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HealthDepot

SecureShield

including Group Accident Only Insurance

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HealthDepot

At Health Depot, we are committed to providing premier customer service and maintaining relationships of trust with all of the people we serve—including our members, carriers and business partners.

We provide access to affordable supplemental health and consumer benefits to the people who need these products most—entrepreneurs, self-employed professionals and contractors. We are also dedicated to empowering our members with valuable resources, information and support to guide them in making their personal and professional lives easier and more fulfilling.

Health Depot offers only the most valuable solutions from trusted names in the consumer products and benefits industry. We work closely with our business partners and vendors to ensure that these products meet our extremely high quality standards.

Vision & Values

Create a community of people who collectively help one another socially by interacting and exchanging ideas with one another, financially by leveraging the power of the group to acquire benefits and services, and physically by providing support, information and benefits related to individual health.

Well-being, Diversity, Discovery, Caring, & Integrity

- We believe in making our members more comfortable, healthy, and happy.
- We recognize that every member is different; each one shaped by unique life experiences with different needs for well-being.
- We promote education and learning new ideas for our members.
- We understand, empathize with, are compassionate toward, and meet the needs and requests of our members.
- We do what is right, are accountable for, and take pride in our actions in everything we do for our members.



Health Depot Association Benefits



Around the clock and around the globe, lifesaving air medical transport is there for you

What if a medical emergency occurred while you were hours from home - or halfway around the globe? It's a frightening situation that happens all too often. Fortunately, your Health Depot membership includes air medical transportation coverage from AirMed. Wherever you are and whatever the medical need, you have seamless access to the highest level of acute care provided by the leading air medical company in North America.

AirMed transports you or your covered dependents to the hospital of your choice as quickly as possible. AirMed maintains a fleet of dedicated medical aircraft -- ICU-equipped jets, all staffed with highly trained doctors, nurses and respiratory therapists. It offers the most experience in the industry, having completed 20,000-plus missions spanning 150 countries. And, it is the only provider with every major worldwide certification, including U.S. Department of Defense air carrier status.

Immediate, coordinated response

From the second you contact AirMed, a team of seasoned experts springs into motion, immediately beginning all necessary coordination of your medical, security or transport needs. You or your dependents are covered with these services 24/7/365:

- Access to a medical consultant
- Pre-trip planning assistance
- Your choice of hospital
- Dedicated patient advocacy
- Arranged medical transport
- Advice on security risks

Critical advantages:

- **The fastest and safest transport** – Founded on top-notch medical logistics across the globe
- **Worldwide medical evacuation** – Transport back to the patient's hospital of choice whether abroad or as close as 150 miles from home
- **Commercial medical assistance** – For situations when a patient has the ability to travel commercially but requires medical assistance
- **24/7 medical services hotline** – On-call nursing staff answer medical-related questions day and night
- **Transportation of mortal remains** – Even in the worst circumstances, count on AirMed for expert, compassionate logistics and care

At home or abroad, the entire suite of AirMed medical transport benefits is available to Health Depot members without deductibles, claim forms or out-of-pocket expenses.

Member Access Information

Call Today: 877-441-6656
or visit www.airmed.com



YOU'RE UNIQUE, your nutrition should be too! IDLife is YOUR own Individually Designed Nutrition Program.

No matter what your goals are in life, to look and feel better, lose weight, or get in the best shape of your life, IDLife is your systematic approach to achieving the health and wellness you've always wanted.

IDLife products are scientifically formulated to help you by providing therapeutic doses of specific nutrients to:

- Restore nutrients depleted by your Rx program
- Help your body resist Rx side effects
- Improve your overall nutrition status thus optimizing your health

Additionally, they have been pre-screened to avoid drug/nutrient interactions that may be present with your current vitamin program.



ENERGY	MEAL REPLACEMENT	PRE WORKOUT	POST WORKOUT
Drink & Chew	Shake	<ul style="list-style-type: none"> • Phase I (short term) - The Advantra Z gives you a rapid onset of energy. • Phase II (mid term) - The caffeine gives you sustained energy, increasing focus, mental clarity metabolism, cognitive function performance and feelings of well-being. • Phase III (long term) - Theobromine helps with fatigue protection, with no jitters or crash, appetite suppression, elevated mood and helps reduce fluid retention. 	<ul style="list-style-type: none"> • Take your workout further and push through the plateau with Pre Workout from IDLife. • A balanced complex of targeted amino acids, branched chain amino acids (BCAAs), vitamins, minerals, enzymes and nutrients to assist in maximizing your physical conditioning and mental focus. • Combine Pre Workout with IDLife Post Workout formula to optimize lean muscle regeneration.
SLEEP STRIPS	APPETITE CONTROL	<ul style="list-style-type: none"> • Uses a complex of nutrients, including Melatonin, L-Theanine and 5HTP. • Brings your body into balance so you can go to sleep fast, stay asleep, and get restful, restorative, deep sleep. • Great mint flavored strips melt in your mouth. • Wake up refreshed, never groggy, and ready to take on whatever the day has in store. 	<ul style="list-style-type: none"> • About 75% of Americans are dehydrated, which can lead to health complications. • IDLife Hydrate is a formula of vital electrolytes, antioxidants, minerals and vitamins. • Hydrate supports cardiovascular, muscular and nervous system functioning to keep you healthy and hydrated.
			<ul style="list-style-type: none"> • IDLife Lean is a natural way to boost metabolism, increase thermogenesis, reduce sugar cravings and promote the preservation and development of lean muscle mass. • Whether your interest is weight management or building lean muscle, choose Lean as a part of your personal nutritional plan.

These statements have not been evaluated by the Food and Drug Administration. This product is not intended to diagnose, treat, cure or prevent any disease.

* IDLife does not represent that its products are certified organic under the United States Department of Agriculture rules and regulations.

Member Access Information

Begin your health improvement journey today! Visit healthdepot.idlife.com to learn more about IDLife, take your free assessment and purchase products at member-only prices.

These statements have not been evaluated by the Food and Drug Administration. This product is not intended to diagnose, treat, cure or prevent any disease.

* IDLife does not represent that its products are certified organic under the United States Department of Agriculture rules and regulations.



FreeWill is an estate planning tool designed to be warm, accessible and totally free – so you can more easily care for the people and causes you love

Creating a will is simple and intuitive with an easy tool with questions about you and your wishes. A will is important for everyone and can ensure that your wishes are known, alleviating some of the stress and cost associated with probate proceedings after a death.

How Does it Work?

FreeWill is made possible through the support of nonprofit organizations. When making a will, many will make a choice to leave a portion of their estate to charity.

You will receive a PDF document that is yours to download and print with instructions on how to make it official. And once you create an account, you can update your will at any time, edit it and generate a new one. Just make sure to print your will and sign it in front of two witnesses in the presence of a notary public.

FreeWill also includes free tools to create an Advance Healthcare Directive, as well as a Durable Financial Power of Attorney.

Make sure your wishes are known and your affairs are handled in the comfort of your home.

Member Access Information

Visit www.freewill.com

Click **Get started now**



HD SecureShield Insurance Benefits

HD SecureShield gives members access to valuable resources especially designed to assist when unexpected emergencies arise. In addition to the non-insured benefits provided by The Health Depot Association, a SecureShield membership also provides members with access to supplemental Group Accident Only Insurance benefits underwritten by Guarantee Trust Life Insurance Company.

Due to advances in medical and emergency care, your chances of surviving an accident or injury have improved. But survival can come with a steep cost. Although most health insurance plans will pay a large percentage of medical expenses, there are many out-of-pocket costs that may not be covered, such as deductibles, coinsurance and copays, as well as non-medical expenses such as mortgage/rent, lost income and other personal expenses.

Centers for Disease Control and Prevention reports the number of emergency department visits for Unintentional Injuries in the U.S. is 29.4 million¹.

Having supplemental insurance can help in the event of an unexpected accident or injury. Best of all, you can use the cash benefits however you choose- for out-of-pocket medical expenses, transportation costs, help with child care, meals or other household duties or even to pay routine monthly bills.

1. Centers for Disease Control and Prevention, National Hospital Ambulatory Medical Care Survey: 2017 Emergency Department Summary Tables, table 16

Prepare for the unexpected with a SecureShield membership.



Guarantee Trust Life Insurance Company



With more than 80 years of experience in the insurance industry, Guarantee Trust Life Insurance Company (GTL) has a proud heritage of providing excellent service and superior insurance products to individuals, families and groups across the country.

GTL believes in doing business the right way. They have a consistent track record of successfully delivering on their promises and preserving the trust that their partners, employees and policyholders place in them.

Their mission is to be recognized as a highly-competent, mid-sized mutual insurer, who by bridging timeless virtues with current best business practices, is effective in marketing targeted life and health products across the country.

Growing Strong

Guarantee Trust Life Insurance Company's current financial condition is the strongest ever. In 2018[†], GTL posted record operating gains while growing surplus by 17 percent, assets by 7 percent, reserves by 7 percent and achieving net premium of \$230 million. 97% of the bonds they hold are designated "Highest Quality" (Class 1) or "High Quality" (Class 2) by the National Association of Insurance Commissioners (NAIC).

Guarantee Trust Life Insurance is a mutual legal reserve company located in Glenview, IL, licensed to conduct business in 49 states and the District of Columbia.

[†] Guarantee Trust Life Insurance Company, Annual Statements 2017-2018



Group Accident Only Insurance Benefits

Accidental Death & Dismemberment Benefit (AD&D) *	
Principal Sum	\$50,000
Primary	100%
Spouse	50%
Child(ren)	25%
Schedule of Benefits	
Loss of Life	
Loss of Both Hands	
Loss of Both Feet	
Loss of the Entire Sight of Both Eyes	
Loss of One Hand and One Foot	100%
Loss of Speech and Hearing	
Loss of One Hand or One Foot and Entire Sight of One Eye	
Loss due to Hemiplegia	
Loss due to Paraplegia	
Loss due to Quadriplegia	
Loss of One Hand or One Foot	
Loss of Entire Sight of One Eye	50%
Loss of Speech or Hearing	
Loss of Hearing in One Ear	25%

* Accidental Death and Dismemberment Benefits are provided as shown in the Schedule of Benefits and pays the member or beneficiary up to the benefit amount listed for the member's death or loss of certain body parts in a Covered Accident. Principal Sum will be reduced by 50% for Injury which occurs on or after a Covered Person's 70th birthday.

Disclaimers

The Group Accident Only Insurance policy is underwritten by Guarantee Trust Life Insurance Company (GTL), Glenview, IL and issued on Form Series MP-1400 to The Health Depot Association as the group master policyholder. All members of The Health Depot Association are eligible to receive these benefits. This insurance is not basic health insurance or major medical coverage and is not designed as a substitute for basic health insurance or major medical coverage. The Group Accident Only Insurance is subject to terms, definitions, condition, exclusions, and limitations of the group policy. Benefits may vary as required by state law and benefits may not be available in all states. This brochure contains only a brief description of coverage and is not a contract. For complete details of coverage, please refer to the certificate. GTL does not provide nor is affiliated with the discount programs provided as a part of membership in The Health Depot Association. Coverage becomes effective on the date provided in the membership material. The insurer has the right to increase premium rates and has the option to cancel coverage.

Dependent Child(ren) are covered from birth to 26 years old.

Spouse includes Common Law Marriage Partner, Domestic Partner or Civil Union Partner if legally recognized in the governing jurisdiction.

Stand-Alone AD&D Exclusions & Limitations

The Policy does not provide benefits for:

- Injury by acts of war, whether declared or not.
- Injury received while traveling or flying by air, except as a fare-paying passenger and not as a pilot or crew member, on a regularly scheduled commercial airline.
- Injury covered by Worker's Compensation, Employer Liability law or Occupational Disease Act or Law.
- Dental treatment, except as specifically stated.
- Injury sustained while committing or attempting to commit a felony.
- Prescription Drugs except as specifically stated.
- Suicide or attempted suicide while sane or insane.
- Intentionally self-inflicted Injury.
- Loss resulting from being legally intoxicated or under the influence of alcohol as defined by the laws of the state or jurisdiction in which the Injury occurs.
- Loss resulting from being under the influence of any drugs or narcotic unless administered on the advice of a Doctor.
- Injury sustained while participating in or practicing for any professional, intercollegiate or sports activity, except as specifically provided.
- Injury which occurs while a Covered Person is on active duty service

in any armed forces. Reserve or National Guard active duty for training is not excluded unless it extends beyond 31 days.

- Injury sustained flying in an ultra-light, hang gliding, parachuting or bungee- cord jumping, by flight in a space craft or any craft designed for navigation above or beyond the earth's atmosphere.
- Injury sustained while driving or riding on vehicles for off-road use including but not limited to all-terrain vehicles (ATV's).
- Injury sustained where a Covered Person is the operator and does not possess a current and valid motor vehicle operator's license, except in a Driver's Education Program.
- Competing in motor sports races or competitions;
- Competing in water sports races or competitions;
- Testing cars/trucks on any racetrack or speedway;
- Handling, storing or transporting explosives;
- Scaling up cliffs or mountain walls;
- Spelunking (exploring caves);
- Handling or working with dangerous animals.
- Injury sustained while water skiing or surfing;
- Injury sustained while snow skiing or snowboarding;
- Injury sustained while roller blading or skateboarding;
- Injury sustained while participating in a rodeo.

Please see certificates for state specific exclusions and limitations.

Guarantee Trust Life Insurance Company

The following rates apply for the coverage underwritten by Guarantee Trust Life Insurance Company as part of your membership in the HD SecureShield membership. The rates by plan are: 50,000 AD&D; Member = \$1.50, Member + Spouse = \$3.00, Member + Child(ren) = \$2.25, Family = \$4.50.

Coverage is subject to termination in accordance with the Association Group Master Policy provisions. Notice of termination provided to the Association is considered notification to all Association Members and will not be sent to you individually by GTL.

CLAIMS ASSISTANCE

Guarantee Trust Life Insurance Company
P.O. Box 1148
Glenview, IL 60025
Email to: AMEClaims@gtlic.com
(800) 338-7452

Frequently Asked Questions

FAQs

Does the HD SecureShield plan cover pre-existing conditions?

There are no Pre-Existing Condition exclusions.

Is there a waiting period before I can use my HD SecureShield plan benefits?

There are no waiting periods.

Is there a co-pay or deductible on the HD SecureShield plan benefits?

There are no co-pays.

How do the benefits pay?

The insurance pays a lump sum benefit directly to the member as shown in the Schedule of Benefits. Enrolled member may also assign benefits if a written assignment is made.

When do the plan benefits terminate?

The Accidental Death & Dismemberment (AD&D) benefit stays active as long as the membership remains in good standing. However, the AD&D Principal Sum reduces 50% for Injury which occurs on or after the member's 70th birthday.

How do I locate In-Network providers and facilities?

There is no "In-Network" requirement on the HD SecureShield plan. You may go to the doctor, hospital or emergency center of your choice.

How do I file claims for my benefits?

You need to register and log in to the member portal at members.healthdepotassociation.com; print the claim form; complete and sign; and send completed form within 60 days after any loss covered by the policy occurs or begins; or as soon as reasonably possible. You will find the claim form in the "Important Documents" section of the member portal.

If I move to another state, will I still be covered under my HD SecureShield plan?

You will continue coverage under the certificate you were issued for your original state of residence.

Who do I contact if I have additional questions about my membership plan benefits?

Please contact Health Depot's Customer Service at **(855) 351-7535** and one of our friendly representatives will be glad to help you!

Member Services

info@healthdepotassociation.com | (855) 351-7535

Member Portal

members.healthdepotassociation.com

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ACCIDENTAL DEATH INSURANCE CLAIM FORM

Please read the important information below:

- Please be sure the Group or Association name is written on the claim form.
- The claim form must be completed and signed by the beneficiary/beneficiaries or Next of Kin.
- The HIPAA Authorization to Permit Use and Disclosure of Health Information must be signed, dated and included with your submission, so that we can contact the Insured's medical provider on their behalf if additional information is needed.
- A "**Certified**" copy of the death certificate with the cause and manner of death shown.
- If the Death Certificate has a pending cause of death, there may be delay as additional information is required.
- Copies of the **police and autopsy** reports if applicable.

- Copy of obituary if available.
- The **original** policy (ies) if available.
- If the policy has been in force less than two years** from the date of the insured's death, please have the Primary Physician's statement completed by the insured's family doctor or the last doctor to have treated the insured.
 - **Processing delays may result if you do not provide all the listed information.**
 - **If you signed a benefits assignment with the funeral home and you have a balance still due, we are required to pay that balance directly to them; otherwise, benefits will be sent to you.**
- We suggest you make photocopies of any information sent for your own records.
- Please send the completed claim form and other documents to:

Guarantee Trust Life Insurance
P.O. Box 1148
Glenview, Illinois 60025
OR Email to: AMEClaims@gtlic.com

For assistance, please contact our Customer Service Department (800) 338-7452



GUARANTEE
TRUST
LIFE

Mail claims to:
P.O. Box 1148
Glenview, Illinois 60025
Or email to: AMEClaims@gtlic.com
For Customer Service, please call: (800) 622-1993

ACCIDENT DEATH MEDICAL CLAIM FORM

TO BE COMPLETED BY THE BENEFICIARY OR NEXT OF KIN

Family First Association KW158, KW159, KW160 series

Group/Association Name or Policy Number

Member ID No.

/ / Male Female

Name of Insured Member

Alternate Name

Insured Member Date of Birth

/ / Male Female

Name of Deceased

Relationship to the Deceased

Deceased Date of Birth

Address (Street)

(City)

(State)

(Zip Code)

/ /

Phone Number

Email (Please provide for faster service)

/ /

Date of Accident

Time of Accident

AM PM

/ /

Date of Death

AM PM

Time of Death

Description of Accident:

Where did it occur? City:

State

Location

Was the Deceased brought to a hospital? Yes No If yes please give the name and addresss of the hospital _____

Did this accident occur while playing in an Intercollegiate or Professional Sport? Yes No

Deceased's occupation:

Was the Deceased self employed? Yes No Was this a work related accident/injury? Yes No

If yes, was this filed with Workers' Compensation? Yes No If no, please explain why: _____

I understand that this information will be used by Guarantee Trust Life Insurance Company for the purpose of evaluating my claim for insurance benefits. I represent that the answers to the above questions are complete, true and correct to the best of my knowledge and belief. I understand that I am entitled to receive a copy of the authorization upon request.

Signature of Beneficiary or Next of Kin

/ /

Date

Printed Name

Relationship to Deceased

Date of Birth

() -

Address (if other than the Deceased)

(Street)

(City)

(State)

(Zip Code)

(Phone Number)

Dear Insured: Below is a listing of the fraud language that your State Department of Insurance requires us to give to you. Please first locate your state of residence and then read the fraud language that pertains to your state. Thank you.

Connecticut
Georgia
Hawaii
Iowa
Illinois
Kansas

Massachusetts
Michigan
Missouri
Mississippi
Montana

Nebraska
North Carolina
North Dakota
Nevada
South Carolina

South Dakota
Utah
Vermont
Wisconsin
Wyoming

Generic Fraud Warning (to be used for above states only)

Any person who knowingly presents a fraudulent claim containing any false or misleading information is guilty of insurance fraud and may be subject to fines and confinement in prison.

Alabama - Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.

Alaska - A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona - For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Arkansas, Louisiana, Rhode Island and West Virginia

Virginia - Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California - For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado - **It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include**

imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Delaware - Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

Florida - Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Idaho - Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony.

Indiana - A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Kentucky - A person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maine – It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.

Maryland – Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Minnesota – A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire – Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

New Jersey – Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico – ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

Ohio and Oregon – Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma – WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Pennsylvania – Any person who knowingly and with intent to defraud any insurance company or other person files statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Tennessee, Virginia and Washington State – It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Texas – Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Washington DC – WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

HIPAA AUTHORIZATION

To Permit Use and Disclosure of Health Information

This Authorization was prepared by GTL for purposes of obtaining information necessary to process a claim for benefits.

Policy/Certificate # _____

Upon presentation of the original or a photocopy of this signed Authorization, I authorize, without restriction (except psychotherapy notes), any licensed physician, medical professional, hospital or other medical-care institution, insurance support organization, pharmacy, governmental agency, insurance company, group policyholder, employer or benefit plan administrator to provide Guarantee Trust Life Insurance Company (GTL) or an agent, attorney, consumer reporting agency or independent administrator, acting on its behalf, all information concerning advice, care or treatment provided the patient, employee or deceased named below, including all information relating to, mental illness, use of drugs or use of alcohol. This Authorization also includes information provided to our health division for underwriting or claim servicing and information provided to any affiliated insurance company on previous applications. If this Authorization is for someone other than myself, that individual and my authority to act on their behalf is explained below. I understand that I or my authorized representative is entitled to receive a copy of the Authorization upon request.

I understand that I have the right to revoke this Authorization, in writing, at any time by sending written notification to my (our) agent or to the Company at the above address. I understand that a revocation will not be effective to the extent the Company has relied on the use or disclosure of the protected health information or if my Authorization was obtained as a condition to determine my eligibility for benefits. Revocation requests must be sent in writing to the attention of the Claim Department Manager.

I understand that Guarantee Trust Life Insurance Company may condition payment of a claim upon my signing this Authorization, if the disclosure of information is necessary to determine the level or validity of the claim payment. I also understand once information is disclosed to us pursuant to this Authorization, the information will remain protected by GTL in accordance with federal or state law.

This authorization shall remain in force and in effect until two (2) years from the date this authorization is signed at which time this authorization will expire.

(Print Please) Name of Insured

Date of Birth

(Please Print) Name of Authorized Representative, or Next of Kin

Relationship of Authorized Representative or Next of Kin to Patient

Signature of Authorized Representative or Next of Kin

Date

ACCIDENT MEDICAL CLAIM FORM

Please read the important information below:

- Please be sure your Group or Association name is written on the claim form.
- The claim form must be completed and signed by the Insured Member.
- The HIPAA Authorization to Permit Use and Disclosure of Health Information must be signed, dated and included with your submission, so that we can contact your medical provider on your behalf if additional information is needed.
- Attach itemized bills to the claim form. For faster processing, ask your medical provider to print an itemized bill on a UB-04 form (for hospital expenses) or on a CMS 1500/HCFA form (for doctor's expenses).

An itemized bill is a statement that indicates:

1. The date(s) of treatment,
2. The type(s) of service,
3. The diagnosis,
4. The medical provider's name and address,
5. The individual charge for each expense.

• Processing delays may result if you do not provide the above information.

- Please send the completed claim form, signed authorization, itemized bills and other insurance payment or denial ("Explanation of Benefits") statements to:

Guarantee Trust Life Insurance
P.O. Box 1148
Glenview, Illinois 60025
OR Fax to: (847) 803-1835
OR Email to: AMEClaims@gtlic.com

- Your policy says you must send complete proof of loss (completed and signed claim form and itemized bills) **within 90 days of the accident**. Additional bills related to the accident should be sent within 90 days of treatment.
- Your plan requires treatment must be sought within a specific time frame. Please refer to the Schedule of Benefits in your Certificate of Insurance for the "Initial Treatment Period."
- If you have other (primary) insurance coverage, please send us a copy of their payment or denial ("Explanation of Benefits") statement.
- Please indicate which bills have been paid by you. If you prefer payment to go directly to the medical provider, please complete and sign the authorization at the bottom of the claim form.
- A claim form needs to be completed only at the beginning of treatment for each accident. Additional bills or follow-up treatment should indicate your name, group or association name and date of accident.

For assistance, please contact our Customer Service Department (800) 622-1993



GUARANTEE
TRUST
LIFE

Mail claims to:

P.O. Box 1148

Glenview, Illinois 60025

Or fax to: (847) 803-1835

Or email to: AMEClaims@gtlic.com

For Customer Service, please call: (800) 622-1993

ACCIDENT MEDICAL CLAIM FORM

TO BE COMPLETED BY THE INSURED MEMBER

Family First Association KW158, 159, 160 series

Group/Association Name or Policy Number

Member ID No.

/ /

Name of Insured Member

Alternate Name

Insured Member Date of Birth

Address (Street)

(City)

(State)

(Zip Code)

() -

Male Female

Phone Number

Email Address

/ /

Patient's Name and Relationship (*If other than Insured Member*)

Patient Date of Birth

/ /

AM PM

Date of Accident

Time of Accident

Description of Accident:

Where did it occur? City: _____ State: _____ Location: _____

What kind of injury did you sustain? _____

Did you go to the emergency room? Yes No If yes, what date: ____/____/____ What facility: _____

Were you hospital confined for this injury? Yes No If yes, what hospital: _____

Due to this injury, were or are you currently totally disabled? Yes No

Did this accident occur while playing in an Intercollegiate or Professional Sport? Yes No

If yes, please indicate type of sport: _____

Are you self employed? Yes No Was this a work related accident/injury? Yes No

If yes, was this filed with Workers' Compensation? Yes No If no, please explain why: _____

Would this Patient and these accident expenses be covered under any other insurance/plan? Yes No

If yes, please state the insurance/plan carriers name: _____

Phone Number: () - _____

Insured/Member Name: _____

Member/Policy Number: _____

More than one carrier? Insurance/plan carriers name: _____

Member/Policy Number: _____

I understand that this information will be used by Guarantee Trust Life Insurance Company for the purpose of evaluating my claim for insurance benefits. I represent that the answers to the above questions are complete, true and correct to the best of my knowledge and belief. I understand that I or my authorized representative is entitled to receive a copy of the authorization upon request.

Insured Member Signature

Print Name

Date

Dear Insured: Below is a listing of the fraud language that your State Department of Insurance requires us to give to you. Please first locate your state of residence and then read the fraud language that pertains to your state. Thank you.

