and foreseeable result of an accidental external bodily Injury or accidental food poisoning.

Accidental Death, Dismemberment or Paralysis and Accidental Loss of Sight, Speech and Hearing Benefit

If, within 365 days of an Accident covered under the policy in accordance with the COVERAGE DESCRIPTION to which this benefit applies, bodily Injury results in any of the following losses, we will pay the benefit amount shown opposite such loss in the Table of Benefits. If the Covered Person sustains more than one such loss as the result of any one Accident, we will pay only the one largest amount to which the Covered Person is entitled.

Table of Benefits

Covered Loss	**Benefit Amount**

Loss of Life	The Principal Sum
Loss of Both Hands	The Principal Sum
Loss of Both Feet	The Principal Sum
Loss of Entire Sight of Both Eyes	The Principal Sum
Loss of One Hand and One Foot	The Principal Sum
Loss of One Hand and Entire Sight of One Eye	The Principal Sum
Loss of One Foot and Entire Sight of One Eye	The Principal Sum
Loss of Speech and Hearing in Both Ears	The Principal Sum
Quadriplegia (total Paralysis of both upper and lower limbs)	The Principal Sum
Paraplegia (total Paralysis of both lower limbs)	The Principal Sum
Loss of One Hand	One-Half The Principal Sum
Loss of One Foot	One-Half The Principal Sum
Loss of Entire Sight of One Eye	One-Half The Principal Sum
Loss of Speech	One-Half The Principal Sum
Loss of Hearing in Both Ears	One-Half The Principal Sum
Hemiplegia (total Paralysis of upper and lower limbs on one side of body)	One-Half The Principal Sum
Loss of Thumb and Index Finger of the Same Hand	One-Quarter The Principal Sum

Additional Definitions - Wherever used in this benefit:

Loss of hand or foot means complete Severance through or above the wrist or ankle joint.

Loss of Entire Sight means the total, permanent loss of sight of the eye. The loss of sight must be unrecoverable by natural, surgical or artificial means.

Loss of a thumb and index finger means complete Severance through or above the metacarpophalangeal joints (the joints between the fingers and the hand).

"Severance" means the complete separation and dismemberment of the part from the body.

"Paralysis" means the loss of use, without Severance, of a limb. This loss must be determined by a Doctor to be complete and not reversible.

Additional Exclusions - In addition to those items listed in the EXCLUSIONS section of the policy, this benefit is also not payable for a loss due to sickness, disease, bodily or mental infirmity or medical or surgical treatment thereof, or bacterial or viral infection. This exclusion does not include infection resulting from an Accidental Injury or infection which results from Accidental, Involuntary or Unintentional ingestion of an infectious organism or accidental ingestion of a contaminated substance.

This benefit will be payable in addition to any other benefit payable under the policy, subject to all the terms and conditions of the policy.

EXCLUSIONS

No benefits will be paid for loss caused by or resulting from:

a) intentionally self-inflicted injuries, suicide or any attempt thereat while sane or insane;

b) declared or undeclared war or any act thereof;

c) the Covered Person's commission of a felony;

d) the Covered Person's participation in, practice for, or orthopedic equipment and appliances used for; Intercollegiate tackle football; Intercollegiate sports; semi-professional sports; or professional sports, (except as specified in the Coverage Descriptions);

e) work-related Injury or Sickness;

f) the Covered Person's use of drugs or alcohol, unless administered by a Doctor;

g) mental or nervous disorders.

h) alcoholism or substance abuse.

In addition to the above exclusions, no benefits will be paid for:

a) eye examinations for glasses; any kind of eye glasses, or prescriptions for any eyeglasses except as required as a result of a covered Injury;

b) hearing examinations or hearing aids except as required as a result of a covered Injury;

c) dental care or treatment other than covered services rendered in connection with the care of sound, natural teeth and gums required on account of Injury to the Covered Person resulting from an Accident that happens while covered under the policy, and rendered within 12 months of the Accident;

d) care or treatment of allergies, including allergy testing;

e) diagnosis and care or treatment of acne;

f) reading or interpreting the results of any diagnostic laboratory, radiology, or cardiovascular tests;

g) care or treatment rendered in connection with cosmetic surgery, except covered services rendered in connection with cosmetic surgery the Covered Person needs as a result of an Accident that happens while covered under the policy. Cosmetic surgery for an accidental Injury must be performed within 90 days of the Accident causing the Injury and while such person's coverage is in force;

h) care or treatment rendered in connection with surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices;

i) care or treatment rendered to a Covered Person while outside the United States of America;

j) for international students only, care or treatment rendered within the Covered Person's home country or country of regular domicile;

k) services provided by a member of the Covered Person's immediate family;

l) services provided by the Policyholder's infirmary or its employees, or Doctors who work for the Policyholder or at any Student Health Center.

PREMIUMS

Premiums are shown on the Schedule of Benefits. Premium must be paid to the Administrator on or before the premium due date. A person's coverage will not be affected by the Policyholder's failure, due to clerical error, to remit premiums to the Administrator on time.

Premiums may be changed on any premium due date, on or after the first Policy Anniversary Date, with 31 days' advance notice in writing to the Policyholder.

Grace Period: The Insured has a 31-day grace period after each ensuing premium due date once the first premium has been paid. If a subsequent premium is not paid by the end of the grace period, coverage will end as of the premium due date. If this happens, the Insured will still owe us all premiums then due, including any premium due for the grace period or for any part of the grace period.