Connecticut
Georgia
Hawaii
Iowa
Illinois
Kansas

Massachusetts
Michigan
Missouri
Mississippi
Montana

Nebraska
North Carolina
North Dakota
Nevada
South Carolina

South Dakota
Utah
Vermont
Wisconsin
Wyoming

General Fraud Warning (to be used for above states only) Any person who knowingly presents a fraudulent claim containing any false or misleading information is guilty of insurance fraud and may be subject to fines and confinement in prison.

Alabama - Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.

Alaska - A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona - For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Arkansas, Louisiana, Rhode Island and West Virginia

Virginia - Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California - For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado - It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include

imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the department of regulatory agencies.

Delaware - Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

District of Columbia - WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida - Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Idaho - Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony.

Indiana - A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Kentucky – A person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maine – It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.

Maryland – Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Minnesota – A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire – Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

New Jersey – Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico – ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

Ohio and Oregon – Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma – WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Pennsylvania – Any person who knowingly and with intent to defraud any insurance company or other person files statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Tennessee, Virginia and Washington State – It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Texas – Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

HIPAA AUTHORIZATION

To Permit Use and Disclosure of Health Information

This Authorization was prepared by GTL for purposes of obtaining information necessary to process a claim for benefits.

Policy/Certificate # _____

Upon presentation of the original or a photocopy of this signed Authorization, I authorize, without restriction (except psychotherapy notes), any licensed physician, medical professional, hospital or other medical-care institution, insurance support organization, pharmacy, governmental agency, insurance company, group policyholder, employer or benefit plan administrator to provide Guarantee Trust Life Insurance Company (GTL) or an agent, attorney, consumer reporting agency or independent administrator, acting on its behalf, all information concerning advice, care or treatment provided the patient, employee or deceased named below, including all information relating to, mental illness, use of drugs or use of alcohol. This Authorization also includes information provided to our health division for underwriting or claim servicing and information provided to any affiliated insurance company on previous applications. If this Authorization is for someone other than myself, that individual and my authority to act on their behalf is explained below. I understand that I or my authorized representative is entitled to receive a copy of the Authorization upon request.

I understand that I have the right to revoke this Authorization, in writing, at any time by sending written notification to my (our) agent or to the Company at the above address. I understand that a revocation will not be effective to the extent the Company has relied on the use or disclosure of the protected health information or if my Authorization was obtained as a condition to determine my eligibility for benefits. Revocation requests must be sent in writing to the attention of the Claim Department Manager.

I understand that Guarantee Trust Life Insurance Company may condition payment of a claim upon my signing this Authorization, if the disclosure of information is necessary to determine the level or validity of the claim payment. I also understand once information is disclosed to us pursuant to this Authorization, the information will remain protected by GTL in accordance with federal or state law.

This authorization shall remain in force and in effect until two (2) years from the date this authorization is signed at which time this authorization will expire.

(Print Please) Name of Patient

Date of Birth

Signature of Patient

Date

(Please Print) Name of Authorized Representative, or Next of Kin

Relationship of Authorized Representative or Next of Kin to Patient

Signature of Authorized Representative or Next of Kin

Date



Email to: _____
or Mail to: _____

BENEFICIARY DESIGNATION FORM (Accident and Group Term)

Group/Association Name or Policy Number(s)

Member ID No.

Name of Insured Member

Alternate Name

/ /

Male Female

Insured Member Date of Birth

Address (Street)

(City)

(State)

(Zip Code)

Phone Number

Email (Please provide for faster service)

GROUP TERM BENEFICIARY INFORMATION

Name of Beneficiary

Date of Birth

Relationship

Address (Street)

(City)

(State)

(Zip Code)

Name of Beneficiary

Date of Birth

Relationship

Address (Street)

(City)

(State)

(Zip Code)

Accidental Death Beneficiary Information [] Keep beneficiary(ies) designation(s) the same for the Group Term coverage above.

Name of Beneficiary

Date of Birth

Relationship

Address (Street)

(City)

(State)

(Zip Code)

Name of Beneficiary

Date of Birth

Relationship

Address (Street)

(City)

(State)

(Zip Code)

I designate the person(s) on this form as my beneficiary(ies) to receive any payment from the association policy(ies) shown above. I fully understand that this designation of beneficiary(ies) applies to the full Death Benefit Amount(s) for the coverage(s) in force.

Insured Member's Signature

/ /

Date

GUARANTEE TRUST LIFE INSURANCE COMPANY

1275 Milwaukee Avenue, Glenview, Illinois 60025

1-800-338-7452

CERTIFICATE OF INSURANCE

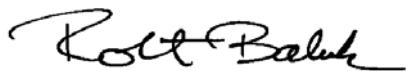
This is Your Certificate of Insurance (Certificate) while You are insured. It briefly explains the rights and benefits that are determined by the Master Policy (Policy). The Policy is a contract between the Policyholder and Us. The Policyholder is shown on the Schedule of Benefits.

The Policy alone constitutes the agreement under which payments are made. We will pay the benefits set forth in the Policy. Benefit payment is governed by all the terms, conditions, provisions, limitations and exclusions of this Certificate and the Policy. The Policy may be amended at any time without Your consent or notice to You. Any such amendment will not affect a claim starting before the amendment takes effect.

Right to Examine: If You are not satisfied with this Certificate, return it to Our home office within ten days after the date You received it. This Certificate will then be canceled and any Premium paid will be refunded.

The Policy is held by the Policyholder. You may inspect it at any time during business hours at the office of the Policyholder.

READ YOUR CERTIFICATE CAREFULLY



Secretary



President

**GROUP ACCIDENT ONLY COVERAGE
THIS IS LIMITED COVERAGE. PLEASE READ YOUR CERTIFICATE CAREFULLY.
NON-PARTICIPATING**

**THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE
FOR MAJOR MEDICAL COVERAGE.**

**THIS IS A LIMITED BENEFIT ACCIDENT ONLY POLICY AND IS NOT
CONSIDERED MINIMUM ESSENTIAL COVERAGE UNDER THE AFFORDABLE
CARE ACT (ACA)**

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DEFINITIONS

Accident: A sudden, unintended and unforeseeable external event to the Covered Person which results in an Injury.

Beneficiary: A person or persons the Covered Person has named to receive any death benefits paid under this Certificate.

Company: Guarantee Trust Life Insurance Company, a mutual company. Also hereinafter referred to as We, Us, Our and Insurer.

Covered Accident: An Accident for which coverage is provided and a benefit is payable while a Covered Person's insurance under the Policy and this Certificate are in effect.

Covered Charge: The Reasonable and Customary charge incurred for a medical service or supply listed in this Certificate which is performed or given under the direction of a Doctor for the Medically Necessary treatment of an Injury caused by a Covered Accident. A Covered Charge is considered incurred on the date the medical treatment or service is rendered or the supply is furnished. Benefits for a Covered Charge are payable as indicated in the Policy/Certificate Schedule.

Covered Person: You, or a Dependent:

1. Who is eligible for coverage as a Covered Person;
2. Who has been accepted for coverage or has been automatically added;
3. Who has paid the required premium; and
4. Whose coverage has become effective and has not terminated.

Doctor: A legally qualified person licensed in the healing arts, practicing within the scope of his or her license and who is not a Covered Person or a Family Member.

Domestic Partner: a person who is Your registered Domestic Partner with the California Secretary of State.

Durable Medical Equipment: A device which:

1. Is primarily and customarily used for medical purposes and is specially equipped with features and functions that are generally not required in the absence of Injury;
2. Is used exclusively by a Covered Person;
3. Is routinely used in a Hospital but can be used effectively in a non-medical facility;
4. Can aid in a Covered Person's recovery from an Injury; and
5. Is prescribed by a Doctor and the device is Medically Necessary for a Covered Person's rehabilitation.

Durable Medical Equipment does not include:

1. Comfort and convenience items;
2. Equipment that can be used by Family Members other than a Covered Person;
3. Health exercise equipment; and
4. Equipment that may increase the value of a Covered Person's Residence.

Such items that do not qualify as Durable Medical Equipment include, but are not limited to:

1. Modifications to a Covered Person's Residence, property or automobiles, such as ramps;
2. Elevators;
3. Spas;
4. Air conditioners;
5. Vehicle hand controls; or
6. Corrective shoes, exercise and sports equipment.

Eligible Person: A member of the Policyholder's organization as defined on the Schedule of Benefits.

Emergency: An Injury for which a Covered Person seeks immediate medical treatment at the nearest available licensed medical facility. The condition must be one which manifests itself by acute symptoms which are sufficiently severe (including severe pain) that without immediate medical care a Covered Person could reasonably expect that: (1) the Covered Person's life or health would be in serious jeopardy; (2) the Covered Person's bodily functions would be seriously impaired; or (3) a body organ or part would be seriously damaged.

Emergency Room: A hospital area equipped and staffed for the prompt treatment of acute trauma, or other medical emergencies. An Emergency Room must be licensed by the state in which it is located under applicable State law as an Emergency Room or emergency department and be open 24 hours a day, 7 days a week. For the purposes of the Policy, Emergency Room includes a licensed Urgent Care Facility.

Experimental/Investigational: A drug, device or medical care or treatment will be considered experimental/investigational if:

1. The drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;
2. The informed consent document utilized with the drug, device, medical care or treatment states or indicates that the drug, device, medical care or treatment is part of a clinical trial, experimental phase or investigational phase or if such a consent document is required by law;
3. The drug, device, medical care or treatment or the patient informed consent document utilized with the drug, device or medical care or treatment was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal or state law requires such review and approval;
4. Reliable evidence shows 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 or diagnosis; or
5. 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 or diagnosis.

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

Family Member: A person who is related to a 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).

Ambulance: Means a vehicle which is licensed as an ambulance by the local regulatory body to provide transportation of a Covered Person as a result of a Covered Accident to a Hospital or transportation from one Hospital to another for a Covered Person who is unable to travel to receive medical care by any other means. An Ambulance must contain life-saving equipment and state-certified ambulance personnel.

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

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

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

1. Services would have been covered in a medical facility if Home Health Care were not given; and
2. A Home Health Care treatment plan is set up, in writing and approved by a Doctor.

Hospice Care: Services provided by a licensed public agency or private organization or any subdivision thereof, which entity shall be known as a hospice and shall be primarily engaged in providing care to an individual for whom a certified medical prognosis has been made indicating a life expectancy of six (6) – twelve (12) months or less and who has elected to receive such care in lieu of other medical benefits available under the Policy.

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

1. Is accredited by the Joint Commission or other accreditation organization accepted by a state;
2. Provides 24-hour nursing service by registered nurses (R.N.);
3. Mainly provides diagnostic and therapeutic care under the supervision of Doctors on an inpatient basis; and
4. Maintains permanent surgical facilities or has an arrangement with another surgical facility supervised by a staff of one or more Doctors.

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

Hospital does not include a place, special ward, floor or other accommodation used for: custodial or educational care; rest; the aged; a nursing home or an institution mainly rendering treatment or services for mental illness or substance misuse.

Immediate Care Facility: A walk-in clinic focused on the delivery of medical care for minor injuries in an ambulatory medical facility outside of a traditional hospital-based or freestanding emergency department.

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

Injury: Bodily injury due to a Covered Accident which:

1. is the proximate cause of, resulting in a covered loss;
2. Occurs after the effective date of a Covered Person's coverage under the Policy; and
3. Occurs while this Policy is in force.

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

Intensive Care Unit (ICU): A specifically designed facility of the Hospital that provides the highest level of medical care; and which is restricted to those patients who are critically ill or injured. Such facility must be separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient confinement. They must be permanently equipped with special life-saving equipment for the care of the critically ill or injured; and under constant and continuous observation by nursing staff assigned on a full-time basis, exclusively to the Intensive Care Unit. Intensive Care Unit does not mean any of these step-down units: progressive care; sub-acute intensive care; intermediate care units; private monitored rooms; observation units; or other facilities which do not meet the standards for Intensive Care.

Medically Necessary: A treatment, drug, device, procedure, supply or service for the diagnosis or treatment of an Injury as determined by Your Doctor in accordance with generally accepted standards of medical and dental practice in the state and country 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. For Accident Related Dental services this means Services which are needed due to an accidental injury caused by a force outside of the mouth or body.

A treatment, drug, device, procedure, supply or service shall not be considered as Medically Necessary if:

1. Is Experimental/Investigational or for research purposes;
2. Is provided solely for education purposes or the convenience of a Covered Person's family, Doctor, Hospital or any other medical provider;
3. 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;
4. Could have been omitted without adversely affecting the person's condition or the quality of medical care;
5. Involves the use of a medical device, drug or substance not formally approved by the United States Food and Drug Administration;
6. Involves a service, supply or drug not considered reasonable and necessary by the Healthcare Financing Administration Medicare Coverage Issues Manual; or
7. Can be safely provided to the patient on a more cost-effective basis such as outpatient, by a different medical professional, or pursuant to generally accepted standards of medical and dental practice in the state and county at the time it is provided.

Orthopedic Appliances: Any supportive device or appliance used in treating a Covered Person's Injury.

Other Valid and Collectible Insurance or Plan: Any reimbursement for or recovery of any element of Covered Charges incurred by the Covered Person available from any other source whatsoever, except gifts and donations, but including without limitation:

1. Any individual, group, blanket, or franchise policy of accident, disability or health insurance;
2. Any arrangement of benefits for members of a group, whether insured or uninsured;
3. Any prepaid service arrangement including a health maintenance or preferred provider organization or any other health benefit plan;
4. Any amount payable for Hospital, medical or other health services. Injury arising out of a motor vehicle accident to the extent such benefits are payable under any medical expense payment provision (by whatever terminology used including such benefits mandated by law) of any motor vehicle insurance policy.
5. Any amount payable for services or injuries or diseases related to a Covered Person's occupation to the extent that the Covered Person actually received benefits under a Worker's Compensation Law or if the Covered Person enters into a settlement to give up his or her rights to recover future medical expenses that would have been payable except for that settlement;
6. Any benefits payable under any program provided or sponsored solely or primarily by any governmental agency or subdivision or through operation of law or regulation.
7. Any medical expense coverage a Contractor carries.

Physical Therapy: Non-surgical physical or mechanical therapy, diathermy, ultrasonic therapy, heat treatment in any form or massage that is intended to preserve, enhance, or restore movement and physical function impaired by Injury. For the purposes of this coverage, chiropractic treatment is not deemed to be Physical Therapy. Physical Therapy must be prescribed by a Doctor and be based upon a plan of treatment for a specified period of time or number of visits.

Policyholder: The entity to which the Policy is issued.

Prescription Drugs: Drugs which may only be dispensed by written prescription under Federal law and are approved for general use by the Food and Drug Administration. The drugs must be dispensed by a licensed pharmacy provider for a Covered Person's outpatient use.

Reasonable and Customary Charges, Fees or Expenses: The most common charge for similar professional services, drugs, procedures, devices, supplies or treatment within the Geographic Area in which the charge is incurred. The most common charge means the lesser of:

1. The actual amount charged by the medical provider;
2. The negotiated rate; or
3. The charge which would have been made by the medical provider for a comparable service or supply made by other providers in the same Geographic Area for the same service or supply.

"Geographic Area" means the three digit zip code in which the service, treatment, procedure, drugs or supplies are provided; or a greater area if necessary to obtain a representative cross-section of charge for a like treatment, service, procedure, device drug or supply.

Rehabilitation Facility: An institution, or part of an institution, licensed, accredited or certified by the State which:

1. Is accredited by the Joint Commission, the Commission on Accreditation of Rehabilitation Facilities or other accreditation organizations accepted by a state;
2. Is primarily engaged in providing comprehensive multi-disciplinary physical services or rehabilitation inpatient care; and
3. Has a transfer agreement with one or more Hospitals.

Rehabilitation Facility does not include an institution which:

1. Provides only minimal care, custodial care, care for the terminally ill, or part-time care services;
2. Primarily provides treatment for mental disorders, chemical dependency or tuberculosis, except if such facility is licensed, certified, or approved as a rehabilitation facility for the treatment of medical conditions; drug addiction or alcoholism.

Residence: The home and land or property on which a Covered Person's dwelling or home is located.

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

Telehealth Care Benefit: We agree to reimburse up to the Doctor's office visit benefit for each Telehealth Care service provided due to accidental Injury. This benefit is subject to the Certificate maximums.

Transportation Network Company: An entity that uses a digital network to connect riders to drivers for the purpose of providing transportation. Transportation Network Company does not include a taxi service or ridesharing arrangements.

Urgent Care Facility: A healthcare facility, which is part of or affiliated with a Hospital, providing short-term medical care for non-life-threatening conditions without an appointment but where immediate medical care is necessary. If required, the facility must be accredited by the Urgent Care Association of America (UCAOA) and/or the American Academy of Urgent Care Medicine, if required in a state, and:

1. Must accept walk-in patients during business hours;
2. Must treat a broad spectrum of injuries, as well as perform minor medical procedures;
3. Have a licensed physician operating as the medical director;
4. Have on-site diagnostic equipment, including x-ray; and
5. Must contain communication lines with local hospitals so that patients who need transfer to an Emergency Room have easy access.

We, Us and Our: Guarantee Trust Life Insurance Company.

You, Your and Yours: The Covered Person to whom this Certificate is issued and whose insurance is in force under the terms of the Policy.

CONDITIONS OF INSURANCE

ELIGIBILITY

Eligible Persons are described in the Schedule of Benefits. A person is insured under the Policy provided such person satisfies the eligibility requirements, becomes insured and remains insured under the terms of the Policy.

EFFECTIVE DATE

Covered Person: Coverage is effective, subject to receipt of premium, on the date agreed to by the Policyholder and Us.

TERMINATION

Covered Person: Coverage will terminate at the earlier of:

1. The date the Policy terminates;
2. The date the Covered Person ceases to be an Eligible Person;
3. The end of the period for which any applicable premium has been paid by the Policyholder on behalf of the Covered Person;
4. The date of entry of a valid judgment of dissolution of marriage between You and a Dependent spouse on the premium due date that follows the judgement.
5. The date of fraudulent misstatement of a material fact by any Covered Person, subject to the Time Limit on Certain Defenses provision. Material misrepresentation includes a failure to disclose other coverages a Covered Person has.

SCOPE OF COVERAGE

Please see the Scope of Coverage section in the Schedule of Benefits. There a Covered Person will find which of the following types of Accident coverage apply to the Covered Person's benefit plan.

Limited/Short-Term Accident Coverage - As shown in the Schedule, for users of specified products and/or services. The user of a specified product or service must have contracted with and paid the fee(s) to use the specified product or service.

- Coverage begins at the start of the contracted and paid service term and ends when the contracted and paid service term ends.

The Covered Person must provide evidence of a contractual agreement and that they were engaged in the use of the specified product or service described above at the time of an accidental Injury. Any receipt or record must show the date and time of the contracted and paid service.

ACCIDENTAL DEATH AND DISMEMBERMENT, LOSS OF SIGHT, SPEECH AND HEARING BENEFIT

If, within 365 days from the date of a Covered Accident, Injury from such Covered Accident results in a loss covered by this benefit, We will pay the benefit in the amount set opposite such loss, as shown on the Schedule of Benefits. If a Covered Person sustains more than one such loss as the result of the Covered Accident, We will pay only one amount, the largest to which a Covered Person is entitled.

Loss of hand or foot means loss by severance at or above the wrist or ankle joint. Loss of sight means the total, permanent loss of sight of the eye. The loss of sight must be irrecoverable by natural, surgical or artificial means. Loss of speech means total, permanent and irrecoverable loss of audible communication. Loss of hearing means total and permanent loss of hearing in both ears which cannot be corrected by any 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.

ACCIDENT MEDICAL EXPENSE BENEFITS

We will pay benefits, as defined and limited below, for Covered Charges incurred by a Covered Person due to Injury caused by a Covered Accident.

Covered Charges are payable only for an Injury:

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

Covered Charges are shown on the Schedule of Benefits.

No Other Valid and Collectible Insurance or Plan

We will pay the incurred Covered Charges up to the Maximum Benefit Amount, Per Injury, subject to the terms, conditions, provisions, limitations, exclusions and other provisions of the Policy/Certificate.

Other Valid and Collectible Insurance or Plan

We will pay the incurred Covered Charges which are in excess of the total benefits payable for the same Injury by any Other Valid and Collectible Insurance or Plan on a provision of service or on an expense incurred basis, up to the Maximum Benefit Amount, Per Accident. Benefit payment is subject to the terms, conditions, provisions, limitations, exclusions and other provisions of the Policy/Certificate.

A Covered Person must provide Us with proof of the amount of benefits paid by Other Valid and Collectible Insurance or Plan or proof of denial of benefits by Other Valid and Collectible Insurance or Plan.

If, for any reason, a Covered Person fails to apply for benefits from Other Valid and Collectible Insurance or Plan, We will pay the benefit that would have been paid under the Policy had the Covered Person filed a claim under the Other Valid and Collectible Insurance or Plan.

If Other Valid and Collectible Insurance or Plan provides benefits on an excess coverage basis, benefits will be paid first by the company or services plan whose policy or service contract has been in effect for the longer period of time at the date of the Injury.

EXCLUSIONS

The Policy/Certificate does not provide benefits for:

- Treatment, services or supplies which:
 - Are not Medically Necessary;
 - Are not prescribed by a Doctor as necessary to treat an Injury;
 - Are determined to be Experimental/Investigational in nature;
 - Are received without charge or legal obligation to pay;
 - Are received from persons employed or retained by any Family Member, unless otherwise specified; or
 - Are not specifically listed as Covered Charges in the Policy.
- Injury by acts of war, whether declared or not;
- Injury received while traveling or flying by air, except as a fare-paying passenger and not as a pilot or crew member, on a regularly scheduled commercial airline.
- Injury covered by Worker's Compensation, Employer Liability law or Occupational Disease Act or Law;
- Dental treatment, except as specifically stated;
- Injury sustained while committing or attempting to commit a felony;
- Prescription Drugs except as specifically stated;
- Suicide or attempted suicide while sane or insane;
- Intentionally self-inflicted Injury;
- Loss resulting from being legally intoxicated or under the influence of alcohol as defined by the laws of the state or jurisdiction in which the Injury occurs;
- Loss resulting from being under the influence of any drugs or narcotic unless administered on the advice of a Doctor;
- Injury sustained while participating in or practicing for any professional, intercollegiate or club sports activity.
- Injury which occurs while a Covered Person is on active duty service in any armed forces. Reserve or National Guard active duty for training is not excluded unless it extends beyond 31 days;
- Injury sustained flying in an ultra-light, hang gliding, parachuting or bungee cord jumping, by flight in a space craft or any craft designed for navigation above or beyond the earth's atmosphere;
- Injury sustained while driving or riding on vehicles for off-road use including but not limited to all-terrain vehicles (ATV's);
- Injury sustained where a Covered Person is the operator and does not possess a current and valid motor vehicle operator's license, except in a Driver's Education Program;
- Treatment in any Veteran's Administration or federal Hospital, except if there is a legal obligation to pay;
- Cosmetic surgery, except for reconstructive surgery on an injured part of the body;
- Covered Charges incurred outside of the United States or its possessions
- Competing in motor sports races or competitions;
- Competing in water sports races or competitions;
- Testing cars/trucks on any racetrack or speedway;
- Handling, storing or transporting explosives;
- Scaling up cliffs or mountain walls;
- Spelunking (exploring caves);
- Injuries that result from working with animals;
- Injury sustained while water skiing or surfboarding;
- Injury sustained while roller blading or skateboarding;
- Injury sustained while participating in a rodeo.
- Re-injury or complications of an Injury caused or contributed to by a condition that existed before the Accident.
- Repetitive motion injuries, strains, hernia, tendonitis, bursitis and heat exhaustion not related to a specific Injury.
- Individual allergic reactions due to exposure to common environmental stimuli, which include, but are not limited to, insects, animals, food, and medication;
- Any claim for which a Covered Person knowingly misrepresents a fact that is material to the claim; and
- Mental or Nervous disorders, including post-traumatic stress disorders.

PREMIUM

Premiums are due and payable in advance by You. Premiums are payable to the Company at its Home Office. Payment of a premium will not maintain the insurance in force beyond the period for which it is paid except for the Grace Period provision.

The premium rates may be changed by the Company. If the rates are changed, the Company will give the Policyholder and You at least 60 days advance written notice. If a change in benefits contained in the Policy increases the Company's liability, premium rates may be changed on the date the Company's liability is increased.

CLAIM PROVISIONS

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

Claim Forms: The insurer, upon receipt of written notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing Proofs of Loss. If such forms are not furnished within 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing Proofs of Loss, written proof covering the occurrence, the character, and the extent of the loss for which claim is made.

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

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

Payment of Claims: Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the Covered Person. Any other accrued indemnities unpaid at the Covered Person's death may, at the option of the insurer, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the Covered Person.

If any indemnity of this Certificate 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, the insurer may pay such indemnity up to an amount not exceeding \$1,000 to any relative by blood or connection by marriage of the Covered Person or beneficiary who is deemed by the insurer to be equitably entitled thereto. Any payment made by the insurer in good faith pursuant to this provision shall fully discharge the insurer to the extent of such payment.

Subject to any written direction of the Covered Person in an application or otherwise all or a portion of any indemnities provided by this Certificate on account of hospital, nursing, medical or surgical service may, at the insurer's option, and unless the Covered Person requests otherwise in writing not later than the time for filing proof of such loss, be paid directly to the hospital or person rendering such services, but it is not required that the service be rendered by a particular hospital or person.

Change of Beneficiary: A Covered Person has the right to change the Beneficiary and the consent of the Beneficiary or Beneficiaries shall not be required for any change. A Beneficiary designation must be signed and dated by the Covered Person during his or her lifetime and be received by Us.

Assignment of Benefits: An assignment of benefits is not binding on Us unless:

1. It is a written request; and
2. It is received by Us at our Home Office.

An assignment will take effect when recorded at Our Home Office. We are not responsible for the validity of any assignment. Any payment, made in good faith, fully discharges the Company to the extent of the payment.

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

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

GENERAL PROVISIONS

Entire Contract; Changes: The Policy, including any endorsements, riders and amendments, the Policy application, and the Covered Person's application, if any, constitute the entire contract between the parties, and any statement made by the Policyholder or by any Covered Person shall, in the absence of fraud, be deemed a representation and not a warranty. No such statement shall be used in defense to a claim hereunder unless it is contained in a written application.

No change in this Policy shall be valid unless approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or waive any of its provisions.

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

(b) After two years from the date of issue of this Policy, no misstatement of the Policyholder, except a fraudulent misstatement made in the application shall be used to void the Policy; and after two years from the effective date of the coverage with respect to which any claim is made no misstatement of any person eligible for coverage under the Policy, except a fraudulent misstatement, made in an application under the policy shall be used to deny a claim for loss incurred or disability (as defined in the policy) commencing after expiration of such two years.

Non-Participating: The Policy is non-participating. It does not share in the Company's profits or surplus earnings.

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

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

INDEPENDENT MEDICAL REVIEW SYSTEM

DEFINITIONS

Disputed Health Care Service: Any health care service eligible for coverage and payment that has been denied, modified, or delayed by Our decision, or by one of Our contracting Doctors, in whole or in part due to a finding that the service is not Medically Necessary or the service is Experimental and Investigational.

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

INDEPENDENT MEDICAL REVIEW

In the event benefits are denied, modified or delayed based on Our determination that health care services are not Medically Necessary or that services are Experimental and Investigational, the insured has the right to request an Independent Medical Review of these Disputed Health Care Services. The California Department of Insurance will contract with one or more independent medical review organizations to conduct Independent Medical Reviews. The California Department of Insurance will have the final authority in deciding whether the Disputed Health Care Services are or are not Medically Necessary or Experimental and Investigational.

REQUESTING AN INDEPENDENT MEDICAL REVIEW

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

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

1. (A) The insured's Doctor has recommended a health care service as Medically Necessary; or
(B) The insured has received urgent care or emergency services that a Doctor determined was Medically Necessary; or
(C) The insured, in the absence of a Doctor's recommendation under (A) or the receipt of urgent care or emergency services by a Doctor under (B), has been seen by a contracting Doctor for the diagnosis or treatment of the medical condition for which the insured seeks independent review. We shall expedite access to a contracting Doctor upon request of an insured. The contracting Doctor need not recommend the Disputed Health Care Service as a condition for the insured to be eligible for an Independent Medical Review.
2. The Disputed Health Care Service has been denied, modified, or delayed by Us, or by one of Our contracting Doctors, based in whole or in part on a decision that the health care service is not Medically Necessary; or
3. The Disputed Health Care Service has been denied by Us, or by one of Our contracting Doctors, based in whole or in part on a decision that the health care service is Experimental or Investigational.
4. The insured has filed a grievance with Us or Our contracting Doctor, and the disputed decision is upheld or the grievance remains unresolved after 30 days. The insured shall not be required to participate in Our grievance process for more than 30 days. In the case of a grievance that requires expedited review, the insured shall not be required to participate in the Our grievance process for more than three days.

The insured may apply for an Independent Medical Review within 6 months of any of the qualifying periods or events noted above. The Commissioner of Insurance may extend the application deadline beyond 6 months if the circumstances of a case warrant the extension.

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

CASE REVIEW PROCEDURE

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

1. The insured's specific needs; and
2. Peer-reviewed scientific and medical evidence regarding the effectiveness of the Disputed Health Care Service;
3. Nationally recognized professional standards;
4. Expert opinion;
5. Generally accepted standards of medical practice; or

6. Treatments that are likely to provide a benefit to a patient for conditions for which other treatments are not clinically efficacious.

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

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

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

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

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

SCHEDULE OF BENEFITS

Policyholder:	Family First Association
Certificate Effective Date:	February 1, 2022
Eligible Persons:	Persons who are members of an Eligible Class as defined by the Policyholder and agreed to by Us. Eligible Class is: Class 1: All members of the Family First Association who have purchased a valid lift ticket from a sponsoring resort. Members are eligible for coverage while skiing or snowboarding while on the property of the sponsoring resort for the duration of the time period specified on the lift ticket.
Scope of Coverage:	Limited/Short-Term Accident Coverage

ACCIDENTAL DEATH AND DISMEMBERMENT, LOSS OF SIGHT, SPEECH AND HEARING BENEFIT

The Principal Sum:	\$20,000
Loss of Life	The Principal Sum
Loss of Both Hands	The Principal Sum
Loss of Both Feet	The Principal Sum
Loss of the Entire Sight of Both Eyes	The Principal Sum
Loss of One Hand and One Foot	The Principal Sum
Loss of Speech and Hearing	The Principal Sum
Loss of One Hand or One Foot and Entire Sight of One Eye	The Principal Sum
Loss of One Hand or One Foot	One-Half The Principal Sum
Loss of Entire Sight of One Eye	One-Half The Principal Sum
Loss of Speech or Hearing	One-Half The Principal Sum
Loss of Hearing in One Ear	One-Quarter The Principal Sum
Loss of Thumb and Index Finger of the Same Hand	One-Quarter The Principal Sum

ACCIDENT MEDICAL EXPENSE BENEFITS

Maximum Amount Per Accident (Certificate Limit)	\$20,000
Deductible Per Accident	\$100
Initial Treatment Period	60 Days
Benefit Period	12 Months

BENEFIT MAXIMUMS

Benefits for Covered Charges are Limited as Stated Below

Treatment, services or supplies incurred for:	Maximum Amount:
Hospital Emergency Care	\$500
Hospital Emergency care	
Imaging (X-Ray) and other diagnostic tests	Up to Certificate Limit
Ambulance Expense: Ground Ambulance expense	Limited to \$250
Prescription Drug Expense	Up to \$500

Treatment, services or supplies incurred for:	Maximum Amount:
Hospital room and board, and general nursing care charges, up to the semi-private room rate.	Up to Certificate Limit
Hospital miscellaneous expense during Hospital Confinement or for outpatient surgery under general anesthetic, such as the cost of the operating room, laboratory tests, Imaging (X-Ray) examinations, anesthesia, drugs (excluding take-home drugs) or medicines.	Up to Certificate Limit
Doctor's fees for surgery	Up to Certificate Limit
Anesthesia services	Up to Certificate Limit
Doctors' visits, inpatient and outpatient expenses, each visit:	Limited to \$75
Durable Medical Equipment	Limited to \$100
Dental treatment for Injury to Sound Natural Teeth	\$250 per tooth up to a maximum of \$500
Physical Therapy limited to 1 visit per day and does not apply when related to surgery	\$60 for first visit; \$30 for each visit thereafter
Registered Nurse expense	Up to Certificate Limit

NOTICE OF PROTECTION PROVIDED BY CALIFORNIA LIFE AND HEALTH INSURANCE GUARANTEE ASSOCIATION

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

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

COVERAGE

- **Persons Covered**

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

- **Amounts of Coverage**

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

- **Life Insurance, Annuities and Structured Settlement Annuities**

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

- **Life Insurance**

80% of death benefits but not to exceed \$300,000

80% of cash surrender or withdrawal values but not to exceed \$100,000

- **Annuities and Structured Settlement Annuities**

80% of the present value of annuity benefits, including net cash withdrawal and

net cash surrender values but not to exceed \$250,000

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

- **Health Insurance**

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

COVERAGE LIMITATIONS AND EXCLUSIONS FROM COVERAGE

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

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

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

NOTICES

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

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

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

Insurance companies and agents are not allowed by California law to use the
CA-NOT2

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

**GUARANTEE TRUST LIFE INSURANCE COMPANY
1275 MILWAUKEE AVENUE
GLENVIEW, ILLINOIS 60025**

CALIFORNIA COMPLAINT NOTICE

ANY POLICYHOLDER THAT HAS A COMPLAINT SHOULD CONTACT THE COMPANY AT 847-699-0600 OR THE AGENT WHO SOLD THEM THE POLICY.

THE CALIFORNIA DEPARTMENT OF INSURANCE SHOULD BE CONTACTED ONLY AFTER THE COMPLAINANT AND THE COMPANY OR ITS AGENT HAVE FAILED TO PRODUCE A SATISFACTORY SOLUTION TO THE PROBLEM.

INSIDE CALIFORNIA

1-800-927-HELP (4357)

OUTSIDE CALIFORNIA

1-213-897-8921

OR WRITE:

**DEPARTMENT OF INSURANCE
300 SOUTH SPRING STREET
LOS ANGELES, CA 90013**

GUARANTEE TRUST LIFE INSURANCE COMPANY PRIVACY NOTICE

At Guarantee Trust Life Insurance Company (GTL) 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 GTL 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

GTL does not disclose any nonpublic personal information about our customers or former customers to anyone without providing notice of the customer's rights to either opt out or opt in the sharing of personal information, 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.

G•T•L
Guarantee Trust Life Insurance Company
1275 Milwaukee Avenue
Glenview, Illinois 60025
1-800-338-7452
Visit us at: www.gtlic.com

GUARANTEE TRUST LIFE INSURANCE COMPANY

1275 Milwaukee Avenue, Glenview, Illinois 60025
1-800-338-7452

CERTIFICATE OF INSURANCE

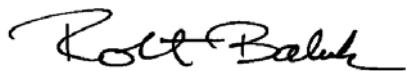
This is Your Certificate of Insurance (Certificate) while You are insured. It briefly explains the rights and benefits that are determined by the Master Policy (Policy). The Policy is a contract between the Policyholder and Us. The Policyholder is shown on the Schedule of Benefits.

The Policy alone constitutes the agreement under which payments are made. We will pay the benefits set forth in the Policy. Benefit payment is governed by all the terms, conditions, provisions, limitations and exclusions of this Certificate and the Policy. The Policy may be amended at any time without Your consent or notice to You. Any such amendment will not affect a claim starting before the amendment takes effect.

Right to Examine: If You are not satisfied with this Certificate, return it to Our home office within ten days after the date You received it. This Certificate will then be canceled and any Premium paid will be refunded.

The Policy is held by the Policyholder. You may inspect it at any time during business hours at the office of the Policyholder.

READ YOUR CERTIFICATE CAREFULLY



Secretary



President

GROUP ACCIDENT ONLY COVERAGE

THIS IS AN ACCIDENT ONLY POLICY AND IT DOES NOT PAY BENEFITS FOR LOSS FROM SICKNESS

**THIS IS LIMITED COVERAGE. PLEASE READ YOUR CERTIFICATE CAREFULLY.
NON-PARTICIPATING**

**THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE
FOR MAJOR MEDICAL COVERAGE.**

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DEFINITIONS

Accident: A sudden, unintended and unforeseeable event to the Covered Person which results in an Injury.

Beneficiary: A person or persons the Covered Person has named to receive any death benefits paid under this Certificate.

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

Covered Accident: An Accident for which coverage is provided and a benefit is payable while a Covered Person's insurance under the Policy and this Certificate are in effect.

Covered Charge: The Reasonable and Customary charge incurred for a medical service or supply listed in this Certificate which is performed or given under the direction of a Doctor for the Medically Necessary treatment of an Injury caused by a Covered Accident. A Covered Charge is considered incurred on the date the medical treatment or service is rendered or the supply is furnished. Benefits for a Covered Charge are payable as indicated in the Policy/Certificate Schedule.

Covered Person: You, or a Dependent:

1. Who is eligible for coverage as a Covered Person;
2. Who has been accepted for coverage or has been automatically added;
3. Who has paid the required premium; and
4. Whose coverage has become effective and has not terminated.

Deductible: The deductible is the amount You must pay before this insurance provides a benefit to You. Any deductible is shown in the Schedule of Benefits. No Benefits will be paid until the deductible is satisfied.

Doctor: A legally qualified person licensed in the healing arts, practicing within the scope of his or her license and who is not a Covered Person or a Family Member.

Durable Medical Equipment: A device which:

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

Durable Medical Equipment does not include:

1. Comfort and convenience items;
2. Equipment that can be used by Family Members other than a Covered Person;
3. Health exercise equipment; and
4. Equipment that may increase the value of a Covered Person's Residence.

Such items that do not qualify as Durable Medical Equipment include, but are not limited to:

1. Modifications to a Covered Person's Residence, property or automobiles, such as ramps;
2. Elevators;
3. Spas;
4. Air conditioners;
5. Vehicle hand controls; or
6. Corrective shoes, exercise and sports equipment.

Eligible Person: A member of the Policyholder's organization as defined on the Schedule of Benefits.

Emergency: An Injury for which a Covered Person seeks immediate medical treatment at the nearest available facility. The condition must be one which manifests itself by acute symptoms which are sufficiently severe (including severe pain) that without immediate medical care a Covered Person could reasonably expect that: (1) the Covered Person's life or health would be in serious jeopardy; (2) the Covered Person's bodily functions would be seriously impaired; or (3) a body organ or part would be seriously damaged.

Emergency Room: A hospital area equipped and staffed for the prompt treatment of acute trauma, or other medical emergencies. An Emergency Room must be licensed by the state in which it is located under applicable State law as an Emergency Room or emergency department and be open 24 hours a day, 7 days a week. For the purposes of the Policy, Emergency Room includes a licensed Urgent Care Facility.

Experimental/Investigational: A drug, device or medical care or treatment will be considered experimental/investigational if:

1. The drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;
2. The informed consent document utilized with the drug, device, medical care or treatment states or indicates that the drug, device, medical care or treatment is part of a clinical trial, experimental phase or investigational phase or if such a consent document is required by law;
3. The drug, device, medical care or treatment or the patient informed consent document utilized with the drug, device or medical care or treatment was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal or state law requires such review and approval;
4. Reliable evidence shows 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 or diagnosis; or
5. 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 or diagnosis.

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

Family Member: A person who is related to a 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).

Ambulance: Means a vehicle which is licensed as an ambulance by the local regulatory body to provide transportation of a Covered Person as a result of a Covered Accident to a Hospital or transportation from one Hospital to another for a Covered Person who is unable to travel to receive medical care by any other means. An Ambulance must contain life-saving equipment and state-certified ambulance personnel.

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

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

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

1. Services would have been covered in a medical facility if Home Health Care were not given; and
2. A Home Health Care treatment plan is set up, in writing and approved by a Doctor.

Hospice Care: Services provided by a licensed public agency or private organization or any subdivision thereof, which entity shall be known as a hospice and shall be primarily engaged in providing care to an individual for whom a certified medical prognosis has been made indicating a life expectancy of six (6) – twelve (12) months or less and who has elected to receive such care in lieu of other medical benefits available under the Policy.

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

1. Is accredited by the Joint Commission or other accreditation organization accepted by a state;
2. Provides 24-hour nursing service by registered nurses (R.N.);
3. Mainly provides diagnostic and therapeutic care under the supervision of Doctors on an inpatient basis; and
4. Maintains permanent surgical facilities or has an arrangement with another surgical facility supervised by a staff of one or more Doctors.

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

Hospital does not include a place, special ward, floor or other accommodation used for: custodial or educational care; rest; the aged; a nursing home or an institution mainly rendering treatment or services for mental illness or substance misuse.

Immediate Care Facility: A walk-in clinic focused on the delivery of medical care for minor injuries in an ambulatory medical facility outside of a traditional hospital-based or freestanding emergency department.

Independent Contractor: An Independent Contractor who has agreed to perform services for entities or individuals that contract with independent workers for short- or long-term or intermittent engagements. Temporary coverage is provided for the period of time the worker is actively logged into an entity's mobile device application or platform and engaged in work for the entity or individual. The term 'Independent Contractor' also includes temporary workers and consultants who are not permanent employees.

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

Injury: Bodily injury due to a Covered Accident which:

1. Results directly from a Covered Accident, independently of disease or bodily infirmity;
2. Occurs after the effective date of a Covered Person's coverage under the Policy; and
3. Occurs while the coverage is in force.

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

Intensive Care Unit (ICU): A specifically designed facility of the Hospital that provides the highest level of medical care; and which is restricted to those patients who are critically ill or injured. Such facility must be separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient confinement. They must be permanently equipped with special life-saving equipment for the care of the critically ill or injured; and under constant and continuous observation by nursing staff assigned on a full-time basis, exclusively to the Intensive Care Unit. Intensive Care Unit does not mean any of these step-down units: progressive care; sub-acute intensive care; intermediate care units; private monitored rooms; observation units; or other facilities which do not meet the standards for Intensive Care.

Medically Necessary: A treatment, drug, device, procedure, supply or service that is necessary and appropriate for the diagnosis or treatment of an Injury as determined by Your Doctor in accordance with generally accepted standards of medical and dental 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. For Accident Related Dental services this means Services which are needed due to an accidental injury caused by a force outside of the mouth or body.

A treatment, drug, device, procedure, supply or service shall not be considered as Medically Necessary if:

1. Is Experimental/Investigational or for research purposes;
2. Is provided solely for education purposes or the convenience of a Covered Person's family, Doctor, Hospital or any other medical provider;
3. 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;
4. Could have been omitted without adversely affecting the person's condition or the quality of medical care;
5. Involves the use of a medical device, drug or substance not formally approved by the United States Food and Drug Administration;

6. Involves a service, supply or drug not considered reasonable and necessary by the Healthcare Financing Administration Medicare Coverage Issues Manual; or
7. Can be safely provided to the patient on a more cost-effective basis such as outpatient, by a different medical professional, or pursuant to a more conservative form of treatment.

Orthopedic Appliances: Any supportive device or appliance used in treating a Covered Person's Injury.

Physical Therapy: Non-surgical physical or mechanical therapy, diathermy, ultrasonic therapy, heat treatment in any form or massage that is intended to preserve, enhance, or restore movement and physical function impaired by Injury. For the purposes of this coverage, chiropractic treatment is not deemed to be Physical Therapy. Physical Therapy must be prescribed by a Doctor and be based upon a plan of treatment for a specified period of time or number of visits.

Policyholder: The entity to which the Policy is issued.

Prescription Drugs: Drugs which may only be dispensed by written prescription under Federal law and are approved for general use by the Food and Drug Administration. The drugs must be dispensed by a licensed pharmacy provider for a Covered Person's outpatient use.

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

1. The actual amount charged by the medical provider;
2. The negotiated rate; or
3. The charge which would have been made by the medical provider for a comparable service or supply made by other providers in the same Geographic Area as reasonably determined by us for the same service or supply.

"Geographic Area" means the three digit zip code in which the service, treatment, procedure, drugs or supplies are provided; or a greater area if necessary to obtain a representative cross-section of charge for a like treatment, service, procedure, device drug or supply.

Rehabilitation Facility: An institution, or part of an institution, licensed, accredited or certified by the State which:

1. Is accredited by the Joint Commission, the Commission on Accreditation of Rehabilitation Facilities or other accreditation organizations accepted by a state;
2. Is primarily engaged in providing comprehensive multi-disciplinary physical services or rehabilitation inpatient care; and
3. Has a transfer agreement with one or more Hospitals.

Rehabilitation Facility does not include an institution which:

1. Provides only minimal care, custodial care, care for the terminally ill, or part-time care services;
2. Primarily provides treatment for mental disorders, chemical dependency or tuberculosis, except if such facility is licensed, certified, or approved as a rehabilitation facility for the treatment of medical conditions; drug addiction or alcoholism.

Residence: The home and land or property on which a Covered Person's dwelling or home is located.

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

Telehealth Care Benefit: We agree to reimburse up to the Doctor's office visit benefit for each Telehealth Care service provided due to accidental Injury. This benefit is subject to the Certificate maximums.

Transportation Network Company: An entity that uses a digital network to connect riders to drivers for the purpose of providing transportation. Transportation Network Company does not include a taxi service or ridesharing arrangements.

Urgent Care Facility: A healthcare facility, which is part of or affiliated with a Hospital, providing short-term medical care for non-life-threatening conditions without an appointment but where immediate medical care is necessary. If required, the facility must be accredited by the Urgent Care Association of America (UCAOA) and/or the American Academy of Urgent Care Medicine, if required in a state, and:

1. Must accept walk-in patients during business hours;
2. Must treat a broad spectrum of injuries, as well as perform minor medical procedures;
3. Have a licensed physician operating as the medical director;
4. Have on-site diagnostic equipment, including x-ray; and
5. Must contain communication lines with local hospitals so that patients who need transfer to an Emergency Room have easy access.

We, Us and Our: Guarantee Trust Life Insurance Company.

You, Your and Yours: The Covered Person to whom this Certificate is issued and whose insurance is in force under the terms of the Policy.

CONDITIONS OF INSURANCE

ELIGIBILITY

Eligible Persons are described in the Schedule of Benefits. A person is insured under the Policy provided such person satisfies the eligibility requirements, becomes insured and remains insured under the terms of the Policy.

EFFECTIVE DATE

Covered Person: Coverage is effective, subject to receipt of premium, on the date agreed to by the Policyholder and Us.

TERMINATION

Covered Person: Coverage will terminate at the earlier of:

1. The date the Policy terminates;
2. The date the Covered Person ceases to be an Eligible Person;
3. The end of the period for which any applicable premium has been paid by the Policyholder on behalf of the Covered Person;
4. The date of entry of a valid judgment of dissolution of marriage between You and a Dependent spouse on the premium due date that follows the judgement.
5. The date of fraud or knowingly misrepresenting a material fact by any Covered Person. Material misrepresentation includes a failure to disclose other coverages a Covered Person has.

SCOPE OF COVERAGE

Please see the Scope of Coverage section in the Schedule of Benefits. There a Covered Person will find which of the following types of Accident coverage apply to the Covered Person's benefit plan.

Limited/Short-Term Accident Coverage - As shown in the Schedule, for users of specified products and/or services. The user of a specified product or service must have contracted with and paid the fee(s) to use the specified product or service.

- Coverage begins at the start of the contracted and paid service term and ends when the contracted and paid service term ends.

The Covered Person must provide evidence of a contractual agreement and that they were engaged in the use of the specified product or service described above at the time of an accidental Injury. Any receipt or record must show the date and time of the contracted and paid service.

ACCIDENTAL DEATH AND DISMEMBERMENT, LOSS OF SIGHT, SPEECH AND HEARING BENEFIT

If, within 365 days from the date of a Covered Accident, Injury from such Covered Accident results in a loss covered by this benefit, We will pay the benefit in the amount set opposite such loss, as shown on the Schedule of Benefits. If a Covered Person sustains more than one such loss as the result of the Covered Accident, We will pay only one amount, the largest to which a Covered Person is entitled.

Loss of hand or foot means loss by severance at or above the wrist or ankle joint. Loss of sight means the total, permanent loss of sight of the eye. The loss of sight must be irrecoverable by natural, surgical or artificial means. Loss of speech means total, permanent and irrecoverable loss of audible communication. Loss of hearing means total and permanent loss of hearing in both ears which cannot be corrected by any 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.

ACCIDENT MEDICAL EXPENSE BENEFITS

After any Deductible has been satisfied, We will pay benefits, as defined and limited below, for Covered Charges incurred by a Covered Person due to Injury caused by a Covered Accident.

Covered Charges are payable only for an Injury:

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

Covered Charges are shown on the Schedule of Benefits.

COORDINATION OF BENEFITS PROVISION

I. Applicability

- A. The following provisions are applied to determine which insurance Plan pays benefits first when a Covered Person is covered by two or more plans. A Plan that pays first is called "primary". All other plans are called "secondary".
- B. If these provisions apply, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another plan. The benefits of This Plan:
 - (1) Shall not be reduced when, under the order of benefit determination rules, This Plan determines its benefits before another plan; but
 - (2) May be reduced when, under the order of benefits determination rules, another plan determines its benefits first. The above reduction is described in Section IV "Effect on the Benefits of This Plan."

II. Definitions

- A. "Plan" is any of these which provides benefits or services for, or because of, medical or dental care or treatment:
 - (1) Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
 - (2) Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act (42 U.S.C.A. 301, et seq.).

Each contract or other arrangement for coverage under (1) or (2) is a separate plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

- B. "This Plan" is the part of the group contract that provides benefits for health care expenses.
- C. "Primary Plan/Secondary Plan:" The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another plan covering the person.

When This Plan is a Primary Plan, its benefits are determined before those of the other plan and without considering the other plan's benefits.

When This Plan is a Secondary Plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits.

When there are more than two plans covering the person, This Plan may be a Primary Plan as to one or more

- other plans, and may be a Secondary Plan as to a different plan or plans.
- D. "Allowable Expense" means a necessary, reasonable and customary item of expense for health care; when the item of expense is covered at least by one or more plans covering the person for whom the claim is made.
- The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private hospital room is medically necessary either in terms of generally accepted medical practice, or as specifically defined in the plan.
- When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.
- E. "Claim Determination Period" means a calendar year. However, it does not include any part of a year during which a person has no coverage under This Plan, or any part of a year before the date this COB provision or a similar provision takes effect.
- ### **III. Order of Benefit Determination Rules**
- A. General. When there is a basis for a claim under This Plan and another plan, This Plan is a Secondary Plan which has its benefits determined after those of the other plan, unless:
- (1) The other plan has rules coordinating its benefits with those of This Plan; and
 - (2) Both those rules and This Plan's rules, in Subsection B below, require that This Plan's benefits be determined before those of the other plan.
- B. Rules. This Plan determines its order of benefits using the first of the following rules which applies:
- (1) Non-Dependent/Dependent. The benefits of the plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the plan which covers the person as a dependent; except that: if the person is also a Medicare beneficiary, Medicare is
 - (a) Secondary to the plan covering the person as a dependent; and
 - (b) Primary to the plan covering the person as other than a dependent, for example a retired employee.
 - (2) Dependent Child/Parents not Separated or Divorced. Except as stated in subsection (B)(3) below, when This Plan and another plan cover the same child as a dependent of different person, called "parents":
 - (a) The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but
 - (b) If both parents have the same birthday, the benefits of the plan which covered the parents longer are determined before those of the plan which covered the other parent for a shorter period of time.