CLAIM PROVISIONS

Notice of Claim: Written notice of claim must be given within 30 days after a loss occurs, or as soon as reasonably possible. The notice must be given to the Administrator. Claims should be sent to:

National Guardian Life Insurance Company
c/o Guarantee Trust Life Insurance Company, 1275 Milwaukee Ave., Glenview, IL 60025

Claim Forms: When the Administrator receives notice of claim that does not contain all necessary information or is not on an appropriate claim form, forms for filing proof of loss will be sent to the claimant along with a request for any missing information. If these forms are not sent within 15 days after receiving notice of claim, the claimant will meet the proof of loss requirements if the Administrator is given, within 90 days, written proof of the nature and extent of the loss. The notice should include the Insured's name, the Policyholder and the policy number.

Proof of Loss: Written proof of loss must be given to the Administrator within 90 days after the loss begins. We will not deny nor reduce any claim if it was not reasonably possible to give proof of loss in the time required. In any event, proof must be given to the Administrator within 1 year after it is due, unless the Insured is legally incapable of doing so.

Time of Payment of Claim: Benefits for loss covered by the policy will be paid within 30 days following the Administrator's receipt of proper written proof of such loss. Failure of the Administrator to pay benefits within such period will entitle the Insured to interest at the rate of 9 percent per annum from the 30th day after receipt of such proof of loss to the date of late payment, provided that interest amounting to less than one dollar need not be paid.

Payment of Claims: All benefits (except those for loss of life) will be paid to the Insured, if living, unless an Assignment of Benefits has been requested by the Insured. Any benefits (except those for loss of life) due and unpaid at the Insured's death will be paid to the Insured's estate.

Upon receipt of due written proof of death, payment for a Covered Person's loss of life will be made to the applicable beneficiary as described in the Beneficiary Designation and Change provision of the General Provisions section.

If any payee is a minor or is not competent to give a valid release for the payment, we may pay any amount due to a parent, guardian, or other person actually supporting him or her. If such payee has no parent, guardian, or other person actually supporting him or her, a payment not exceeding $1,000 may be made, at our option, to any relative by blood or connection by marriage of the payee, who, in our opinion, has assumed the custody and support of the minor or responsibility for the incompetent person's affairs. Any payment made by us in good faith pursuant to these provisions will fully release us to the extent of such payment.

Physical Examination: At our expense, we may have a person claiming benefits examined as often as reasonably necessary while the claim is pending.

Legal Action: No legal action may be brought to recover on the policy before 60 days after written proof of loss has been furnished as required by the policy. No such action may be brought after 3 years from the time written proof of loss is required to be furnished.

GENERAL PROVISIONS

Entire Contract; Changes: The policy (including the application, endorsements and attached papers) is the entire contract. In the absence of fraud or intentional misrepresentation of material fact in applying for or procuring coverage

under the terms of the policy, all statements made by the Policyholder will be considered representations and not warranties. No written statement made by the Policyholder will be used in any contest unless a copy of the statement is furnished to the Policyholder. The enrollments of persons eligible for coverage (if any), are not a part of the policy; we may not use any statement contained in them to contest the policy or deny a claim. No change in the policy is valid unless it has been approved by one of our executive officers. This approval must be attached to or endorsed on the policy. No agent may change the policy or waive any provision.

Incontestability: The validity of the policy will not be contested except for nonpayment of premiums.

Time Limit On Certain Defenses: After 2 years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such 2 year period.

Beneficiary Designation and Change: The Insured's designated beneficiary(ies) is (are) the person(s) named by the Insured, as shown in the Policyholder's records. If the Insured is a minor, his or her parent or guardian may exercise this right for the Insured. The Insured is the beneficiary for any loss of life benefits payable due to the death of a Covered Dependent. If the Insured is not living on the date of a Covered Dependent's death, the beneficiary is the Insured's estate.

A legally competent Insured over the age of majority or if the Insured is a minor his or her parent or guardian may change the designated beneficiary at any time, unless an irrevocable designation has been made. The change may be executed, without the consent of the designated beneficiary(ies), by providing the Administrator, or, if we have agreed upon in advance, the Policyholder, with a written request for change. When the request is received, whether the Insured is then living or not, the change of beneficiary will relate back to and take effect as of the date of execution of the written request, but without prejudice to us on account of any payment that is made prior to receipt of the request.

If there is no designated beneficiary, or if no designated beneficiary is living after the Insured's death, benefits will be paid, in equal shares, to the survivors in the first surviving class of those that follow: The Insured's (1) spouse; (2) children; (3) parents; or (4) brothers and sisters. If no class has a survivor, the beneficiary is the Insured's estate.

Conformity With State Law: If any part of the policy conflicts with the law of the state of delivery on the date the policy goes into effect, the policy is amended to meet the minimum requirements of such law.

Records Maintained; Examination and Audit: The Policyholder or its agent will keep records showing the essential facts of each person's coverage. We may examine these records at any time that the policy is in force, within 3 years after the policy expires, and later if claims are still pending.

Not in Lieu of Workers' Compensation: The policy is not in lieu of and does not affect requirements for coverage under Workers' Compensation laws.

Termination of Policy: The policy will terminate on the Policy Termination Date shown on the first page. Termination will be without prejudice to a claim for covered services that were incurred while the policy was in force.