However, if the other plan does not have the rule described in subsection (2)(a) immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.
 - (3) Dependent Child/Separated or Divorced. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
 - (a) First, the plan of the parent with custody of the child;
 - (b) Then, the plan of the spouse of the parent with the custody of the child; and
 - (c) Finally, the plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any Claim Determination Period or Plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.
 - (4) Dependent Child/Joint Custody. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined in Paragraph III subsection B(2) above.

- (5) Active/Inactive Employee. The benefits of a plan which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a plan which covers that person as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this Rule (4) is ignored.
- (6) Continuation coverage. If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following shall be the order of benefit determination:
 - (a) First, the benefits of a plan covering the person as an employee, member or subscriber (or as that person's dependent);
 - (b) Second, the benefits under the continuation coverage.
- (7) Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the plan which covered an employee, member or subscriber longer are determined before those of the plan which covered that person for the shorter term.

IV. Effect on the Benefits of this Plan

- A. When This Section Applies. This Section IV applies when, in accordance with Section III "Order of Benefit Determination Rules," This Plan is a Secondary Plan as to one or more other plans. In that event the benefits of This Plan may be reduced under this section. Such other plan or plans are referred to as "the other plans" in (B) immediately below.
- B. Reduction in this Plan's Benefits. The benefits of This Plan will be reduced when the sum of:
 - (1) The benefits that would be payable for the Allowable Expense under This Plan in the absence of this COB provision; and
 - (2) The benefits that would be payable for the Allowable Expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made; exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other plans do not total more than those Allowable Expenses.

When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

V. Right to Receive and Release Needed Information

Certain facts are needed to apply these COB rules. We have the right to decide which facts We need. We may get needed facts from or give them to any other organization or person. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give Us any facts We need to pay the claim.

VI. Facility of Payment

A payment made under another plan may include an amount which should have been paid under This Plan. If it does, We may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We 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 reasonable cash value of the benefits provided in the form of services.

VII. Right of Recovery

If the amount of the payments made by Us is more than We should have paid under this COB provision, We may recover the excess from one or more of:

- A. The persons We have paid or for whom it was paid;
- B. Insurance companies; or
- C. Other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

EXCLUSIONS

The Policy/Certificate does not provide benefits for:

- Treatment, services or supplies which:
 - Are not Medically Necessary;
 - Are not prescribed by a Doctor as necessary to treat an Injury;
 - Are determined to be Experimental/Investigational in nature;
 - Are received without charge or legal obligation to pay;
 - Are received from persons employed or retained by any Family Member, unless otherwise specified; or
 - Are not specifically listed as Covered Charges in the Policy.
- Injury by acts of war, whether declared or not;
- Injury received while traveling or flying by air, except as a fare-paying passenger and not as a pilot or crew member, on a regularly scheduled commercial airline.
- Injury covered by Worker's Compensation, Employer Liability law or Occupational Disease Act or Law;
- Dental treatment, except as specifically stated;
- Injury sustained while committing or attempting to commit a felony;
- Prescription Drugs except as specifically stated;
- Suicide or attempted suicide while sane or insane;
- Injury sustained while participating in or practicing for any professional, intercollegiate or club sports activity.
- Injury which occurs while a Covered Person is on active duty service in any armed forces. Reserve or National Guard active duty for training is not excluded unless it extends beyond 31 days;
- Injury sustained flying in an ultra-light, hang gliding, parachuting or bungee cord jumping, by flight in a space craft or any craft designed for navigation above or beyond the earth's atmosphere;
- Injury sustained while driving or riding on vehicles for off-road use including but not limited to all-terrain vehicles (ATV's);
- Injury sustained where a Covered Person is the operator and does not possess a current and valid motor vehicle operator's license, except in a Driver's Education Program;
- Treatment in any Veteran's Administration or federal Hospital, except if there is a legal obligation to pay;
- Cosmetic surgery, except for reconstructive surgery on an injured part of the body;
- Covered Charges incurred outside of the United States or its possessions
- Competing in motor sports races or competitions;
- Competing in water sports races or competitions;
- Testing cars/trucks on any racetrack or speedway;
- Handling, storing or transporting explosives;
- Scaling up cliffs or mountain walls;
- Spelunking (exploring caves);
- Injuries that result from working with animals;
- Injury sustained while water skiing or surfboarding;
- Injury sustained while roller blading or skateboarding;
- Injury sustained while participating in a rodeo.
- Re-injury or complications of an Injury caused by a condition that existed before the Accident.
- Repetitive motion injuries, strains, hernia, tendonitis, bursitis and heat exhaustion not related to a specific Injury.
- Individual allergic reactions due to exposure to common environmental stimuli, which include, but are not limited to, insects, animals, food, and medication;
- Any claim for which a Covered Person knowingly misrepresents a fact that is material to the claim; and
- Mental or Nervous disorders, including post-traumatic stress disorders.

PREMIUM

Premiums are due and payable in advance by You. Premiums are payable to the Company at its Home Office. Payment of a premium will not maintain the insurance in force beyond the period for which it is paid except for the Grace Period provision.

The premium rates may be changed by the Company. If the rates are changed, the Company will give the Policyholder and You at least 60 days advance written notice. If a change in benefits contained in the Policy increases the Company's liability, premium rates may be changed on the date the Company's liability is increased.

CLAIM PROVISIONS

Notice of Claim: Written notice of claim must be given to the Company or its authorized representative within 60 days after a covered loss starts, or as soon thereafter as is reasonably possible. Notice should include information sufficient to identify the Covered Person.

Claim Forms: The Company, upon receipt of written notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing Proofs of Loss. If such forms are not furnished within 15 days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of the Policy as to Proof of Loss upon submitting, within the time fixed in the Policy for filing Proof of Loss, written proof covering the occurrence, the character, and the extent of the loss for which claim is made.

Proof of Loss: Proof of Loss as required by the Company must be given to the Company within 90 days after the loss. The Company will accept late proof if:

1. It was not reasonably possible to give proof in that time; and
2. The proof is given within twelve (12) months from the date of loss. This twelve (12) month limit will not apply in the absence of legal capacity.

Proof of Loss includes, but is not limited to:

1. Receipts, credit card statements and/or invoices showing that a contracted service was provided;
2. Evidence that the Covered Person was performing the covered activity at the time of the accidental Injury;
3. Evidence that the Covered Person reported the Injury to the provider of any contracted services; and
4. Evidence that covered medical expense was incurred by the Covered Person.

Time of Payment of Claims: Benefits will be paid as soon as We receive proper proof of loss unless the Policy provides for periodic payment. When the Policy provides for periodic payment, the benefits will accrue and will be paid monthly subject to proper Proof of Loss.

All claims and indemnities payable under the Policy will be paid within 30 days following Our receipt of due proof of loss. If We fail to pay within such period, We will pay 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. Interest amounting to less than one dollar will not be paid.

Payment of Claims: Benefits payable under this Certificate for a Covered Person's loss of life will be paid to the Covered Person's named Beneficiary, or if there is no named Beneficiary, then to the first surviving class of the Covered Person's relatives listed below. All other benefits will be payable to the Covered Person or to a medical services provider if We have received a valid assignment completed and signed by the Covered Person.

Unless the Covered Person designates a Beneficiary on the enrollment form or by writing to Us, benefits for Death will be paid in equal shares to the first surviving class of beneficiaries below:

1. The Covered Person's living spouse;
2. The Covered Person's living children;
3. The Covered Person's living parents;
4. The Covered Person's living brothers and sisters.

Instead of paying any of the above classes, We may pay benefits to a Covered Person's Estate. Any payment made in good faith shall discharge Our liability to the extent of such payment.

Subject to the Covered Person's written direction or of the Covered Person's legal or natural guardian, if a Covered Person is a minor or otherwise incompetent to make such a direction, all or a portion of any indemnities provided by this Certificate as a result of medical, surgical, dental, hospital or nursing service may, at the Company's option, and unless the Company is requested in writing not later than the time for filing proofs of loss, be paid directly to the hospital or person rendering such services.

Change of Beneficiary: A Covered Person has the right to change the Beneficiary and the consent of the Beneficiary or Beneficiaries shall not be required for any change. A Beneficiary designation must be signed and dated by the Covered Person during his or her lifetime and be received by Us.

Assignment of Benefits: An assignment of benefits is not binding on Us unless:

1. It is a written request; and
2. It is received by Us at our Home Office.

An assignment will take effect when recorded at Our Home Office. We are not responsible for the validity of any assignment. Any payment, made in good faith, fully discharges the Company to the extent of the payment.

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

Legal Actions: A legal action may not be brought to recover on the Policy within 60 days after written Proof of Loss has been given as required. No such action may be brought after 3 years from the time written proof was required to be given.

Subrogation: We are assigned the right to recover from the negligent third party, or his or her insurer, to the extent of the benefits we paid for that sickness or injury. You are required to furnish any information or assistance, or provide any documents that we may reasonably require in order to exercise our rights under this provision. This provision applies whether or not the third party admits liability.

Reimbursement Provision: If a Covered Person recovers expenses for Injury that occurred due to the negligence of a third party, We have the right to first reimbursement for all benefits We paid from any and all damages collected from the negligent third party for those same expenses whether by action at law, settlement, or compromise, by the Covered Person, the Covered Person's parents if the Covered Person is a minor, or the Covered Person's legal representative as a result of that Injury. The Covered Person is required to furnish any information or assistance, or provide any documents that We may reasonably require in order to exercise Our rights under this provision. This provision applies whether or not the third party admits liability.

GENERAL PROVISIONS

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

Failure by the Company to enforce any Policy provision shall not waive, modify or render such provision unenforceable at any other time or under any given set of circumstances, whether the circumstances are or are not the same.

Non-Participating: The Policy is non-participating. It does not share in the Company's profits or surplus earnings.

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

Conformity with State Statutes: If any provision of the Policy or this Certificate is contrary to any law to which it is subject, such provision is hereby amended to conform to the minimum requirements of such law.

**NOTICE OF PROTECTION PROVIDED BY
ILLINOIS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION**

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

The Association was established to provide protection in the unlikely event that your member life, annuity, health maintenance organization or health insurance company becomes financially unable to meet its obligations and is placed into Receivership by the Insurance Department of the state in which the company is domiciled. If this should happen, the Association will typically arrange to continue coverage, pay claims, or otherwise provide protection in accordance with Illinois law, with funding from assessments paid by other insurance companies and health maintenance organizations.

The basic protections provided by the Association per insured in each insolvency are:

- Life Insurance
 - \$300,000 for death benefits
 - \$100,000 for cash surrender or withdrawal values
- Health Insurance
 - \$500,000 for health benefit plans*
 - \$300,000 for disability insurance benefits
 - \$300,000 for long-term care insurance benefits
 - \$100,000 for other types of health insurance benefits
- Annuities
 - \$250,000 for withdrawal and cash values

*The maximum amount of protection for each individual, regardless of the number of policies or contracts, is \$300,000, except special rules apply with regard to health benefit plan benefits for which the maximum amount of protection is \$500,000.

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

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

*Illinois Life and Health
Insurance Guaranty Association
901 Warrenville Road, Suite 400
Lisle, Illinois 60532-4324*

*Illinois Department of Insurance
4th Floor
320 West Washington Street
Springfield, Illinois 62767*

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

The Association is not an insurance company or health maintenance organization. If you wish to contact your insurance company or health maintenance organization, please use the phone number found in your policy or contact the Illinois Department of Insurance at DOI.InfoDesk@illinois.gov.

SCHEDULE OF BENEFITS

Policyholder:	Family First Association
Certificate Effective Date:	February 1, 2022
Eligible Persons:	Persons who are members of an Eligible Class as defined by the Policyholder and agreed to by Us. Eligible Classes are: Class 1: All members of the Family First Association who have purchased a valid lift ticket from a sponsoring resort. Members are eligible for coverage while skiing or snowboarding while on the property of the sponsoring resort for the duration of the time period specified on the lift ticket.
Scope of Coverage:	Limited/Short-Term Accident Coverage

ACCIDENTAL DEATH AND DISMEMBERMENT, LOSS OF SIGHT, SPEECH AND HEARING BENEFIT

The Principal Sum:	\$20,000
Loss of Life	The Principal Sum
Loss of Both Hands	The Principal Sum
Loss of Both Feet	The Principal Sum
Loss of the Entire Sight of Both Eyes	The Principal Sum
Loss of One Hand and One Foot	The Principal Sum
Loss of Speech and Hearing	The Principal Sum
Loss of One Hand or One Foot and Entire Sight of One Eye	The Principal Sum
Loss of One Hand or One Foot	One-Half The Principal Sum
Loss of Entire Sight of One Eye	One-Half The Principal Sum
Loss of Speech or Hearing	One-Half The Principal Sum
Loss of Hearing in One Ear	One-Quarter The Principal Sum
Loss of Thumb and Index Finger of the Same Hand	One-Quarter The Principal Sum

ACCIDENT MEDICAL EXPENSE BENEFITS

Maximum Amount Per Accident (Certificate Limit)	\$20,000
Benefit Percent *	100%
Deductible Per Accident	\$100
Initial Treatment Period	60 Days
Benefit Period	12 Months

BENEFIT MAXIMUMS

Benefits for Covered Charges are Limited as Stated Below

Treatment, services or supplies incurred for:	Maximum Amount:
Hospital Emergency Care Hospital Emergency care	\$500
Imaging (X-Ray) and other diagnostic tests	Up to Certificate Limit
Ambulance Expense: Ground Ambulance expense	Limited to \$250

Treatment, services or supplies incurred for:	Maximum Amount:
Prescription Drug Expense	Up to \$500
Hospital room and board, and general nursing care charges, up to the semi-private room rate.	Up to Certificate Limit
Hospital miscellaneous expense during Hospital Confinement or for outpatient surgery under general anesthetic, such as the cost of the operating room, laboratory tests, Imaging (X-Ray) examinations, anesthesia, drugs (excluding take-home drugs) or medicines.	Up to Certificate Limit
Doctor's fees for surgery	Up to Certificate Limit
Anesthesia services	Up to Certificate Limit
Doctors' visits, inpatient and outpatient expenses, each visit:	Limited to \$75
Durable Medical Equipment	Limited to \$100
Dental treatment for Injury to Sound Natural Teeth	\$250 per tooth up to a maximum of \$500
Physical Therapy limited to 1 visit per day and does not apply when related to surgery	\$60 for first visit; \$30 for each visit thereafter
Registered Nurse expense	Up to Certificate Limit

GUARANTEE TRUST LIFE INSURANCE COMPANY PRIVACY NOTICE

At Guarantee Trust Life Insurance Company (GTL) 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 GTL 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

GTL does not disclose any nonpublic personal information about our customers or former customers to anyone without providing notice of the customer's rights to either opt out or opt in the sharing of personal information, 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.

G•T•L
Guarantee Trust Life Insurance Company
1275 Milwaukee Avenue
Glenview, Illinois 60025
1-800-338-7452
Visit us at: www.gtlic.com

GUARANTEE TRUST LIFE INSURANCE COMPANY

1275 Milwaukee Avenue, Glenview, Illinois 60025
1-800-338-7452

CERTIFICATE OF INSURANCE

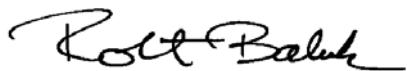
This is Your Certificate of Insurance (Certificate) while You are insured. It briefly explains the rights and benefits that are determined by the Master Policy (Policy). The Policy is a contract between the Policyholder and Us. The Policyholder is shown on the Schedule of Benefits.

The Policy alone constitutes the agreement under which payments are made. We will pay the benefits set forth in the Policy. Benefit payment is governed by all the terms, conditions, provisions, limitations and exclusions of this Certificate and the Policy. The Policy may be amended at any time without Your consent or notice to You. Any such amendment will not affect a claim starting before the amendment takes effect.

Right to Examine: If You are not satisfied with this Certificate, return it to Our home office within ten days after the date You received it. This Certificate will then be canceled and any Premium paid will be refunded.

The Policy is held by the Policyholder. You may inspect it at any time during business hours at the office of the Policyholder.

READ YOUR CERTIFICATE CAREFULLY



Secretary



President

**GROUP ACCIDENT ONLY COVERAGE
THIS IS LIMITED COVERAGE. PLEASE READ YOUR CERTIFICATE CAREFULLY.
NON-PARTICIPATING**

**THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE
FOR MAJOR MEDICAL COVERAGE.**

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DEFINITIONS

Accident: A sudden, unintended and unforeseeable external event to the Covered Person which results in an Injury. Suicide or attempted suicide while sane or insane and intentionally self-inflicted injuries are not considered an Accident.

Beneficiary: A person or persons the Covered Person has named to receive any death benefits paid under this Certificate.

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

Covered Accident: An Accident for which coverage is provided and a benefit is payable while a Covered Person's insurance under the Policy and this Certificate are in effect.

Covered Charge: The Reasonable and Customary charge incurred for a medical service or supply listed in this Certificate which is performed or given under the direction of a Doctor for the Medically Necessary treatment of an Injury caused by a Covered Accident. A Covered Charge is considered incurred on the date the medical treatment or service is rendered or the supply is furnished. Benefits for a Covered Charge are payable as indicated in the Policy/Certificate Schedule.

Covered Person: You, or a Dependent:

1. Who is eligible for coverage as a Covered Person;
2. Who has been accepted for coverage or has been automatically added;
3. Who has paid the required premium; and
4. Whose coverage has become effective and has not terminated.

Deductible: The deductible is the amount You must pay before this insurance provides a benefit to You. Any deductible is shown in the Schedule of Benefits. No Benefits will be paid until the deductible is satisfied.

Doctor: A legally qualified person licensed in the healing arts, practicing within the scope of his or her license and who is not a Covered Person or a Family Member.

Durable Medical Equipment: A device which:

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

Durable Medical Equipment does not include:

1. Comfort and convenience items;
2. Equipment that can be used by Family Members other than a Covered Person;
3. Health exercise equipment; and
4. Equipment that may increase the value of a Covered Person's Residence.

Such items that do not qualify as Durable Medical Equipment include, but are not limited to:

1. Modifications to a Covered Person's Residence, property or automobiles, such as ramps;
2. Elevators;
3. Spas;
4. Air conditioners;
5. Vehicle hand controls; or
6. Corrective shoes, exercise and sports equipment.

Eligible Person: A member of the Policyholder's organization as defined on the Schedule of Benefits.

Emergency: An Injury for which a Covered Person seeks immediate medical treatment at the nearest available facility. The condition must be one which manifests itself by acute symptoms which are sufficiently severe (including severe pain) that without immediate medical care a Covered Person could reasonably expect that: (1) the Covered Person's life or health would be in serious jeopardy; (2) the Covered Person's bodily functions would be seriously impaired; or (3) a body organ or part would be seriously damaged.

Emergency Room: A hospital area equipped and staffed for the prompt treatment of acute trauma, or other medical emergencies. An Emergency Room must be licensed by the state in which it is located under applicable State law as an Emergency Room or emergency department and be open 24 hours a day, 7 days a week. For the purposes of the Policy, Emergency Room includes a licensed Urgent Care Facility.

Experimental/Investigational: A drug, device or medical care or treatment will be considered experimental/investigational if:

1. The drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;
2. The informed consent document utilized with the drug, device, medical care or treatment states or indicates that the drug, device, medical care or treatment is part of a clinical trial, experimental phase or investigational phase or if such a consent document is required by law;
3. The drug, device, medical care or treatment or the patient informed consent document utilized with the drug, device or medical care or treatment was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal or state law requires such review and approval;
4. Reliable evidence shows 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 or diagnosis; or
5. 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 or diagnosis.

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

Family Member: A person who is related to a 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).

Ambulance: Means a vehicle which is licensed as an ambulance by the local regulatory body to provide transportation of a Covered Person as a result of a Covered Accident to a Hospital or transportation from one Hospital to another for a Covered Person who is unable to travel to receive medical care by any other means. An Ambulance must contain life-saving equipment and state-certified ambulance personnel.

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

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

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

1. Services would have been covered in a medical facility if Home Health Care were not given; and
2. A Home Health Care treatment plan is set up, in writing and approved by a Doctor.

Hospice Care: Services provided by a licensed public agency or private organization or any subdivision thereof, which entity shall be known as a hospice and shall be primarily engaged in providing care to an individual for whom a certified medical prognosis has been made indicating a life expectancy of six (6) – twelve (12) months or less and who has elected to receive such care in lieu of other medical benefits available under the Policy.

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

1. Is accredited by the Joint Commission or other accreditation organization accepted by a state;
2. Provides 24-hour nursing service by registered nurses (R.N.);
3. Mainly provides diagnostic and therapeutic care under the supervision of Doctors on an inpatient basis; and
4. Maintains permanent surgical facilities or has an arrangement with another surgical facility supervised by a staff of one or more Doctors.

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

Hospital does not include a place, special ward, floor or other accommodation used for: custodial or educational care; rest; the aged; a nursing home or an institution mainly rendering treatment or services for mental illness or substance misuse.

Immediate Care Facility: A walk-in clinic focused on the delivery of medical care for minor injuries in an ambulatory medical facility outside of a traditional hospital-based or freestanding emergency department.

Independent Contractor: An Independent Contractor who has agreed to perform services for entities or individuals that contract with independent workers for short- or long-term or intermittent engagements. Temporary coverage is provided for the period of time the worker is actively logged into an entity's mobile device application or platform and engaged in work for the entity or individual. The term 'Independent Contractor' also includes temporary workers and consultants who are not permanent employees.

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

Injury: Bodily injury due to a Covered Accident which:

1. Results solely and directly from a Covered Accident, independently of disease, bodily infirmity or any other causes;
2. Occurs after the effective date of a Covered Person's coverage under the Policy; and
3. Occurs while the coverage is in force.

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

Intensive Care Unit (ICU): A specifically designed facility of the Hospital that provides the highest level of medical care; and which is restricted to those patients who are critically ill or injured. Such facility must be separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient confinement. They must be permanently equipped with special life-saving equipment for the care of the critically ill or injured; and under constant and continuous observation by nursing staff assigned on a full-time basis, exclusively to the Intensive Care Unit. Intensive Care Unit does not mean any of these step-down units: progressive care; sub-acute intensive care; intermediate care units; private monitored rooms; observation units; or other facilities which do not meet the standards for Intensive Care.

Medically Necessary: A treatment, drug, device, procedure, supply or service that is necessary and appropriate for the diagnosis or treatment of an Injury as determined by Your Doctor in accordance with generally accepted standards of medical and dental 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. For Accident Related Dental services this means Services which are needed due to an accidental injury caused by a force outside of the mouth or body.

A treatment, drug, device, procedure, supply or service shall not be considered as Medically Necessary if:

1. Is Experimental/Investigational or for research purposes;
2. Is provided solely for education purposes or the convenience of a Covered Person's family, Doctor, Hospital or any other medical provider;
3. 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;
4. Could have been omitted without adversely affecting the person's condition or the quality of medical care;
5. Involves the use of a medical device, drug or substance not formally approved by the United States Food and Drug Administration;

6. Involves a service, supply or drug not considered reasonable and necessary by the Healthcare Financing Administration Medicare Coverage Issues Manual; or
7. Can be safely provided to the patient on a more cost-effective basis such as outpatient, by a different medical professional, or pursuant to a more conservative form of treatment.

Orthopedic Appliances: Any supportive device or appliance used in treating a Covered Person's Injury.

Other Valid and Collectible Insurance or Plan: Any reimbursement for or recovery of any element of Covered Charges incurred by the Covered Person available from any other source whatsoever, except gifts and donations, but including without limitation:

1. Any individual, group, blanket, or franchise policy of accident, disability or health insurance;
2. Any arrangement of benefits for members of a group, whether insured or uninsured;
3. Any prepaid service arrangement including a health maintenance or preferred provider organization or any other health benefit plan;
4. Any amount payable for Hospital, medical or other health services. Injury arising out of a motor vehicle accident to the extent such benefits are payable under any medical expense payment provision (by whatever terminology used including such benefits mandated by law) of any motor vehicle insurance policy.
5. Any amount payable for services or injuries or diseases related to a Covered Person's occupation to the extent that the Covered Person actually received benefits under a Worker's Compensation Law or if the Covered Person enters into a settlement to give up his or her rights to recover future medical expenses that would have been payable except for that settlement;
6. Social Security Disability Benefits, except that Other Valid and Collectible Insurance or Plan shall not include any increase in Social Security Disability Benefits payable to the Covered Person after the Covered Person becomes disabled while insured hereunder.
7. Any benefits payable under any program provided or sponsored solely or primarily by any governmental agency or subdivision or through operation of law or regulation.
8. Any medical expense coverage an Independent Contractor carries.

Physical Therapy: Non-surgical physical or mechanical therapy, diathermy, ultrasonic therapy, heat treatment in any form or massage that is intended to preserve, enhance, or restore movement and physical function impaired by Injury. For the purposes of this coverage, chiropractic treatment is not deemed to be Physical Therapy. Physical Therapy must be prescribed by a Doctor and be based upon a plan of treatment for a specified period of time or number of visits.

Policyholder: The entity to which the Policy is issued.

Prescription Drugs: Drugs which may only be dispensed by written prescription under Federal law and are approved for general use by the Food and Drug Administration. The drugs must be dispensed by a licensed pharmacy provider for a Covered Person's outpatient use.

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

1. The actual amount charged by the medical provider;
2. The negotiated rate; or
3. The charge which would have been made by the medical provider for a comparable service or supply made by other providers in the same Geographic Area as reasonably determined by us for the same service or supply.

"Geographic Area" means the three digit zip code in which the service, treatment, procedure, drugs or supplies are provided; or a greater area if necessary to obtain a representative cross-section of charge for a like treatment, service, procedure, device drug or supply.

Rehabilitation Facility: An institution, or part of an institution, licensed, accredited or certified by the State which:

1. Is accredited by the Joint Commission, the Commission on Accreditation of Rehabilitation Facilities or other accreditation organizations accepted by a state;
2. Is primarily engaged in providing comprehensive multi-disciplinary physical services or rehabilitation inpatient care; and

3. Has a transfer agreement with one or more Hospitals.

Rehabilitation Facility does not include an institution which:

1. Provides only minimal care, custodial care, care for the terminally ill, or part-time care services;
2. Primarily provides treatment for mental disorders, chemical dependency or tuberculosis, except if such facility is licensed, certified, or approved as a rehabilitation facility for the treatment of medical conditions; drug addiction or alcoholism.

Residence: The home and land or property on which a Covered Person's dwelling or home is located.

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

Telehealth Care Benefit: We agree to reimburse up to the Doctor's office visit benefit for each Telehealth Care service provided due to accidental Injury. This benefit is subject to the Certificate maximums.

Transportation Network Company: An entity that uses a digital network to connect riders to drivers for the purpose of providing transportation. Transportation Network Company does not include a taxi service or ridesharing arrangements.

Urgent Care Facility: A healthcare facility, which is part of or affiliated with a Hospital, providing short-term medical care for non-life-threatening conditions without an appointment but where immediate medical care is necessary. If required, the facility must be accredited by the Urgent Care Association of America (UCAOA) and/or the American Academy of Urgent Care Medicine, if required in a state, and:

1. Must accept walk-in patients during business hours;
2. Must treat a broad spectrum of injuries, as well as perform minor medical procedures;
3. Have a licensed physician operating as the medical director;
4. Have on-site diagnostic equipment, including x-ray; and
5. Must contain communication lines with local hospitals so that patients who need transfer to an Emergency Room have easy access.

We, Us and Our: Guarantee Trust Life Insurance Company.

You, Your and Yours: The Covered Person to whom this Certificate is issued and whose insurance is in force under the terms of the Policy.

CONDITIONS OF INSURANCE

ELIGIBILITY

Eligible Persons are described in the Schedule of Benefits. A person is insured under the Policy provided such person satisfies the eligibility requirements, becomes insured and remains insured under the terms of the Policy.

EFFECTIVE DATE

Covered Person: Coverage is effective, subject to receipt of premium, on the date agreed to by the Policyholder and Us.

TERMINATION

Covered Person: Coverage will terminate at the earlier of:

1. The date the Policy terminates;
2. The date the Covered Person ceases to be an Eligible Person;
3. The end of the period for which any applicable premium has been paid by the Policyholder on behalf of the Covered Person;
4. The date of entry of a valid judgment of dissolution of marriage between You and a Dependent spouse on the premium due date that follows the judgement.
5. The date of fraud or knowingly misrepresenting a material fact by any Covered Person. Material misrepresentation includes a failure to disclose other coverages a Covered Person has.

SCOPE OF COVERAGE

Please see the Scope of Coverage section in the Schedule of Benefits. There a Covered Person will find which of the following types of Accident coverage apply to the Covered Person's benefit plan.

Limited/Short-Term Accident Coverage - As shown in the Schedule, for users of specified products and/or services. The user of a specified product or service must have contracted with and paid the fee(s) to use the specified product or service.

- Coverage begins at the start of the contracted and paid service term and ends when the contracted and paid service term ends.

The Covered Person must provide evidence of a contractual agreement and that they were engaged in the use of the specified product or service described above at the time of an accidental Injury. Any receipt or record must show the date and time of the contracted and paid service.

ACCIDENTAL DEATH AND DISMEMBERMENT, LOSS OF SIGHT, SPEECH AND HEARING BENEFIT

If, within 365 days from the date of a Covered Accident, Injury from such Covered Accident results in a loss covered by this benefit, We will pay the benefit in the amount set opposite such loss, as shown on the Schedule of Benefits. If a Covered Person sustains more than one such loss as the result of the Covered Accident, We will pay only one amount, the largest to which a Covered Person is entitled.

Loss of hand or foot means loss by severance at or above the wrist or ankle joint. Loss of sight means the total, permanent loss of sight of the eye. The loss of sight must be irrecoverable by natural, surgical or artificial means. Loss of speech means total, permanent and irrecoverable loss of audible communication. Loss of hearing means total and permanent loss of hearing in both ears which cannot be corrected by any 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.

ACCIDENT MEDICAL EXPENSE BENEFITS

After any Deductible has been satisfied, We will pay benefits, as defined and limited below, for Covered Charges incurred by a Covered Person due to Injury caused by a Covered Accident.

Covered Charges are payable only for an Injury:

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

Covered Charges are shown on the Schedule of Benefits.

No Other Valid and Collectible Insurance or Plan

We will pay the Benefit Percent of incurred Covered Charges up to the Maximum Benefit Amount, Per Injury, subject to the terms, conditions, provisions, limitations, exclusions and other provisions of the Policy/Certificate.

Other Valid and Collectible Insurance or Plan

After any Deductible has been satisfied, We will pay the Benefit Percent of incurred Covered Charges which are in excess of the total benefits payable for the same Injury by any Other Valid and Collectible Insurance or Plan on a provision of service or on an expense incurred basis, up to the Maximum Benefit Amount, Per Accident. Benefit payment is subject to the terms, conditions, provisions, limitations, exclusions and other provisions of the Policy/Certificate.

A Covered Person must provide Us with proof of the amount of benefits paid by Other Valid and Collectible Insurance or Plan or proof of denial of benefits by Other Valid and Collectible Insurance or Plan.

If, for any reason, a Covered Person fails to apply for benefits from Other Valid and Collectible Insurance or Plan, We will pay the benefit that would have been paid under the Policy had the Covered Person filed a claim under the Other Valid and Collectible Insurance or Plan.

If Other Valid and Collectible Insurance or Plan provides benefits on an excess coverage basis, benefits will be paid first by the company or services plan whose policy or service contract has been in effect for the longer period of time at the date of the Injury.

EXCLUSIONS

The Policy/Certificate does not provide benefits for:

- Treatment, services or supplies which:
 - Are not Medically Necessary;
 - Are not prescribed by a Doctor as necessary to treat an Injury;
 - Are determined to be Experimental/Investigational in nature;
 - Are received without charge or legal obligation to pay;
 - Are received from persons employed or retained by any Family Member, unless otherwise specified; or
 - Are not specifically listed as Covered Charges in the Policy.
- Injury by acts of war, whether declared or not;
- Injury received while traveling or flying by air, except as a fare-paying passenger and not as a pilot or crew member, on a regularly scheduled commercial airline.
- Injury covered by Worker's Compensation, Employer Liability law or Occupational Disease Act or Law;
- Dental treatment, except as specifically stated;
- Prescription Drugs except as specifically stated;
- Illegal Occupation or Criminal Activity: We are not liable for any loss to which a contributing cause was an Insured Person's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation or other willful criminal activity. "Willful criminal activity" does not include a civil infraction or other activity that does not rise to the level of a misdemeanor or felony. As used in this Certificate, "willful criminal activity" includes, but is not limited to, operating a vehicle while intoxicated in violation of the Michigan vehicle code, or a similar law in a jurisdiction outside of Michigan.
- Injury sustained while participating in or practicing for any professional, intercollegiate or club sports activity.
- Injury which occurs while a Covered Person is on active duty service in any armed forces. Reserve or National Guard active duty for training is not excluded unless it extends beyond 31 days;
- Injury sustained flying in an ultra-light, hang gliding, parachuting or bungee cord jumping, by flight in a space craft or any craft designed for navigation above or beyond the earth's atmosphere;
- Injury sustained while driving or riding on vehicles for off-road use including but not limited to all-terrain vehicles (ATV's);
- Injury sustained where a Covered Person is the operator and does not possess a current and valid motor vehicle operator's license, except in a Driver's Education Program;
- Treatment in any Veteran's Administration or federal Hospital, except if there is a legal obligation to pay;
- Cosmetic surgery, except for reconstructive surgery on an injured part of the body;
- Covered Charges incurred outside of the United States or its possessions
- Competing in motor sports races or competitions;
- Competing in water sports races or competitions;
- Testing cars/trucks on any racetrack or speedway;
- Handling, storing or transporting explosives;
- Scaling up cliffs or mountain walls;
- Spelunking (exploring caves);
- Injuries that result from working with animals;
- Injury sustained while water skiing or surfing;
- Injury sustained while roller blading or skateboarding;
- Injury sustained while participating in a rodeo.
- Re-injury or complications of an Injury caused or contributed to by a condition that existed before the Accident.
- Repetitive motion injuries, strains, hernia, tendonitis, bursitis and heat exhaustion not related to a specific Injury.
- Individual allergic reactions due to exposure to common environmental stimuli, which include, but are not limited to, insects, animals, food, and medication;
- Any claim for which a Covered Person knowingly misrepresents a fact that is material to the claim; and
- Mental or Nervous disorders, including post-traumatic stress disorders.

PREMIUM

Premiums are due and payable in advance by You. Premiums are payable to the Company at its Home Office. Payment of a premium will not maintain the insurance in force beyond the period for which it is paid except for the Grace Period provision.

The premium rates may be changed by the Company. If the rates are changed, the Company will give the Policyholder and You at least 60 days advance written notice. If a change in benefits contained in the Policy increases the Company's liability, premium rates may be changed on the date the Company's liability is increased.

CLAIM PROVISIONS

Notice of Claim: Written notice of claim must be given to the Company or its authorized representative within 60 days after a covered loss starts, or as soon thereafter as is reasonably possible. Notice should include information sufficient to identify the Covered Person.

Claim Forms: The Company, upon receipt of written notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing Proofs of Loss. If such forms are not furnished within 15 days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of the Policy as to Proof of Loss upon submitting, within the time fixed in the Policy for filing Proof of Loss, written proof covering the occurrence, the character, and the extent of the loss for which claim is made.

Proof of Loss: Proof of Loss as required by the Company must be given to the Company within 90 days after the loss. The Company will accept late proof if:

1. It was not reasonably possible to give proof in that time; and
2. The proof is given within twelve (12) months from the date of loss. This twelve (12) month limit will not apply in the absence of legal capacity.

Proof of Loss includes, but is not limited to:

1. Receipts, credit card statements and/or invoices showing that a contracted service was provided;
2. Evidence that the Covered Person was performing the covered activity at the time of the accidental Injury;
3. Evidence that the Covered Person reported the Injury to the provider of any contracted services; and
4. Evidence that covered medical expense was incurred by the Covered Person.

Time of Payment of Claims: Benefits will be paid as soon as We receive proper proof of loss unless the Policy provides for periodic payment. When the Policy provides for periodic payment, the benefits will accrue and will be paid monthly subject to proper Proof of Loss.

Payment of Claims: Benefits payable under this Certificate for a Covered Person's loss of life will be paid to the Covered Person's named Beneficiary, or if there is no named Beneficiary, then to the first surviving class of the Covered Person's relatives listed below. All other benefits will be payable to the Covered Person or to a medical services provider if We have received a valid assignment completed and signed by the Covered Person.

Unless the Covered Person designates a Beneficiary on the enrollment form or by writing to Us, benefits for Death will be paid in equal shares to the first surviving class of beneficiaries below:

1. The Covered Person's living spouse;
2. The Covered Person's living children;
3. The Covered Person's living parents;
4. The Covered Person's living brothers and sisters.

Instead of paying any of the above classes, We may pay benefits to a Covered Person's Estate. Any payment made in good faith shall discharge Our liability to the extent of such payment.

Subject to the Covered Person's written direction or of the Covered Person's legal or natural guardian, if a Covered Person is a minor or otherwise incompetent to make such a direction, all or a portion of any indemnities provided by this Certificate as a result of medical, surgical, dental, hospital or nursing service may, at the Company's option, and unless the Company is requested in writing not later than the time for filing proofs of loss, be paid directly to the hospital or person rendering such services.

Change of Beneficiary: A Covered Person has the right to change the Beneficiary and the consent of the Beneficiary or Beneficiaries shall not be required for any change. A Beneficiary designation must be signed and dated by the Covered Person during his or her lifetime and be received by Us.

Assignment of Benefits: An assignment of benefits is not binding on Us unless:

1. It is a written request; and
2. It is received by Us at our Home Office.

An assignment will take effect when recorded at Our Home Office. We are not responsible for the validity of any assignment. Any payment, made in good faith, fully discharges the Company to the extent of the payment.

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

Legal Actions: A legal action may not be brought to recover on the Policy within 60 days after written Proof of Loss has been given as required. No such action may be brought after 3 years from the time written proof was required to be given.

Subrogation: When benefits are paid to or for a Covered Person under the terms of the Policy, We shall be subrogated, unless otherwise prohibited by law, to a Covered Person's rights of recovery 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 the recovery by the Company of the benefits it has paid for such hospitalization and treatment and the Company shall pay fees and costs associated with such recovery.

Time Limit on Certain Defenses: After 3 years from the date of issue of this Certificate, We will not use a misstatement, except a fraudulent misstatement, made by a Covered Person in the application for this Certificate to void the coverage or to deny a claim for loss incurred or disability, as defined in this Certificate, beginning after the expiration of the 3-year period.

GENERAL PROVISIONS

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

Failure by the Company to enforce any Policy provision shall not waive, modify or render such provision unenforceable at any other time or under any given set of circumstances, whether the circumstances are or are not the same.

Non-Participating: The Policy is non-participating. It does not share in the Company's profits or surplus earnings.

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

Conformity with State Statutes: If any provision of the Policy or this Certificate is contrary to any law to which it is subject, such provision is hereby amended to conform to the minimum requirements of such law.

SCHEDULE OF BENEFITS

Policyholder:	Family First Association
Certificate Effective Date:	February 1, 2022
Eligible Persons:	Persons who are members of an Eligible Class as defined by the Policyholder and agreed to by Us. Eligible Classes are: Class 1: All members of the ABC Association who have purchased a valid lift ticket from a sponsoring resort. Members are eligible for coverage while skiing or snowboarding while on the property of the sponsoring resort for the duration of the time period specified on the lift ticket.
Scope of Coverage:	Limited/Short-Term Accident Coverage

ACCIDENTAL DEATH AND DISMEMBERMENT, LOSS OF SIGHT, SPEECH AND HEARING BENEFIT

The Principal Sum:	\$20,000
Loss of Life	The Principal Sum
Loss of Both Hands	The Principal Sum
Loss of Both Feet	The Principal Sum
Loss of the Entire Sight of Both Eyes	The Principal Sum
Loss of One Hand and One Foot	The Principal Sum
Loss of Speech and Hearing	The Principal Sum
Loss of One Hand or One Foot and Entire Sight of One Eye	The Principal Sum
Loss of One Hand or One Foot	One-Half The Principal Sum
Loss of Entire Sight of One Eye	One-Half The Principal Sum
Loss of Speech or Hearing	One-Half The Principal Sum
Loss of Hearing in One Ear	One-Quarter The Principal Sum
Loss of Thumb and Index Finger of the Same Hand	One-Quarter The Principal Sum

ACCIDENT MEDICAL EXPENSE BENEFITS

Maximum Amount Per Accident (Certificate Limit)	\$20,000
Benefit Percent *	100%
Deductible Per Accident	\$100
Initial Treatment Period	60 Days
Benefit Period	12 Months

BENEFIT MAXIMUMS

Benefits for Covered Charges are Limited as Stated Below

Treatment, services or supplies incurred for:	Maximum Amount:
Hospital Emergency Care	\$500
Hospital Emergency care	
Imaging (X-Ray) and other diagnostic tests	Up to Certificate Limit

Treatment, services or supplies incurred for:	Maximum Amount:
Ambulance Expense: Ground Ambulance expense	Limited to \$250
Prescription Drug Expense	Up to \$500
Hospital room and board, and general nursing care charges, up to the semi-private room rate.	Up to Certificate Limit
Hospital miscellaneous expense during Hospital Confinement or for outpatient surgery under general anesthetic, such as the cost of the operating room, laboratory tests, Imaging (X-Ray) examinations, anesthesia, drugs (excluding take-home drugs) or medicines.	Up to Certificate Limit
Doctor's fees for surgery	Up to Certificate Limit
Anesthesia services	Up to Certificate Limit
Doctors' visits, inpatient and outpatient expenses, each visit:	Limited to \$75
Durable Medical Equipment	Limited to \$100
Dental treatment for Injury to Sound Natural Teeth	\$250 per tooth up to a maximum of \$500
Physical Therapy limited to 1 visit per day and does not apply when related to surgery	\$60 for first visit; \$30 for each visit thereafter
Registered Nurse expense	Up to Certificate Limit

GUARANTEE TRUST LIFE INSURANCE COMPANY PRIVACY NOTICE

At Guarantee Trust Life Insurance Company (GTL) 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 GTL 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

GTL does not disclose any nonpublic personal information about our customers or former customers to anyone without providing notice of the customer's rights to either opt out or opt in the sharing of personal information, 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.

G•T•L
Guarantee Trust Life Insurance Company
1275 Milwaukee Avenue
Glenview, Illinois 60025
1-800-338-7452
Visit us at: www.gtlic.com

GUARANTEE TRUST LIFE INSURANCE COMPANY

1275 Milwaukee Avenue, Glenview, Illinois 60025

1-800-338-7452

CERTIFICATE OF INSURANCE

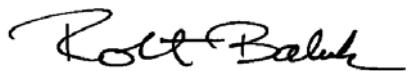
This is Your Certificate of Insurance (Certificate) while You are insured. It briefly explains the rights and benefits that are determined by the Master Policy (Policy). The Policy is a contract between the Policyholder and Us. The Policyholder is shown on the Schedule of Benefits.

The Policy alone constitutes the agreement under which payments are made. We will pay the benefits set forth in the Policy. Benefit payment is governed by all the terms, conditions, provisions, limitations and exclusions of this Certificate and the Policy. The Policy may be amended at any time without Your consent or notice to You. Any such amendment will not affect a claim starting before the amendment takes effect.

Right to Examine: If You are not satisfied with this Certificate, return it to Our home office within ten days after the date You received it. This Certificate will then be canceled and any Premium paid will be refunded.

The Policy is held by the Policyholder. You may inspect it at any time during business hours at the office of the Policyholder.

READ YOUR CERTIFICATE CAREFULLY



Secretary



President

**GROUP ACCIDENT ONLY COVERAGE
THIS IS LIMITED COVERAGE. PLEASE READ YOUR CERTIFICATE CAREFULLY.
NON-PARTICIPATING**

**THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE
FOR MAJOR MEDICAL COVERAGE.**

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DEFINITIONS

Accident: A sudden, unintended and unforeseeable external event to the Covered Person which results in an Injury.

Beneficiary: A person or persons the Covered Person has named to receive any death benefits paid under this Certificate.

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

Covered Accident: An Accident for which coverage is provided and a benefit is payable while a Covered Person's insurance under the Policy and this Certificate are in effect.

Covered Charge: The Reasonable and Customary charge incurred for a medical service or supply listed in this Certificate which is performed or given under the direction of a Doctor for the Medically Necessary treatment of an Injury caused by a Covered Accident. A Covered Charge is considered incurred on the date the medical treatment or service is rendered or the supply is furnished. Benefits for a Covered Charge are payable as indicated in the Policy/Certificate Schedule.

Covered Person: You, or a Dependent:

1. Who is eligible for coverage as a Covered Person;
2. Who has been accepted for coverage or has been automatically added;
3. Who has paid the required premium; and
4. Whose coverage has become effective and has not terminated.

Deductible: The deductible is the amount You must pay before this insurance provides a benefit to You. Any deductible is shown in the Schedule of Benefits. No Benefits will be paid until the deductible is satisfied.

Doctor: A legally qualified person licensed in the healing arts, practicing within the scope of his or her license and who is not a Covered Person or a Family Member.

Durable Medical Equipment: A device which:

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

Durable Medical Equipment does not include:

1. Comfort and convenience items;
2. Equipment that can be used by Family Members other than a Covered Person;
3. Health exercise equipment; and
4. Equipment that may increase the value of a Covered Person's Residence.

Such items that do not qualify as Durable Medical Equipment include, but are not limited to:

1. Modifications to a Covered Person's Residence, property or automobiles, such as ramps;
2. Elevators;
3. Spas;
4. Air conditioners;
5. Vehicle hand controls; or
6. Corrective shoes, exercise and sports equipment.

Eligible Person: A member of the Policyholder's organization as defined on the Schedule of Benefits.

Emergency: An Injury for which a Covered Person seeks immediate medical treatment at the nearest available facility. The condition must be one which manifests itself by acute symptoms which are sufficiently severe (including severe pain) that without immediate medical care a Covered Person could reasonably expect that: (1) the Covered Person's life or health would be in serious jeopardy; (2) the Covered Person's bodily functions would be seriously impaired; or (3) a body organ or part would be seriously damaged.

Emergency Room: A hospital area equipped and staffed for the prompt treatment of acute trauma, or other medical emergencies. An Emergency Room must be licensed by the state in which it is located under applicable State law as an Emergency Room or emergency department and be open 24 hours a day, 7 days a week. For the purposes of the Policy, Emergency Room includes a licensed Urgent Care Facility.

Experimental/Investigational: A drug, device or medical care or treatment will be considered experimental/investigational if:

1. The drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;
2. The informed consent document utilized with the drug, device, medical care or treatment states or indicates that the drug, device, medical care or treatment is part of a clinical trial, experimental phase or investigational phase or if such a consent document is required by law;
3. The drug, device, medical care or treatment or the patient informed consent document utilized with the drug, device or medical care or treatment was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal or state law requires such review and approval;
4. Reliable evidence shows 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 or diagnosis; or
5. 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 or diagnosis.

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

Family Member: A person who is related to a 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).

Ambulance: Means a vehicle which is licensed as an ambulance by the local regulatory body to provide transportation of a Covered Person as a result of a Covered Accident to a Hospital or transportation from one Hospital to another for a Covered Person who is unable to travel to receive medical care by any other means. An Ambulance must contain life-saving equipment and state-certified ambulance personnel.

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

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

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

1. Services would have been covered in a medical facility if Home Health Care were not given; and
2. A Home Health Care treatment plan is set up, in writing and approved by a Doctor.

Hospice Care: Services provided by a licensed public agency or private organization or any subdivision thereof, which entity shall be known as a hospice and shall be primarily engaged in providing care to an individual for whom a certified medical prognosis has been made indicating a life expectancy of six (6) – twelve (12) months or less and who has elected to receive such care in lieu of other medical benefits available under the Policy.

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

1. Is accredited by the Joint Commission or other accreditation organization accepted by a state;
2. Provides 24-hour nursing service by registered nurses (R.N.);
3. Mainly provides diagnostic and therapeutic care under the supervision of Doctors on an inpatient basis; and
4. Maintains permanent surgical facilities or has an arrangement with another surgical facility supervised by a staff of one or more Doctors.

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

Hospital does not include a place, special ward, floor or other accommodation used for: custodial or educational care; rest; the aged; a nursing home or an institution mainly rendering treatment or services for mental illness or substance misuse.

Immediate Care Facility: A walk-in clinic focused on the delivery of medical care for minor injuries in an ambulatory medical facility outside of a traditional hospital-based or freestanding emergency department.

Independent Contractor: An Independent Contractor who has agreed to perform services for entities or individuals that contract with independent workers for short- or long-term or intermittent engagements. Temporary coverage is provided for the period of time the worker is actively logged into an entity's mobile device application or platform and engaged in work for the entity or individual. The term 'Independent Contractor' also includes temporary workers and consultants who are not permanent employees.

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

Injury: Bodily injury due to a Covered Accident which:

1. Results solely and directly from a Covered Accident, independently of disease, bodily infirmity or any other causes;
2. Occurs after the effective date of a Covered Person's coverage under the Policy; and
3. Occurs while the coverage is in force.

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

Intensive Care Unit (ICU): A specifically designed facility of the Hospital that provides the highest level of medical care; and which is restricted to those patients who are critically ill or injured. Such facility must be separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient confinement. They must be permanently equipped with special life-saving equipment for the care of the critically ill or injured; and under constant and continuous observation by nursing staff assigned on a full-time basis, exclusively to the Intensive Care Unit. Intensive Care Unit does not mean any of these step-down units: progressive care; sub-acute intensive care; intermediate care units; private monitored rooms; observation units; or other facilities which do not meet the standards for Intensive Care.

Medically Necessary: A treatment, drug, device, procedure, supply or service that is necessary and appropriate for the diagnosis or treatment of an Injury as determined by Your Doctor in accordance with generally accepted standards of medical and dental 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. For Accident Related Dental services this means Services which are needed due to an accidental injury caused by a force outside of the mouth or body.

A treatment, drug, device, procedure, supply or service shall not be considered as Medically Necessary if:

1. Is Experimental/Investigational or for research purposes;
2. Is provided solely for education purposes or the convenience of a Covered Person's family, Doctor, Hospital or any other medical provider;
3. 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;
4. Could have been omitted without adversely affecting the person's condition or the quality of medical care;
5. Involves the use of a medical device, drug or substance not formally approved by the United States Food and Drug Administration;

6. Involves a service, supply or drug not considered reasonable and necessary by the Healthcare Financing Administration Medicare Coverage Issues Manual; or
7. Can be safely provided to the patient on a more cost-effective basis such as outpatient, by a different medical professional, or pursuant to a more conservative form of treatment.

We reserve the right to determine whether a service, supply or drug is Medically Necessary.

Orthopedic Appliances: Any supportive device or appliance used in treating a Covered Person's Injury.

Other Valid and Collectible Insurance or Plan: Any reimbursement for or recovery of any element of Covered Charges incurred by the Covered Person available from any other source whatsoever, except gifts and donations, but including without limitation:

1. Any individual, group, blanket, or franchise policy of accident, disability or health insurance;
2. Any arrangement of benefits for members of a group, whether insured or uninsured;
3. Any prepaid service arrangement including a health maintenance or preferred provider organization or any other health benefit plan;
4. Any amount payable for Hospital, medical or other health services. Injury arising out of a motor vehicle accident to the extent such benefits are payable under any medical expense payment provision (by whatever terminology used including such benefits mandated by law) of any motor vehicle insurance policy.
5. Any amount payable for services or injuries or diseases related to a Covered Person's occupation to the extent that the Covered Person actually received benefits under a Worker's Compensation Law or if the Covered Person enters into a settlement to give up his or her rights to recover future medical expenses that would have been payable except for that settlement;
6. Social Security Disability Benefits, except that Other Valid and Collectible Insurance or Plan shall not include any increase in Social Security Disability Benefits payable to the Covered Person after the Covered Person becomes disabled while insured hereunder.
7. Any benefits payable under any program provided or sponsored solely or primarily by any governmental agency or subdivision or through operation of law or regulation.
8. Any medical expense coverage an Independent Contractor carries.

Physical Therapy: Non-surgical physical or mechanical therapy, diathermy, ultrasonic therapy, heat treatment in any form or massage that is intended to preserve, enhance, or restore movement and physical function impaired by Injury. For the purposes of this coverage, chiropractic treatment is not deemed to be Physical Therapy. Physical Therapy must be prescribed by a Doctor and be based upon a plan of treatment for a specified period of time or number of visits.

Policyholder: The entity to which the Policy is issued.

Prescription Drugs: Drugs which may only be dispensed by written prescription under Federal law and are approved for general use by the Food and Drug Administration. The drugs must be dispensed by a licensed pharmacy provider for a Covered Person's outpatient use.

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

1. The actual amount charged by the medical provider;
2. The negotiated rate; or
3. The charge which would have been made by the medical provider for a comparable service or supply made by other providers in the same Geographic Area as reasonably determined by us for the same service or supply.

"Geographic Area" means the three digit zip code in which the service, treatment, procedure, drugs or supplies are provided; or a greater area if necessary to obtain a representative cross-section of charge for a like treatment, service, procedure, device drug or supply.

Rehabilitation Facility: An institution, or part of an institution, licensed, accredited or certified by the State which:

1. Is accredited by the Joint Commission, the Commission on Accreditation of Rehabilitation Facilities or other accreditation organizations accepted by a state;
2. Is primarily engaged in providing comprehensive multi-disciplinary physical services or rehabilitation inpatient care; and
3. Has a transfer agreement with one or more Hospitals.

Rehabilitation Facility does not include an institution which:

1. Provides only minimal care, custodial care, care for the terminally ill, or part-time care services;
2. Primarily provides treatment for mental disorders, chemical dependency or tuberculosis, except if such facility is licensed, certified, or approved as a rehabilitation facility for the treatment of medical conditions; drug addiction or alcoholism.

Residence: The home and land or property on which a Covered Person's dwelling or home is located.

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

Telehealth Care Benefit: We agree to reimburse up to the Doctor's office visit benefit for each Telehealth Care service provided due to accidental Injury. This benefit is subject to the Certificate maximums.

Transportation Network Company: An entity that uses a digital network to connect riders to drivers for the purpose of providing transportation. Transportation Network Company does not include a taxi service or ridesharing arrangements.

Urgent Care Facility: A healthcare facility, which is part of or affiliated with a Hospital, providing short-term medical care for non-life-threatening conditions without an appointment but where immediate medical care is necessary. If required, the facility must be accredited by the Urgent Care Association of America (UCAOA) and/or the American Academy of Urgent Care Medicine, if required in a state, and:

1. Must accept walk-in patients during business hours;
2. Must treat a broad spectrum of injuries, as well as perform minor medical procedures;
3. Have a licensed physician operating as the medical director;
4. Have on-site diagnostic equipment, including x-ray; and
5. Must contain communication lines with local hospitals so that patients who need transfer to an Emergency Room have easy access.

We, Us and Our: Guarantee Trust Life Insurance Company.

You, Your and Yours: The Covered Person to whom this Certificate is issued and whose insurance is in force under the terms of the Policy.

CONDITIONS OF INSURANCE

ELIGIBILITY

Eligible Persons are described in the Schedule of Benefits. A person is insured under the Policy provided such person satisfies the eligibility requirements, becomes insured and remains insured under the terms of the Policy.

EFFECTIVE DATE

Covered Person: Coverage is effective, subject to receipt of premium, on the date agreed to by the Policyholder and Us.

TERMINATION

Covered Person: Coverage will terminate at the earlier of:

1. The date the Policy terminates;
2. The date the Covered Person ceases to be an Eligible Person;
3. The end of the period for which any applicable premium has been paid by the Policyholder on behalf of the Covered Person;
4. The date of entry of a valid judgment of dissolution of marriage between You and a Dependent spouse on the premium due date that follows the judgement.

5. The date of fraud or knowingly misrepresenting a material fact by any Covered Person. Material misrepresentation includes a failure to disclose other coverages a Covered Person has.

SCOPE OF COVERAGE

Please see the Scope of Coverage section in the Schedule of Benefits. There a Covered Person will find which of the following types of Accident coverage apply to the Covered Person's benefit plan.

Limited/Short-Term Accident Coverage - As shown in the Schedule, for users of specified products and/or services. The user of a specified product or service must have contracted with and paid the fee(s) to use the specified product or service.

- Coverage begins at the start of the contracted and paid service term and ends when the contracted and paid service term ends.

The Covered Person must provide evidence of a contractual agreement and that they were engaged in the use of the specified product or service described above at the time of an accidental Injury. Any receipt or record must show the date and time of the contracted and paid service.

ACCIDENTAL DEATH AND DISMEMBERMENT, LOSS OF SIGHT, SPEECH AND HEARING BENEFIT

If, within 365 days from the date of a Covered Accident, Injury from such Covered Accident results in a loss covered by this benefit, We will pay the benefit in the amount set opposite such loss, as shown on the Schedule of Benefits. If a Covered Person sustains more than one such loss as the result of the Covered Accident, We will pay only one amount, the largest to which a Covered Person is entitled.

Loss of hand or foot means loss by severance at or above the wrist or ankle joint. Loss of sight means the total, permanent loss of sight of the eye. The loss of sight must be irrecoverable by natural, surgical or artificial means. Loss of speech means total, permanent and irrecoverable loss of audible communication. Loss of hearing means total and permanent loss of hearing in both ears which cannot be corrected by any 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.

ACCIDENT MEDICAL EXPENSE BENEFITS

After any Deductible has been satisfied, We will pay benefits, as defined and limited below, for Covered Charges incurred by a Covered Person due to Injury caused by a Covered Accident.

Covered Charges are payable only for an Injury:

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

Covered Charges are shown on the Schedule of Benefits.

No Other Valid and Collectible Insurance or Plan

We will pay the Benefit Percent of incurred Covered Charges up to the Maximum Benefit Amount, Per Injury, subject to the terms, conditions, provisions, limitations, exclusions and other provisions of the Policy/Certificate.

Other Valid and Collectible Insurance or Plan

After any Deductible has been satisfied, We will pay the Benefit Percent of incurred Covered Charges which are in excess of the total benefits payable for the same Injury by any Other Valid and Collectible Insurance or Plan on a provision of service or on an expense incurred basis, up to the Maximum Benefit Amount, Per Accident. Benefit payment is subject to the terms, conditions, provisions, limitations, exclusions and other provisions of the Policy/Certificate.

A Covered Person must provide Us with proof of the amount of benefits paid by Other Valid and Collectible Insurance or Plan or proof of denial of benefits by Other Valid and Collectible Insurance or Plan.

If, for any reason, a Covered Person fails to apply for benefits from Other Valid and Collectible Insurance or Plan, We will pay the benefit that would have been paid under the Policy had the Covered Person filed a claim under the Other Valid and Collectible Insurance or Plan.

If Other Valid and Collectible Insurance or Plan provides benefits on an excess coverage basis, benefits will be paid first by the company or services plan whose policy or service contract has been in effect for the longer period of time at the date of the Injury.

EXCLUSIONS

The Policy/Certificate does not provide benefits for:

- Treatment, services or supplies which:
 - Are not Medically Necessary;
 - Are not prescribed by a Doctor as necessary to treat an Injury;
 - Are determined to be Experimental/Investigational in nature;
 - Are received without charge or legal obligation to pay;
 - Are received from persons employed or retained by any Family Member, unless otherwise specified; or
 - Are not specifically listed as Covered Charges in the Policy.
- Injury by acts of war, whether declared or not;
- Injury received while traveling or flying by air, except as a fare-paying passenger and not as a pilot or crew member, on a regularly scheduled commercial airline.
- Injury covered by Worker's Compensation, Employer Liability law or Occupational Disease Act or Law;
- Dental treatment, except as specifically stated;
- Injury sustained while committing or attempting to commit a felony;
- Prescription Drugs except as specifically stated;
- Suicide or attempted suicide while sane or insane;
- Intentionally self-inflicted Injury;
- Loss resulting from being legally intoxicated or under the influence of alcohol as defined by the laws of the state or jurisdiction in which the Injury occurs;
- Loss resulting from being under the influence of any drugs or narcotic unless administered on the advice of a Doctor;
- Injury sustained while participating in or practicing for any professional, intercollegiate or club sports activity.
- Injury which occurs while a Covered Person is on active duty service in any armed forces. Reserve or National Guard active duty for training is not excluded unless it extends beyond 31 days;
- Injury sustained flying in an ultra-light, hang gliding, parachuting or bungee cord jumping, by flight in a space craft or any craft designed for navigation above or beyond the earth's atmosphere;
- Injury sustained while driving or riding on vehicles for off-road use including but not limited to all-terrain vehicles (ATV's);
- Injury sustained where a Covered Person is the operator and does not possess a current and valid motor vehicle operator's license, except in a Driver's Education Program;
- Treatment in any Veteran's Administration or federal Hospital, except if there is a legal obligation to pay;
- Cosmetic surgery, except for reconstructive surgery on an injured part of the body;
- Covered Charges incurred outside of the United States or its possessions
- Competing in motor sports races or competitions;
- Competing in water sports races or competitions;
- Testing cars/trucks on any racetrack or speedway;
- Handling, storing or transporting explosives;
- Scaling up cliffs or mountain walls;
- Spelunking (exploring caves);
- Injuries that result from working with animals;
- Injury sustained while water skiing or surfboarding;
- Injury sustained while roller blading or skateboarding;

EXCLUSIONS, continued

- Injury sustained while participating in a rodeo.
- Re-injury or complications of an Injury caused or contributed to by a condition that existed before the Accident.
- Repetitive motion injuries, strains, hernia, tendonitis, bursitis and heat exhaustion not related to a specific Injury.
- Individual allergic reactions due to exposure to common environmental stimuli, which include, but are not limited to, insects, animals, food, and medication;
- Any claim for which a Covered Person knowingly misrepresents a fact that is material to the claim; and
- Mental or Nervous disorders, including post-traumatic stress disorders.

PREMIUM

Premiums are due and payable in advance by You. Premiums are payable to the Company at its Home Office. Payment of a premium will not maintain the insurance in force beyond the period for which it is paid except for the Grace Period provision.

The premium rates may be changed by the Company. If the rates are changed, the Company will give the Policyholder and You at least 60 days advance written notice. If a change in benefits contained in the Policy increases the Company's liability, premium rates may be changed on the date the Company's liability is increased.

CLAIM PROVISIONS

Notice of Claim: Written notice of claim must be given to the Company or its authorized representative within 60 days after a covered loss starts, or as soon thereafter as is reasonably possible. Notice should include information sufficient to identify the Covered Person.

Claim Forms: The Company, upon receipt of written notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing Proofs of Loss. If such forms are not furnished within 15 days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of the Policy as to Proof of Loss upon submitting, within the time fixed in the Policy for filing Proof of Loss, written proof covering the occurrence, the character, and the extent of the loss for which claim is made.

Proof of Loss: Proof of Loss as required by the Company must be given to the Company within 90 days after the loss. The Company will accept late proof if:

1. It was not reasonably possible to give proof in that time; and
2. The proof is given within twelve (12) months from the date of loss. This twelve (12) month limit will not apply in the absence of legal capacity.

Proof of Loss includes, but is not limited to:

1. Receipts, credit card statements and/or invoices showing that a contracted service was provided;
2. Evidence that the Covered Person was performing the covered activity at the time of the accidental Injury;
3. Evidence that the Covered Person reported the Injury to the provider of any contracted services; and
4. Evidence that covered medical expense was incurred by the Covered Person.

Time of Payment of Claims: Benefits will be paid as soon as We receive proper proof of loss unless the Policy provides for periodic payment. When the Policy provides for periodic payment, the benefits will accrue and will be paid monthly subject to proper Proof of Loss.

Payment of Claims: Benefits payable under this Certificate for a Covered Person's loss of life will be paid to the Covered Person's named Beneficiary, or if there is no named Beneficiary, then to the first surviving class of the Covered Person's relatives listed below. All other benefits will be payable to the Covered Person or to a medical services provider if We have received a valid assignment completed and signed by the Covered Person.

Unless the Covered Person designates a Beneficiary on the enrollment form or by writing to Us, benefits for Death will be paid in equal shares to the first surviving class of beneficiaries below:

1. The Covered Person's living spouse;
2. The Covered Person's living children;
3. The Covered Person's living parents;
4. The Covered Person's living brothers and sisters.

Instead of paying any of the above classes, We may pay benefits to a Covered Person's Estate. Any payment made in good faith shall discharge Our liability to the extent of such payment.

Subject to the Covered Person's written direction or of the Covered Person's legal or natural guardian, if a Covered Person is a minor or otherwise incompetent to make such a direction, all or a portion of any indemnities provided by this Certificate as a result of medical, surgical, dental, hospital or nursing service may, at the Company's option, and unless the Company is requested in writing not later than the time for filing proofs of loss, be paid directly to the hospital or person rendering such services.

Change of Beneficiary: A Covered Person has the right to change the Beneficiary and the consent of the Beneficiary or Beneficiaries shall not be required for any change. A Beneficiary designation must be signed and dated by the Covered Person during his or her lifetime and be received by Us.

Assignment of Benefits: An assignment of benefits is not binding on Us unless:

1. It is a written request; and
2. It is received by Us at our Home Office.

An assignment will take effect when recorded at Our Home Office. We are not responsible for the validity of any assignment. Any payment, made in good faith, fully discharges the Company to the extent of the payment.

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

Legal Actions: A legal action may not be brought to recover on the Policy within 60 days after written Proof of Loss has been given as required. No such action may be brought after 3 years from the time written proof was required to be given.

Subrogation: When benefits are paid to or for a Covered Person under the terms of the Policy, We shall be subrogated, unless otherwise prohibited by law, to a Covered Person's rights of recovery 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 the recovery by the Company of the benefits it has paid for such hospitalization and treatment and the Company shall pay fees and costs associated with such recovery. Our right of subrogation may not be enforced until the Covered Person has been fully compensated for their injuries.

GENERAL PROVISIONS

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

Failure by the Company to enforce any Policy provision shall not waive, modify or render such provision unenforceable at any other time or under any given set of circumstances, whether the circumstances are or are not the same.

Non-Participating: The Policy is non-participating. It does not share in the Company's profits or surplus earnings.

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

Conformity with Montana Statutes: The provisions of this policy conform to the minimum requirements of Montana law and control over any conflicting statutes of any state in which the insured resides on or after the effective date of this policy.

SCHEDULE OF BENEFITS

Policyholder:	Family First Association
Certificate Effective Date:	February 1, 2022
Eligible Persons:	Persons who are members of an Eligible Class as defined by the Policyholder and agreed to by Us. Eligible Classes are: Class 1: All members of the ABC Association who have purchased a valid lift ticket from a sponsoring resort. Members are eligible for coverage while skiing or snowboarding while on the property of the sponsoring resort for the duration of the time period specified on the lift ticket.
Scope of Coverage:	Limited/Short-Term Accident Coverage

ACCIDENTAL DEATH AND DISMEMBERMENT, LOSS OF SIGHT, SPEECH AND HEARING BENEFIT

The Principal Sum:	\$20,000
Loss of Life	The Principal Sum
Loss of Both Hands	The Principal Sum
Loss of Both Feet	The Principal Sum
Loss of the Entire Sight of Both Eyes	The Principal Sum
Loss of One Hand and One Foot	The Principal Sum
Loss of Speech and Hearing	The Principal Sum
Loss of One Hand or One Foot and Entire Sight of One Eye	The Principal Sum
Loss of One Hand or One Foot	One-Half The Principal Sum
Loss of Entire Sight of One Eye	One-Half The Principal Sum
Loss of Speech or Hearing	One-Half The Principal Sum
Loss of Hearing in One Ear	One-Quarter The Principal Sum
Loss of Thumb and Index Finger of the Same Hand	One-Quarter The Principal Sum

ACCIDENT MEDICAL EXPENSE BENEFITS

Maximum Amount Per Accident (Certificate Limit)	\$20,000
Benefit Percent *	100%
Deductible Per Accident	\$100
Initial Treatment Period	60 Days
Benefit Period	12 Months

BENEFIT MAXIMUMS

Benefits for Covered Charges are Limited as Stated Below

Treatment, services or supplies incurred for:	Maximum Amount:
Hospital Emergency Care Hospital Emergency care	\$500
Imaging (X-Ray) and other diagnostic tests	Up to Certificate Limit
Ambulance Expense: Ground Ambulance expense	Limited to \$250
Prescription Drug Expense	Up to \$500
Hospital room and board, and general nursing care charges, up to the semi-private room rate.	Up to Certificate Limit
Hospital miscellaneous expense during Hospital Confinement or for outpatient surgery under general anesthetic, such as the cost of the operating room, laboratory tests, Imaging (X-Ray) examinations, anesthesia, drugs (excluding take-home drugs) or medicines.	Up to Certificate Limit
Doctor's fees for surgery	Up to Certificate Limit
Anesthesia services	Up to Certificate Limit
Doctors' visits, inpatient and outpatient expenses, each visit:	Limited to \$75
Durable Medical Equipment	Limited to \$100
Dental treatment for Injury to Sound Natural Teeth	\$250 per tooth up to a maximum of \$500
Physical Therapy limited to 1 visit per day and does not apply when related to surgery	\$60 for first visit; \$30 for each visit thereafter
Registered Nurse expense	Up to Certificate Limit

GUARANTEE TRUST LIFE INSURANCE COMPANY PRIVACY NOTICE

At Guarantee Trust Life Insurance Company (GTL) 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 GTL 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

GTL does not disclose any nonpublic personal information about our customers or former customers to anyone without providing notice of the customer's rights to either opt out or opt in the sharing of personal information, 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.

G•T•L
Guarantee Trust Life Insurance Company
1275 Milwaukee Avenue
Glenview, Illinois 60025
1-800-338-7452
Visit us at: www.gtlic.com

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

This notice provides a **brief summary** of the Montana Life and Health Insurance Guaranty Association (Association) and the protection it provides for policyholders, effective January 1, 2020.

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

In the event a company is placed into liquidation, benefits provided by the Association are payable according to the insurance policy or certificate subject to the terms and conditions found in the Montana Life and Health Insurance Guaranty Association law, and subject to the following maximum limits:

- Life Insurance - \$300,000 in death benefits, but limited to \$100,000 in cash surrender and net cash withdrawal values
- Health Insurance
 - \$500,000 in health insurance benefits
 - \$300,000 in disability income insurance benefits
 - \$300,000 in long-term care insurance benefits
 - \$100,000 in other types of health insurance benefits
- Annuities - \$250,000 present value, including net cash surrender and net cash withdrawal values

The maximum amount of protection is \$300,000 in benefits with respect to any one life regardless of the number of policies or contracts, except with respect to the \$500,000 maximum in health insurance benefits but not including disability, long term care or other types of health insurance benefits.

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

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

Montana Life and Health Insurance Guaranty Association PO Box 8247 Missoula, MT 59807 877-678-1048 or administrator@mtlifega.org	Office of the Montana State Auditor Commissioner of Securities and Insurance 840 Helena Ave. Helena, MT 59601 406-444-2040
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IF YOUR INSURANCE COMPANY IS IN GOOD STANDING AND NOT IN LIQUIDATION, PLEASE DIRECT QUESTIONS ABOUT YOUR POLICY TO YOUR INSURANCE COMPANY!

Insurance companies and agents are not allowed by Montana law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance.

When selecting an insurance company, you should not rely on Association coverage.

If there is any inconsistency between this notice and Montana law, then Montana law will control.

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

RIDER

This rider is a part of the policy or certificate to which it is attached. It takes effect on the Effective Date of the policy or certificate.

The following provision is hereby added to the policy or certificate:

CONFORMITY WITH MONTANA STATUTES

The provisions of the policy or certificate conform to the minimum requirements of Montana law and control over any conflicting statutes of any state in which the insured resides on or after the effective date of this policy or certificate.

The policy or certificate is hereby amended as follows:

STATEMENT OF SEX

All reference to sex is deleted in the policy or certificate and attachments.

This rider is subject to all the terms and provisions of the policy or certificate except where changed by this rider.

Thomas J. Gruelof
Secretary

R. K. Johnson
President

GUARANTEE TRUST LIFE INSURANCE COMPANY

1275 Milwaukee Avenue, Glenview, Illinois 60025

1-800-338-7452

CERTIFICATE OF INSURANCE

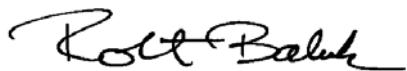
This is Your Certificate of Insurance (Certificate) while You are insured. It briefly explains the rights and benefits that are determined by the Master Policy (Policy). The Policy is a contract between the Policyholder and Us. The Policyholder is shown on the Schedule of Benefits.

The Policy alone constitutes the agreement under which payments are made. We will pay the benefits set forth in the Policy. Benefit payment is governed by all the terms, conditions, provisions, limitations and exclusions of this Certificate and the Policy. The Policy may be amended at any time without Your consent or notice to You. Any such amendment will not affect a claim starting before the amendment takes effect.

Right to Examine: If You are not satisfied with this Certificate, return it to Our home office within ten days after the date You received it. This Certificate will then be canceled and any Premium paid will be refunded.

The Policy is held by the Policyholder. You may inspect it at any time during business hours at the office of the Policyholder.

READ YOUR CERTIFICATE CAREFULLY



Secretary



President

GROUP ACCIDENT ONLY COVERAGE

THIS IS LIMITED COVERAGE – READ IT CAREFULLY NON-PARTICIPATING

**THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE
FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM
ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.**

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DEFINITIONS

Accident: A sudden, unintended and unforeseeable external event to the Covered Person which results in an Injury.

Beneficiary: A person or persons the Covered Person has named to receive any death benefits paid under this Certificate.

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

Covered Accident: An Accident for which coverage is provided and a benefit is payable while a Covered Person's insurance under the Policy and this Certificate are in effect.

Covered Charge: The Reasonable and Customary charge incurred for a medical service or supply listed in this Certificate which is performed or given under the direction of a Doctor for the Medically Necessary treatment of an Injury caused by a Covered Accident. A Covered Charge is considered incurred on the date the medical treatment or service is rendered or the supply is furnished. Benefits for a Covered Charge are payable as indicated in the Policy/Certificate Schedule.

Covered Person: You, or a Dependent:

1. Who is eligible for coverage as a Covered Person;
2. Who has been accepted for coverage or has been automatically added;
3. Who has paid the required premium; and
4. Whose coverage has become effective and has not terminated.

Doctor: A legally qualified person licensed in the healing arts, practicing within the scope of his or her license and who is not a Covered Person or a Family Member.

Durable Medical Equipment: A device which:

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

Durable Medical Equipment does not include:

1. Comfort and convenience items;
2. Equipment that can be used by Family Members other than a Covered Person;
3. Health exercise equipment; and
4. Equipment that may increase the value of a Covered Person's Residence.

Such items that do not qualify as Durable Medical Equipment include, but are not limited to:

1. Modifications to a Covered Person's Residence, property or automobiles, such as ramps;
2. Elevators;
3. Spas;
4. Air conditioners;
5. Vehicle hand controls; or
6. Corrective shoes, exercise and sports equipment.

Eligible Person: A member of the Policyholder's organization as defined on the Schedule of Benefits.

Emergency: An Injury for which a Covered Person seeks immediate medical treatment at the nearest available facility. The condition must be one which manifests itself by acute symptoms which are sufficiently severe (including severe pain) that without immediate medical care a Covered Person could reasonably expect that: (1) the Covered Person's life or health would be in serious jeopardy; (2) the Covered Person's bodily functions would be seriously impaired; or (3) a body organ or part would be seriously damaged.

Emergency Room: A hospital area equipped and staffed for the prompt treatment of acute trauma, or other medical emergencies. An Emergency Room must be licensed by the state in which it is located under applicable State law as an Emergency Room or emergency department and be open 24 hours a day, 7 days a week. For the purposes of the Policy, Emergency Room includes a licensed Urgent Care Facility.

Experimental/Investigational: A drug, device or medical care or treatment will be considered experimental/investigational if:

1. The drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;
2. The informed consent document utilized with the drug, device, medical care or treatment states or indicates that the drug, device, medical care or treatment is part of a clinical trial, experimental phase or investigational phase or if such a consent document is required by law;
3. The drug, device, medical care or treatment or the patient informed consent document utilized with the drug, device or medical care or treatment was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal or state law requires such review and approval;
4. Reliable evidence shows 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 or diagnosis; or
5. 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 or diagnosis.

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

Family Member: A person who is related to a Covered Person in any of the following ways: spouse, parent (includes stepparent), brother or sister (includes stepbrother or stepsister), or child (includes legally adopted, step or foster child).

Ambulance: Means a vehicle which is licensed as an ambulance by the local regulatory body to provide transportation of a Covered Person as a result of a Covered Accident to a Hospital or transportation from one Hospital to another for a Covered Person who is unable to travel to receive medical care by any other means. An Ambulance must contain life-saving equipment and state-certified ambulance personnel.

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

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

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

1. Services would have been covered in a medical facility if Home Health Care were not given; and
2. A Home Health Care treatment plan is set up, in writing and approved by a Doctor.

Hospice Care: Services provided by a licensed public agency or private organization or any subdivision thereof, which entity shall be known as a hospice and shall be primarily engaged in providing care to an individual for whom a certified medical prognosis has been made indicating a life expectancy of six (6) – twelve (12) months or less and who has elected to receive such care in lieu of other medical benefits available under the Policy.

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

1. Is accredited by the Joint Commission or other accreditation organization accepted by a state;
2. Provides 24-hour nursing service by registered nurses (R.N.);
3. Mainly provides diagnostic and therapeutic care under the supervision of Doctors on an inpatient basis; and
4. Maintains permanent surgical facilities or has an arrangement with another surgical facility supervised by a staff of one or more Doctors.

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

Hospital does not include a place, special ward, floor or other accommodation used for: custodial or educational care; rest; the aged; a nursing home or an institution mainly rendering treatment or services for mental illness or substance misuse.

Immediate Care Facility: A walk-in clinic focused on the delivery of medical care for minor injuries in an ambulatory medical facility outside of a traditional hospital-based or freestanding emergency department.

Independent Contractor: An Independent Contractor who has agreed to perform services for entities or individuals that contract with independent workers for short- or long-term or intermittent engagements. Temporary coverage is provided for the period of time the worker is actively logged into an entity's mobile device application or platform and engaged in work for the entity or individual. The term 'Independent Contractor' also includes temporary workers and consultants who are not permanent employees.

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

Injury: accidental bodily injuries sustained by the insured person which are the direct and independent cause of the loss and occur while the insurance is in force.

Intensive Care Unit (ICU): A specifically designed facility of the Hospital that provides the highest level of medical care; and which is restricted to those patients who are critically ill or injured. Such facility must be separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient confinement. They must be permanently equipped with special life-saving equipment for the care of the critically ill or injured; and under constant and continuous observation by nursing staff assigned on a full-time basis, exclusively to the Intensive Care Unit. Intensive Care Unit does not mean any of these step-down units: progressive care; sub-acute intensive care; intermediate care units; private monitored rooms; observation units; or other facilities which do not meet the standards for Intensive Care.

Medically Necessary: A treatment, drug, device, procedure, supply or service that is necessary and appropriate for the diagnosis or treatment of an Injury as determined by Your Doctor in accordance with generally accepted standards of medical and dental 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. For Accident Related Dental services this means Services which are needed due to an accidental injury caused by a force outside of the mouth or body.

A treatment, drug, device, procedure, supply or service shall not be considered as Medically Necessary if:

1. Is Experimental/Investigational or for research purposes;
2. Is provided solely for education purposes or the convenience of a Covered Person's family, Doctor, Hospital or any other medical provider;
3. 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;
4. Could have been omitted without adversely affecting the person's condition or the quality of medical care;
5. Involves the use of a medical device, drug or substance not formally approved by the United States Food and Drug Administration;
6. Involves a service, supply or drug not considered reasonable and necessary by the Healthcare Financing Administration Medicare Coverage Issues Manual; or
7. Can be safely provided to the patient on a more cost-effective basis such as outpatient, by a different medical professional, or pursuant to a more conservative form of treatment.

We reserve the right to determine whether a service, supply or drug is Medically Necessary.

Orthopedic Appliances: Any supportive device or appliance used in treating a Covered Person's Injury.

Other Valid and Collectible Insurance or Plan: Any reimbursement for or recovery of any element of Covered Charges incurred by the Covered Person available from any other source whatsoever, except gifts and donations, but including without limitation:

1. Any individual, group, blanket, or franchise policy of accident, disability or health insurance;
2. Any arrangement of benefits for members of a group, whether insured or uninsured;
3. Any prepaid service arrangement including a health maintenance or preferred provider organization or any other health benefit plan;
4. Any amount payable for Hospital, medical or other health services. Injury arising out of a motor vehicle accident to the extent such benefits are payable under any medical expense payment provision (by whatever terminology used including such benefits mandated by law) of any motor vehicle insurance policy.
5. Any amount payable for services or injuries or diseases related to a Covered Person's occupation to the extent that the Covered Person actually received benefits under a Worker's Compensation Law or if the Covered Person enters into a settlement to give up his or her rights to recover future medical expenses that would have been payable except for that settlement;
6. Social Security Disability Benefits, except that Other Valid and Collectible Insurance or Plan shall not include any increase in Social Security Disability Benefits payable to the Covered Person after the Covered Person becomes disabled while insured hereunder.
7. Any benefits payable under any program provided or sponsored solely or primarily by any governmental agency or subdivision or through operation of law or regulation.
8. Any medical expense coverage an Independent Contractor carries.

Physical Therapy: Non-surgical physical or mechanical therapy, diathermy, ultrasonic therapy, heat treatment in any form or massage that is intended to preserve, enhance, or restore movement and physical function impaired by Injury. For the purposes of this coverage, chiropractic treatment is not deemed to be Physical Therapy. Physical Therapy must be prescribed by a Doctor and be based upon a plan of treatment for a specified period of time or number of visits.

Policyholder: The entity to which the Policy is issued.

Prescription Drugs: Drugs which may only be dispensed by written prescription under Federal law and are approved for general use by the Food and Drug Administration. The drugs must be dispensed by a licensed pharmacy provider for a Covered Person's outpatient use.

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

1. The actual amount charged by the medical provider;
2. The negotiated rate; or
3. The charge which would have been made by the medical provider for a comparable service or supply made by other providers in the same Geographic Area as reasonably determined by us for the same service or supply.

"Geographic Area" means the three digit zip code in which the service, treatment, procedure, drugs or supplies are provided; or a greater area if necessary to obtain a representative cross-section of charge for a like treatment, service, procedure, device drug or supply.

Rehabilitation Facility: An institution, or part of an institution, licensed, accredited or certified by the State which:

1. Is accredited by the Joint Commission, the Commission on Accreditation of Rehabilitation Facilities or other accreditation organizations accepted by a state;
2. Is primarily engaged in providing comprehensive multi-disciplinary physical services or rehabilitation inpatient care; and
3. Has a transfer agreement with one or more Hospitals.

Rehabilitation Facility does not include an institution which:

1. Provides only minimal care, custodial care, care for the terminally ill, or part-time care services;
2. Primarily provides treatment for mental disorders, chemical dependency or tuberculosis, except if such facility is licensed, certified, or approved as a rehabilitation facility for the treatment of medical conditions; drug addiction or alcoholism.

Residence: The home and land or property on which a Covered Person's dwelling or home is located.

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

Telehealth Care Benefit: We agree to reimburse up to the Doctor's office visit benefit for each Telehealth Care service provided due to accidental Injury. This benefit is subject to the Certificate maximums.

Transportation Network Company: An entity that uses a digital network to connect riders to drivers for the purpose of providing transportation. Transportation Network Company does not include a taxi service or ridesharing arrangements.

Urgent Care Facility: A healthcare facility, which is part of or affiliated with a Hospital, providing short-term medical care for non-life-threatening conditions without an appointment but where immediate medical care is necessary. If required, the facility must be accredited by the Urgent Care Association of America (UCAOA) and/or the American Academy of Urgent Care Medicine, if required in a state, and:

1. Must accept walk-in patients during business hours;
2. Must treat a broad spectrum of injuries, as well as perform minor medical procedures;
3. Have a licensed physician operating as the medical director;
4. Have on-site diagnostic equipment, including x-ray; and
5. Must contain communication lines with local hospitals so that patients who need transfer to an Emergency Room have easy access.

We, Us and Our: Guarantee Trust Life Insurance Company.

You, Your and Yours: The Covered Person to whom this Certificate is issued and whose insurance is in force under the terms of the Policy.

CONDITIONS OF INSURANCE

ELIGIBILITY

Eligible Persons are described in the Schedule of Benefits. A person is insured under the Policy provided such person satisfies the eligibility requirements, becomes insured and remains insured under the terms of the Policy.

EFFECTIVE DATE

Covered Person: Coverage is effective, subject to receipt of premium, on the date agreed to by the Policyholder and Us.

TERMINATION

Covered Person: Coverage will terminate at the earlier of:

1. The date the Policy terminates;
2. The date the Covered Person ceases to be an Eligible Person;
3. The end of the period for which any applicable premium has been paid by the Policyholder on behalf of the Covered Person;
4. The date of entry of a valid judgment of dissolution of marriage between You and a Dependent spouse on the premium due date that follows the judgement.
5. The date of fraud or knowingly misrepresenting a material fact by any Covered Person. Material misrepresentation includes a failure to disclose other coverages a Covered Person has.

SCOPE OF COVERAGE

Please see the Scope of Coverage section in the Schedule of Benefits. There a Covered Person will find which of the following types of Accident coverage apply to the Covered Person's benefit plan.

Limited/Short-Term Accident Coverage - As shown in the Schedule, for users of specified products and/or services. The user of a specified product or service must have contracted with and paid the fee(s) to use the specified product or service.

- Coverage begins at the start of the contracted and paid service term and ends when the contracted and paid service term ends.

The Covered Person must provide evidence of a contractual agreement and that they were engaged in the use of the specified product or service described above at the time of an accidental Injury. Any receipt or record must show the date and time of the contracted and paid service.

ACCIDENTAL DEATH AND DISMEMBERMENT, LOSS OF SIGHT, SPEECH AND HEARING BENEFIT

If Injury to a Covered Person results in any of the Losses shown in the Schedule of Benefits for this Benefit, We will pay the benefit amount shown in the Schedule of Benefits for such Loss. Such Loss (other than Loss of Life) must occur within 365 days from the date of a Covered Accident, Injury from such Covered Accident which results in a loss covered by this benefit. If a Covered Person sustains more than one such loss as the result of the Covered Accident, We will pay only one amount, the largest to which a Covered Person is entitled.

Loss of hand or foot means loss by severance at or above the wrist or ankle joint. Loss of sight means the total, permanent loss of sight of the eye. The loss of sight must be irrecoverable by natural, surgical or artificial means. Loss of speech means total, permanent and irrecoverable loss of audible communication. Loss of hearing means total and permanent loss of hearing in both ears which cannot be corrected by any 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.

ACCIDENT MEDICAL EXPENSE BENEFITS

We will pay benefits, as defined and limited below, for Covered Charges incurred by a Covered Person due to Injury caused by a Covered Accident.

Covered Charges are payable only for an Injury:

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

Covered Charges are shown on the Schedule of Benefits.

No Other Valid and Collectible Insurance or Plan

We will pay the Benefit Percent of incurred Covered Charges up to the Maximum Benefit Amount, Per Injury, subject to the terms, conditions, provisions, limitations, exclusions and other provisions of the Policy/Certificate.

Other Valid and Collectible Insurance or Plan

We will pay the Benefit Percent of incurred Covered Charges which are in excess of the total benefits payable for the same Injury by any Other Valid and Collectible Insurance or Plan on a provision of service or on an expense incurred basis, up to the Maximum Benefit Amount, Per Accident. Benefit payment is subject to the terms, conditions, provisions, limitations, exclusions and other provisions of the Policy/Certificate.

A Covered Person must provide Us with proof of the amount of benefits paid by Other Valid and Collectible Insurance or Plan or proof of denial of benefits by Other Valid and Collectible Insurance or Plan.

If, for any reason, a Covered Person fails to apply for benefits from Other Valid and Collectible Insurance or Plan, We will pay the benefit that would have been paid under the Policy had the Covered Person filed a claim under the Other Valid and Collectible Insurance or Plan.

If Other Valid and Collectible Insurance or Plan provides benefits on an excess coverage basis, benefits will be paid first by the company or services plan whose policy or service contract has been in effect for the longer period of time at the date of the Injury.

EXCLUSIONS

The Policy/Certificate does not provide benefits for:

- Treatment, services or supplies which:
 - Are not Medically Necessary;
 - Are not prescribed by a Doctor as necessary to treat an Injury;
 - Are determined to be Experimental/Investigational in nature;
 - Are received without charge or legal obligation to pay;
 - Are received from persons employed or retained by any Family Member, unless otherwise specified; or
 - Are not specifically listed as Covered Charges in the Policy.
- Injury by acts of war, whether declared or not;
- Injury received while traveling or flying by air, except as a fare-paying passenger and not as a pilot or crew member, on a regularly scheduled commercial airline.
- Injury covered by Worker's Compensation, Employer Liability law or Occupational Disease Act or Law;
- Dental treatment, except as specifically stated;
- Injury sustained while committing or attempting to commit a felony;
- Prescription Drugs except as specifically stated;
- Suicide or attempted suicide while sane or insane;
- Intentionally self-inflicted Injury;
- Loss resulting from being legally intoxicated or under the influence of alcohol as defined by the laws of the state or jurisdiction in which the Injury occurs;
- Loss resulting from being under the influence of any drugs or narcotic unless administered on the advice of a Doctor;
- Injury sustained while participating in or practicing for any professional, intercollegiate or club sports activity.
- Injury which occurs while a Covered Person is on active duty service in any armed forces. Reserve or National Guard active duty for training is not excluded unless it extends beyond 31 days;
- Injury sustained flying in an ultra-light, hang gliding, parachuting or bungee cord jumping, by flight in a space craft or any craft designed for navigation above or beyond the earth's atmosphere;
- Injury sustained while driving or riding on vehicles for off-road use including but not limited to all-terrain vehicles (ATV's);
- Injury sustained where a Covered Person is the operator and does not possess a current and valid motor vehicle operator's license, except in a Driver's Education Program;
- Treatment in any Veteran's Administration or federal Hospital, except if there is a legal obligation to pay;
- Cosmetic surgery, except for reconstructive surgery on an injured part of the body;
- Covered Charges incurred outside of the United States or its possessions
- Competing in motor sports races or competitions;
- Competing in water sports races or competitions;
- Testing cars/trucks on any racetrack or speedway;
- Handling, storing or transporting explosives;
- Scaling up cliffs or mountain walls;
- Spelunking (exploring caves);
- Injuries that result from working with animals;
- Injury sustained while water skiing or surfboarding;
- Injury sustained while roller blading or skateboarding;
- Injury sustained while participating in a rodeo.
- Re-injury or complications of an Injury caused or contributed to by a condition that existed before the Accident.
- Repetitive motion injuries, strains, hernia, tendonitis, bursitis and heat exhaustion not related to a specific Injury.

EXCLUSIONS, continued

- Individual allergic reactions due to exposure to common environmental stimuli, which include, but are not limited to, insects, animals, food, and medication;
- Any claim for which a Covered Person knowingly misrepresents a fact that is material to the claim; and
- Mental or Nervous disorders, including post-traumatic stress disorders.

PREMIUM

Premiums are due and payable in advance by You. Premiums are payable to the Company at its Home Office. Payment of a premium will not maintain the insurance in force beyond the period for which it is paid except for the Grace Period provision.

The premium rates may be changed by the Company. If the rates are changed, the Company will give the Policyholder and You at least 60 days advance written notice. If a change in benefits contained in the Policy increases the Company's liability, premium rates may be changed on the date the Company's liability is increased.

CLAIM PROVISIONS

Notice of Claim: Written notice of claim must be given to the Company or its authorized representative within 60 days after a covered loss starts, or as soon thereafter as is reasonably possible. Notice should include information sufficient to identify the Covered Person.

Claim Forms: The Company, upon receipt of written notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing Proofs of Loss. If such forms are not furnished within 15 days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of the Policy as to Proof of Loss upon submitting, within the time fixed in the Policy for filing Proof of Loss, written proof covering the occurrence, the character, and the extent of the loss for which claim is made.

Proof of Loss: Proof of Loss as required by the Company must be given to the Company within 90 days after the loss. The Company will accept late proof if:

1. It was not reasonably possible to give proof in that time; and
2. The proof is given within twelve (12) months from the date of loss. This twelve (12) month limit will not apply in the absence of legal capacity.

Proof of Loss includes, but is not limited to:

1. Receipts, credit card statements and/or invoices showing that a contracted service was provided;
2. Evidence that the Covered Person was performing the covered activity at the time of the accidental Injury;
3. Evidence that the Covered Person reported the Injury to the provider of any contracted services; and
4. Evidence that covered medical expense was incurred by the Covered Person.

Time of Payment of Claims: Benefits will be paid as soon as We receive proper proof of loss unless the Policy provides for periodic payment. When the Policy provides for periodic payment, the benefits will accrue and will be paid monthly subject to proper Proof of Loss.

Payment of Claims: Benefits payable under this Certificate for a Covered Person's loss of life will be paid to the Covered Person's named Beneficiary, or if there is no named Beneficiary, then to the first surviving class of the Covered Person's relatives listed below. All other benefits will be payable to the Covered Person or to a medical services provider if We have received a valid assignment completed and signed by the Covered Person.

Unless the Covered Person designates a Beneficiary on the enrollment form or by writing to Us, benefits for Death will be paid in equal shares to the first surviving class of beneficiaries below:

1. The Covered Person's living spouse;
2. The Covered Person's living children;
3. The Covered Person's living parents;
4. The Covered Person's living brothers and sisters.

Instead of paying any of the above classes, We may pay benefits to a Covered Person's Estate. Any payment made in good faith shall discharge Our liability to the extent of such payment.

Subject to the Covered Person's written direction or of the Covered Person's legal or natural guardian, if a Covered Person is a minor or otherwise incompetent to make such a direction, all or a portion of any indemnities provided by this Certificate as a result of medical, surgical, dental, hospital or nursing service may, at the Company's option, and unless the Company is requested in writing not later than the time for filing proofs of loss, be paid directly to the hospital or person rendering such services.

Change of Beneficiary: A Covered Person has the right to change the Beneficiary and the consent of the Beneficiary or Beneficiaries shall not be required for any change. A Beneficiary designation must be signed and dated by the Covered Person during his or her lifetime and be received by Us.

Assignment of Benefits: An assignment of benefits is not binding on Us unless:

1. It is a written request; and
2. It is received by Us at our Home Office.

An assignment will take effect when recorded at Our Home Office. We are not responsible for the validity of any assignment. Any payment, made in good faith, fully discharges the Company to the extent of the payment.

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

Legal Actions: A legal action may not be brought to recover on the Policy within 60 days after written Proof of Loss has been given as required. No such action may be brought after 3 years from the time written proof was required to be given.

Subrogation: When benefits are paid to or for a Covered Person under the terms of the Policy, We shall be subrogated, unless otherwise prohibited by law, to a Covered Person's rights of recovery 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 the recovery by the Company of the benefits it has paid for such hospitalization and treatment and the Company shall pay fees and costs associated with such recovery.

GENERAL PROVISIONS

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

Failure by the Company to enforce any Policy provision shall not waive, modify or render such provision unenforceable at any other time or under any given set of circumstances, whether the circumstances are or are not the same.

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

(b) After two years from the date of issue of this Certificate, no misstatement of the Covered Person, except a fraudulent misstatement made in the application shall be used to void the Certificate; and after two years from the effective date of the coverage with respect to which any claim is made no misstatement of any person eligible for coverage under the Certificate, except a fraudulent misstatement, made in an application under the certificate shall be used to deny a claim for loss incurred or disability (as defined in the policy) commencing after expiration of such two years.

Non-Participating: The Policy is non-participating. It does not share in the Company's profits or surplus earnings.

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

Conformity with State Statutes: If any provision of the Policy or this Certificate is contrary to any law to which it is subject, such provision is hereby amended to conform to the minimum requirements of such law.

SCHEDULE OF BENEFITS

Policyholder:	Family First Association
Certificate Effective Date:	February 1, 2022
Eligible Persons:	Persons who are members of an Eligible Class as defined by the Policyholder and agreed to by Us. Eligible Classes are: Class 1: All members of the Family First Association who have purchased a valid lift ticket from a sponsoring resort. Members are eligible for coverage while skiing or snowboarding while on the property of the sponsoring resort for the duration of the time period specified on the lift ticket.
Scope of Coverage:	Limited/Short-Term Accident Coverage

ACCIDENTAL DEATH AND DISMEMBERMENT, LOSS OF SIGHT, SPEECH AND HEARING BENEFIT

The Principal Sum:	\$20,000
Loss of Life	The Principal Sum
Loss of Both Hands	The Principal Sum
Loss of Both Feet	The Principal Sum
Loss of the Entire Sight of Both Eyes	The Principal Sum
Loss of One Hand and One Foot	The Principal Sum
Loss of Speech and Hearing	The Principal Sum
Loss of One Hand or One Foot and Entire Sight of One Eye	The Principal Sum
Loss of One Hand or One Foot	One-Half The Principal Sum
Loss of Entire Sight of One Eye	One-Half The Principal Sum
Loss of Speech or Hearing	One-Half The Principal Sum
Loss of Hearing in One Ear	One-Quarter The Principal Sum
Loss of Thumb and Index Finger of the Same Hand	One-Quarter The Principal Sum

ACCIDENT MEDICAL EXPENSE BENEFITS

Maximum Amount Per Accident (Certificate Limit)	\$20,000
Deductible Per Accident	\$100
Benefit Percent *	100%
Initial Treatment Period	60 Days
Benefit Period	12 Months

BENEFIT MAXIMUMS **Benefits for Covered Charges are Limited as Stated Below**

Treatment, services or supplies incurred for:	Maximum Amount:
Hospital Emergency Care	\$500
Hospital Emergency care	
Imaging (X-Ray) and other diagnostic tests	Up to Certificate Limit
Ambulance Expense: Ground Ambulance expense	Limited to \$250

Treatment, services or supplies incurred for:	Maximum Amount:
Prescription Drug Expense	Up to \$500
Hospital room and board, and general nursing care charges, up to the semi-private room rate.	Up to Certificate Limit
Hospital miscellaneous expense during Hospital Confinement or for outpatient surgery under general anesthetic, such as the cost of the operating room, laboratory tests, Imaging (X-Ray) examinations, anesthesia, drugs (excluding take-home drugs) or medicines.	Up to Certificate Limit
Doctor's fees for surgery	Up to Certificate Limit
Anesthesia services	Up to Certificate Limit
Doctors' visits, inpatient and outpatient expenses, each visit:	Limited to \$75
Durable Medical Equipment	Limited to \$100
Dental treatment for Injury to Sound Natural Teeth	\$250 per tooth up to a maximum of \$500
Physical Therapy limited to 1 visit per day and does not apply when related to surgery	\$60 for first visit; \$30 for each visit thereafter
Registered Nurse expense	Up to Certificate Limit

GUARANTEE TRUST LIFE INSURANCE COMPANY PRIVACY NOTICE

At Guarantee Trust Life Insurance Company (GTL) 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 GTL 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

GTL does not disclose any nonpublic personal information about our customers or former customers to anyone without providing notice of the customer's rights to either opt out or opt in the sharing of personal information, 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.

G•T•L
Guarantee Trust Life Insurance Company
1275 Milwaukee Avenue
Glenview, Illinois 60025
1-800-338-7452
Visit us at: www.gtlic.com

GUARANTEE TRUST LIFE INSURANCE COMPANY

1275 Milwaukee Avenue, Glenview, Illinois 60025

1-800-338-7452

CERTIFICATE OF INSURANCE

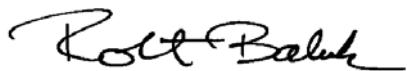
This is Your Certificate of Insurance (Certificate) while You are insured. It briefly explains the rights and benefits that are determined by the Master Policy (Policy). The Policy is a contract between the Policyholder and Us. The Policyholder is shown on the Schedule of Benefits.

The Policy alone constitutes the agreement under which payments are made. We will pay the benefits set forth in the Policy. Benefit payment is governed by all the terms, conditions, provisions, limitations and exclusions of this Certificate and the Policy. The Policy may be amended at any time without Your consent or notice to You. Any such amendment will not affect a claim starting before the amendment takes effect.

Right to Examine: If You are not satisfied with this Certificate, return it to Our home office within ten days after the date You received it. This Certificate will then be canceled and any Premium paid will be refunded.

The Policy is held by the Policyholder. You may inspect it at any time during business hours at the office of the Policyholder.

READ YOUR CERTIFICATE CAREFULLY



Secretary



President

**GROUP ACCIDENT ONLY COVERAGE
THIS IS LIMITED COVERAGE. PLEASE READ YOUR CERTIFICATE CAREFULLY.
NON-PARTICIPATING**

**THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE
FOR MAJOR MEDICAL COVERAGE.**

NOTICE: Unless specified otherwise, benefits under this Policy are paid based on Reasonable and Customary Charges, Fees or Expenses as defined herein. Therefore, benefits may be less than the provider's billed charges. For information on how We determine Reasonable and Customary Charges, Fees or Expenses, You may contact Our Customer Service Department at 800-338-7452.

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DEFINITIONS

Accident: A sudden, unintended and unforeseeable external event to the Covered Person which results in an Injury.

Beneficiary: A person or persons the Covered Person has named to receive any death benefits paid under this Certificate.

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

Covered Accident: An Accident for which coverage is provided and a benefit is payable while a Covered Person's insurance under the Policy and this Certificate are in effect.

Covered Charge: The Reasonable and Customary charge incurred for a medical service or supply listed in this Certificate which is performed or given under the direction of a Doctor for the Medically Necessary treatment of an Injury caused by a Covered Accident. A Covered Charge is considered incurred on the date the medical treatment or service is rendered or the supply is furnished. Benefits for a Covered Charge are payable as indicated in the Policy/Certificate Schedule.

Covered Person: You, or a Dependent:

1. Who is eligible for coverage as a Covered Person;
2. Who has been accepted for coverage or has been automatically added;
3. Who has paid the required premium; and
4. Whose coverage has become effective and has not terminated.

Deductible: The deductible is the amount You must pay before this insurance provides a benefit to You. Any deductible is shown in the Schedule of Benefits. No Benefits will be paid until the deductible is satisfied.

Doctor: A legally qualified person licensed in the healing arts, practicing within the scope of his or her license and who is not a Covered Person or a Family Member.

Durable Medical Equipment: A device which:

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

Durable Medical Equipment does not include:

1. Comfort and convenience items;
2. Equipment that can be used by Family Members other than a Covered Person;
3. Health exercise equipment; and
4. Equipment that may increase the value of a Covered Person's Residence.

Such items that do not qualify as Durable Medical Equipment include, but are not limited to:

1. Modifications to a Covered Person's Residence, property or automobiles, such as ramps;
2. Elevators;
3. Spas;
4. Air conditioners;
5. Vehicle hand controls; or
6. Corrective shoes, exercise and sports equipment.

Eligible Person: A member of the Policyholder's organization as defined on the Schedule of Benefits.

Emergency: An Injury for which a Covered Person seeks immediate medical treatment at the nearest available facility. The condition must be one which manifests itself by acute symptoms which are sufficiently severe (including severe pain) that without immediate medical care a Covered Person could reasonably expect that: (1) the Covered Person's life or health would be in serious jeopardy; (2) the Covered Person's bodily functions would be seriously impaired; or (3) a body organ or part would be seriously damaged.

Emergency Room: A hospital area equipped and staffed for the prompt treatment of acute trauma, or other medical emergencies. An Emergency Room must be licensed by the state in which it is located under applicable State law as an Emergency Room or emergency department and be open 24 hours a day, 7 days a week. For the purposes of the Policy, Emergency Room includes a licensed Urgent Care Facility.

Experimental/Investigational: A drug, device or medical care or treatment will be considered experimental/investigational if:

1. The drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;
2. The informed consent document utilized with the drug, device, medical care or treatment states or indicates that the drug, device, medical care or treatment is part of a clinical trial, experimental phase or investigational phase or if such a consent document is required by law;
3. The drug, device, medical care or treatment or the patient informed consent document utilized with the drug, device or medical care or treatment was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal or state law requires such review and approval;
4. Reliable evidence shows 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 or diagnosis; or
5. 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 or 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.

Management staff in Our Claims Department will make the determination if the drug, device or medical care is Experimental/Investigational based on the above criteria.

Family Member: A person who is related to a 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).

Ambulance: Means a vehicle which is licensed as an ambulance by the local regulatory body to provide transportation of a Covered Person as a result of a Covered Accident to a Hospital or transportation from one Hospital to another for a Covered Person who is unable to travel to receive medical care by any other means. An Ambulance must contain life-saving equipment and state-certified ambulance personnel.

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

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

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

1. Services would have been covered in a medical facility if Home Health Care were not given; and
2. A Home Health Care treatment plan is set up, in writing and approved by a Doctor.

Hospice Care: Services provided by a licensed public agency or private organization or any subdivision thereof, which entity shall be known as a hospice and shall be primarily engaged in providing care to an individual for whom a certified

medical prognosis has been made indicating a life expectancy of six (6) – twelve (12) months or less and who has elected to receive such care in lieu of other medical benefits available under the Policy.

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

1. Is accredited by the Joint Commission or other accreditation organization accepted by a state;
2. Provides 24-hour nursing service by registered nurses (R.N.);
3. Mainly provides diagnostic and therapeutic care under the supervision of Doctors on an inpatient basis; and
4. Maintains permanent surgical facilities or has an arrangement with another surgical facility supervised by a staff of one or more Doctors.

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

Hospital does not include a place, special ward, floor or other accommodation used for: custodial or educational care; rest; the aged; a nursing home or an institution mainly rendering treatment or services for mental illness or substance misuse.

Immediate Care Facility: A walk-in clinic focused on the delivery of medical care for minor injuries in an ambulatory medical facility outside of a traditional hospital-based or freestanding emergency department.

Independent Contractor: An Independent Contractor who has agreed to perform services for entities or individuals that contract with independent workers for short- or long-term or intermittent engagements. Temporary coverage is provided for the period of time the worker is actively logged into an entity's mobile device application or platform and engaged in work for the entity or individual. The term 'Independent Contractor' also includes temporary workers and consultants who are not permanent employees.

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

Injury: Bodily injury due to a Covered Accident which:

1. Results solely and directly from a Covered Accident, independently of disease, bodily infirmity or any other causes;
2. Occurs after the effective date of a Covered Person's coverage under the Policy; and
3. Occurs while the coverage is in force.

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

Intensive Care Unit (ICU): A specifically designed facility of the Hospital that provides the highest level of medical care; and which is restricted to those patients who are critically ill or injured. Such facility must be separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient confinement. They must be permanently equipped with special life-saving equipment for the care of the critically ill or injured; and under constant and continuous observation by nursing staff assigned on a full-time basis, exclusively to the Intensive Care Unit. Intensive Care Unit does not mean any of these step-down units: progressive care; sub-acute intensive care; intermediate care units; private monitored rooms; observation units; or other facilities which do not meet the standards for Intensive Care.

Medically Necessary: A treatment, drug, device, procedure, supply or service that is necessary and appropriate for the diagnosis or treatment of an Injury as determined by Your Doctor in accordance with generally accepted standards of medical and dental 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. For Accident Related Dental services this means Services which are needed due to an accidental injury caused by a force outside of the mouth or body.

A treatment, drug, device, procedure, supply or service shall not be considered as Medically Necessary if it:

1. Is Experimental/Investigational or for research purposes;
2. Is provided solely for education purposes or the convenience of a Covered Person's family, Doctor, Hospital or any other medical provider;

3. 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;
4. Could have been omitted without adversely affecting the person's condition or the quality of medical care;
5. Involves the use of a medical device, drug or substance not formally approved by the United States Food and Drug Administration;
6. Involves a service, supply or drug not considered reasonable and necessary by the Healthcare Financing Administration Medicare Coverage Issues Manual; or
7. Can be safely provided to the patient on a more cost-effective basis such as outpatient, by a different medical professional, or pursuant to a more conservative form of treatment.

We reserve the right to determine whether a service, supply or drug is Medically Necessary.

Orthopedic Appliances: Any supportive device or appliance used in treating a Covered Person's Injury.

Other Valid and Collectible Insurance or Plan: Any reimbursement for or recovery of any element of Covered Charges incurred by the Covered Person available from any other source whatsoever, except gifts and donations, but including without limitation:

1. Any individual, group, blanket, or franchise policy of accident, disability or health insurance;
2. Any arrangement of benefits for members of a group, whether insured or uninsured;
3. Any prepaid service arrangement including a health maintenance or preferred provider organization or any other health benefit plan;
4. Any amount payable for Hospital, medical or other health services. Injury arising out of a motor vehicle accident to the extent such benefits are payable under any medical expense payment provision (by whatever terminology used including such benefits mandated by law) of any motor vehicle insurance policy.
5. Any amount payable for services or injuries or diseases related to a Covered Person's occupation to the extent that the Covered Person actually received benefits under a Worker's Compensation Law or if the Covered Person enters into a settlement to give up his or her rights to recover future medical expenses that would have been payable except for that settlement;
6. Social Security Disability Benefits, except that Other Valid and Collectible Insurance or Plan shall not include any increase in Social Security Disability Benefits payable to the Covered Person after the Covered Person becomes disabled while insured hereunder.
7. Any benefits payable under any program provided or sponsored solely or primarily by any governmental agency or subdivision or through operation of law or regulation.
8. Any medical expense coverage an Independent Contractor carries.

Physical Therapy: Non-surgical physical or mechanical therapy, diathermy, ultrasonic therapy, heat treatment in any form or massage that is intended to preserve, enhance, or restore movement and physical function impaired by Injury. For the purposes of this coverage, chiropractic treatment is not deemed to be Physical Therapy. Physical Therapy must be prescribed by a Doctor and be based upon a plan of treatment for a specified period of time or number of visits.

Policyholder: The entity to which the Policy is issued.

Prescription Drugs: Drugs which may only be dispensed by written prescription under Federal law and are approved for general use by the Food and Drug Administration. The drugs must be dispensed by a licensed pharmacy provider for a Covered Person's outpatient use.

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

1. The actual amount charged by the medical provider;
2. The negotiated rate; or
3. The charge which would have been made by the medical provider for a comparable service or supply made by other providers in the same Geographic Area as reasonably determined by us for the same service or supply.

“Geographic Area” means the three digit zip code in which the service, treatment, procedure, drugs or supplies are provided; or a greater area if necessary to obtain a representative cross-section of charge for a like treatment, service, procedure, device drug or supply.

Rehabilitation Facility: An institution, or part of an institution, licensed, accredited or certified by the State which:

1. Is accredited by the Joint Commission, the Commission on Accreditation of Rehabilitation Facilities or other accreditation organizations accepted by a state;
2. Is primarily engaged in providing comprehensive multi-disciplinary physical services or rehabilitation inpatient care; and
3. Has a transfer agreement with one or more Hospitals.

Rehabilitation Facility does not include an institution which:

1. Provides only minimal care, custodial care, care for the terminally ill, or part-time care services;
2. Primarily provides treatment for mental disorders, chemical dependency or tuberculosis, except if such facility is licensed, certified, or approved as a rehabilitation facility for the treatment of medical conditions; drug addiction or alcoholism.

Residence: The home and land or property on which a Covered Person’s dwelling or home is located.

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

Telehealth Care Benefit: We agree to reimburse up to the Doctor’s office visit benefit for each Telehealth Care service provided due to accidental Injury. This benefit is subject to the Certificate maximums.

Transportation Network Company: An entity that uses a digital network to connect riders to drivers for the purpose of providing transportation. Transportation Network Company does not include a taxi service or ridesharing arrangements.

Urgent Care Facility: A healthcare facility, which is part of or affiliated with a Hospital, providing short-term medical care for non-life-threatening conditions without an appointment but where immediate medical care is necessary. If required, the facility must be accredited by the Urgent Care Association of America (UCAOA) and/or the American Academy of Urgent Care Medicine, if required in a state, and:

1. Must accept walk-in patients during business hours;
2. Must treat a broad spectrum of injuries, as well as perform minor medical procedures;
3. Have a licensed physician operating as the medical director;
4. Have on-site diagnostic equipment, including x-ray; and
5. Must contain communication lines with local hospitals so that patients who need transfer to an Emergency Room have easy access.

We, Us and Our: Guarantee Trust Life Insurance Company.

You, Your and Yours: The Covered Person to whom this Certificate is issued and whose insurance is in force under the terms of the Policy.

CONDITIONS OF INSURANCE

ELIGIBILITY

Eligible Persons are described in the Schedule of Benefits. A person is insured under the Policy provided such person satisfies the eligibility requirements, becomes insured and remains insured under the terms of the Policy.

EFFECTIVE DATE

Covered Person: Coverage is effective, subject to receipt of premium, on the date agreed to by the Policyholder and Us.

TERMINATION

Covered Person: Coverage will terminate at the earlier of:

1. The date the Policy terminates;

2. The date the Covered Person ceases to be an Eligible Person;
3. The end of the period for which any applicable premium has been paid by the Policyholder on behalf of the Covered Person;
4. The date of entry of a valid judgment of dissolution of marriage between You and a Dependent spouse on the premium due date that follows the judgement.
5. The date of fraud or knowingly misrepresenting a material fact by any Covered Person. Material misrepresentation includes a failure to disclose other coverages a Covered Person has.

SCOPE OF COVERAGE

Please see the Scope of Coverage section in the Schedule of Benefits. There a Covered Person will find which of the following types of Accident coverage apply to the Covered Person's benefit plan.

Limited/Short-Term Accident Coverage - As shown in the Schedule, for users of specified products and/or services. The user of a specified product or service must have contracted with and paid the fee(s) to use the specified product or service.

- Coverage begins at the start of the contracted and paid service term and ends when the contracted and paid service term ends.

The Covered Person must provide evidence of a contractual agreement and that they were engaged in the use of the specified product or service described above at the time of an accidental Injury. Any receipt or record must show the date and time of the contracted and paid service.

ACCIDENTAL DEATH AND DISMEMBERMENT, LOSS OF SIGHT, SPEECH AND HEARING BENEFIT

If, within 365 days from the date of a Covered Accident, Injury from such Covered Accident results in a loss covered by this benefit, We will pay the benefit in the amount set opposite such loss, as shown on the Schedule of Benefits. If a Covered Person sustains more than one such loss as the result of the Covered Accident, We will pay only one amount, the largest to which a Covered Person is entitled.

Loss of hand or foot means loss by severance at or above the wrist or ankle joint. Loss of sight means the total, permanent loss of sight of the eye. The loss of sight must be irrecoverable by natural, surgical or artificial means. Loss of speech means total, permanent and irrecoverable loss of audible communication. Loss of hearing means total and permanent loss of hearing in both ears which cannot be corrected by any 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.

ACCIDENT MEDICAL EXPENSE BENEFITS

After any Deductible has been satisfied, We will pay benefits, as defined and limited below, for Covered Charges incurred by a Covered Person due to Injury caused by a Covered Accident.

Covered Charges are payable only for an Injury:

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

Covered Charges are shown on the Schedule of Benefits.

No Other Valid and Collectible Insurance or Plan

We will pay the Benefit Percent of incurred Covered Charges up to the Maximum Benefit Amount, Per Injury, subject to the terms, conditions, provisions, limitations, exclusions and other provisions of the Policy/Certificate.

Other Valid and Collectible Insurance or Plan

After any Deductible has been satisfied, We will pay the Benefit Percent of incurred Covered Charges which are in excess of the total benefits payable for the same Injury by any Other Valid and Collectible Insurance or Plan on a provision of service or on an expense incurred basis, up to the Maximum Benefit Amount, Per Accident. Benefit payment is subject to the terms, conditions, provisions, limitations, exclusions and other provisions of the Policy/Certificate.

A Covered Person must provide Us with proof of the amount of benefits paid by Other Valid and Collectible Insurance or Plan or proof of denial of benefits by Other Valid and Collectible Insurance or Plan.

If, for any reason, a Covered Person fails to apply for benefits from Other Valid and Collectible Insurance or Plan, We will pay the benefit that would have been paid under the Policy had the Covered Person filed a claim under the Other Valid and Collectible Insurance or Plan.

If Other Valid and Collectible Insurance or Plan provides benefits on an excess coverage basis, benefits will be paid first by the company or services plan whose policy or service contract has been in effect for the longer period of time at the date of the Injury.

EXCLUSIONS

The Policy/Certificate does not provide benefits for:

- Treatment, services or supplies which:
 - Are not Medically Necessary;
 - Are not prescribed by a Doctor as necessary to treat an Injury;
 - Are determined to be Experimental/Investigational in nature;
 - Are received without charge or legal obligation to pay;
 - Are received from persons employed or retained by any Family Member, unless otherwise specified; or
 - Are not specifically listed as Covered Charges in the Policy.
- Injury by acts of war, whether declared or not;
- Injury received while traveling or flying by air, except as a fare-paying passenger and not as a pilot or crew member, on a regularly scheduled commercial airline.
- Injury covered by Worker's Compensation, Employer Liability law or Occupational Disease Act or Law;
- Dental treatment, except as specifically stated;
- Injury sustained while committing or attempting to commit a felony;
- Prescription Drugs except as specifically stated;
- Suicide or attempted suicide while sane or insane;
- Intentionally self-inflicted Injury;
- Loss resulting from being legally intoxicated or under the influence of alcohol as defined by the laws of the state or jurisdiction in which the Injury occurs;
- Loss resulting from being under the influence of any drugs or narcotic unless administered on the advice of a Doctor;
- Injury sustained while participating in or practicing for any professional, intercollegiate or club sports activity.
- Injury which occurs while a Covered Person is on active duty service in any armed forces. Reserve or National Guard active duty for training is not excluded unless it extends beyond 31 days;
- Injury sustained flying in an ultra-light, hang gliding, parachuting or bungee cord jumping, by flight in a space craft or any craft designed for navigation above or beyond the earth's atmosphere;
- Injury sustained while driving or riding on vehicles for off-road use including but not limited to all-terrain vehicles (ATV's);
- Injury sustained where a Covered Person is the operator and does not possess a current and valid motor vehicle operator's license, except in a Driver's Education Program;
- Treatment in any Veteran's Administration or federal Hospital, except if there is a legal obligation to pay;
- Cosmetic surgery, except for reconstructive surgery on an injured part of the body;
- Covered Charges incurred outside of the United States or its possessions
- Competing in motor sports races or competitions;
- Competing in water sports races or competitions;

EXCLUSIONS, continued

- Testing cars/trucks on any racetrack or speedway;
- Handling, storing or transporting explosives;
- Scaling up cliffs or mountain walls;
- Spelunking (exploring caves);
- Injuries that result from working with animals;
- Injury sustained while water skiing or surfboarding;
- Injury sustained while roller blading or skateboarding;
- Injury sustained while participating in a rodeo.
- Re-injury or complications of an Injury caused or contributed to by a condition that existed before the Accident.
- Repetitive motion injuries, strains, hernia, tendonitis, bursitis and heat exhaustion not related to a specific Injury.
- Individual allergic reactions due to exposure to common environmental stimuli, which include, but are not limited to, insects, animals, food, and medication;
- Any claim for which a Covered Person knowingly misrepresents a fact that is material to the claim; and
- Mental or Nervous disorders, including post-traumatic stress disorders.

PREMIUM

Premiums are due and payable in advance by You. Premiums are payable to the Company at its Home Office. Payment of a premium will not maintain the insurance in force beyond the period for which it is paid except for the Grace Period provision.

The premium rates may be changed by the Company. If the rates are changed, the Company will give the Policyholder and You at least 60 days advance written notice. If a change in benefits contained in the Policy increases the Company's liability, premium rates may be changed on the date the Company's liability is increased.

CLAIM PROVISIONS

Notice of Claim: Written notice of claim must be given to the Company or its authorized representative within 60 days after a covered loss starts, or as soon thereafter as is reasonably possible. Notice should include information sufficient to identify the Covered Person.

Claim Forms: The Company, upon receipt of written notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing Proofs of Loss. If such forms are not furnished within 15 days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of the Policy as to Proof of Loss upon submitting, within the time fixed in the Policy for filing Proof of Loss, written proof covering the occurrence, the character, and the extent of the loss for which claim is made.

Proof of Loss: Proof of Loss as required by the Company must be given to the Company within 90 days after the loss. The Company will accept late proof if:

1. It was not reasonably possible to give proof in that time; and
2. The proof is given within twelve (12) months from the date of loss. This twelve (12) month limit will not apply in the absence of legal capacity.

Proof of Loss includes, but is not limited to:

1. Receipts, credit card statements and/or invoices showing that a contracted service was provided;
2. Evidence that the Covered Person was performing the covered activity at the time of the accidental Injury;
3. Evidence that the Covered Person reported the Injury to the provider of any contracted services; and
4. Evidence that covered medical expense was incurred by the Covered Person.

Time of Payment of Claims: Benefits will be paid as soon as We receive proper proof of loss unless the Policy provides for periodic payment. When the Policy provides for periodic payment, the benefits will accrue and will be paid monthly subject to proper Proof of Loss.

Payment of Claims: Benefits payable under this Certificate for a Covered Person's loss of life will be paid to the Covered Person's named Beneficiary, or if there is no named Beneficiary, then to the first surviving class of the Covered Person's relatives listed below. All other benefits will be payable to the Covered Person or to a medical services provider if We have received a valid assignment completed and signed by the Covered Person.

Unless the Covered Person designates a Beneficiary on the enrollment form or by writing to Us, benefits for Death will be paid in equal shares to the first surviving class of beneficiaries below:

1. The Covered Person's living spouse;
2. The Covered Person's living children;
3. The Covered Person's living parents;
4. The Covered Person's living brothers and sisters.

Instead of paying any of the above classes, We may pay benefits to a Covered Person's Estate. Any payment made in good faith shall discharge Our liability to the extent of such payment.

Subject to the Covered Person's written direction or of the Covered Person's legal or natural guardian, if a Covered Person is a minor or otherwise incompetent to make such a direction, all or a portion of any indemnities provided by this Certificate as a result of medical, surgical, dental, hospital or nursing service may, at the Company's option, and unless the Company is requested in writing not later than the time for filing proofs of loss, be paid directly to the hospital or person rendering such services.

Change of Beneficiary: A Covered Person has the right to change the Beneficiary and the consent of the Beneficiary or Beneficiaries shall not be required for any change. A Beneficiary designation must be signed and dated by the Covered Person during his or her lifetime and be received by Us.

Assignment of Benefits: An assignment of benefits is not binding on Us unless:

1. It is a written request; and
2. It is received by Us at our Home Office.

An assignment will take effect when recorded at Our Home Office. We are not responsible for the validity of any assignment. Any payment, made in good faith, fully discharges the Company to the extent of the payment.

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

Legal Actions: A legal action may not be brought to recover on the Policy within 60 days after written Proof of Loss has been given as required. No such action may be brought after 3 years from the time written proof was required to be given.

Subrogation: When benefits are paid to or for a Covered Person under the terms of the Policy, We shall be subrogated, unless otherwise prohibited by law, to a Covered Person's rights of recovery 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 only be exercised after the Covered Person has been made whole and shall extend only to the recovery by the Company of the benefits it has paid for such hospitalization and treatment and the Company shall pay fees and costs associated with such recovery.

GENERAL PROVISIONS

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

Failure by the Company to enforce any Policy provision shall not waive, modify or render such provision unenforceable at any other time or under any given set of circumstances, whether the circumstances are or are not the same.

Non-Participating: The Policy is non-participating. It does not share in the Company's profits or surplus earnings.

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

Conformity with State Statutes: If any provision of the Policy or this Certificate is contrary to any law to which it is subject, such provision is hereby amended to conform to the minimum requirements of such law.

SCHEDULE OF BENEFITS

Policyholder:	Family First Association
Certificate Effective Date:	February 1, 2022
Eligible Persons:	Persons who are members of an Eligible Class as defined by the Policyholder and agreed to by Us. Eligible Classes are: Class 1: All members of the Family First Association who have purchased a valid lift ticket from a sponsoring resort. Members are eligible for coverage while skiing or snowboarding while on the property of the sponsoring resort for the duration of the time period specified on the lift ticket.
Scope of Coverage:	Limited/Short-Term Accident Coverage

ACCIDENTAL DEATH AND DISMEMBERMENT, LOSS OF SIGHT, SPEECH AND HEARING BENEFIT

The Principal Sum:	\$20,000
Loss of Life	The Principal Sum
Loss of Both Hands	The Principal Sum
Loss of Both Feet	The Principal Sum
Loss of the Entire Sight of Both Eyes	The Principal Sum
Loss of One Hand and One Foot	The Principal Sum
Loss of Speech and Hearing	The Principal Sum
Loss of One Hand or One Foot and Entire Sight of One Eye	The Principal Sum
Loss of One Hand or One Foot	One-Half The Principal Sum
Loss of Entire Sight of One Eye	One-Half The Principal Sum
Loss of Speech or Hearing	One-Half The Principal Sum
Loss of Hearing in One Ear	One-Quarter The Principal Sum
Loss of Thumb and Index Finger of the Same Hand	One-Quarter The Principal Sum

ACCIDENT MEDICAL EXPENSE BENEFITS

Maximum Amount Per Accident (Certificate Limit)	\$20,000
Benefit Percent *	100%
Deductible Per Accident	\$100
Initial Treatment Period	60 Days
Benefit Period	12 Months

BENEFIT MAXIMUMS

Benefits for Covered Charges are Limited as Stated Below

Treatment, services or supplies incurred for:	Maximum Amount:
Hospital Emergency Care	\$500
Hospital Emergency care	
Imaging (X-Ray) and other diagnostic tests	Up to Certificate Limit
Ambulance Expense: Ground Ambulance expense	Limited to \$250
Prescription Drug Expense	Up to \$500

Treatment, services or supplies incurred for:	Maximum Amount:
Hospital room and board, and general nursing care charges, up to the semi-private room rate.	Up to Certificate Limit
Hospital miscellaneous expense during Hospital Confinement or for outpatient surgery under general anesthetic, such as the cost of the operating room, laboratory tests, Imaging (X-Ray) examinations, anesthesia, drugs (excluding take-home drugs) or medicines.	Up to Certificate Limit
Doctor's fees for surgery	Up to Certificate Limit
Anesthesia services	Up to Certificate Limit
Doctors' visits, inpatient and outpatient expenses, each visit:	Limited to \$75
Durable Medical Equipment	Limited to \$100
Dental treatment for Injury to Sound Natural Teeth	\$250 per tooth up to a maximum of \$500
Physical Therapy limited to 1 visit per day and does not apply when related to surgery	\$60 for first visit; \$30 for each visit thereafter
Registered Nurse expense	Up to Certificate Limit

This Policy is NOT a Medicare Supplement. For more information, see "Wisconsin Guide to Health Insurance for People with Medicare" given to you when you applied for this Policy.

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

**COMPLAINT NOTICE
STATE OF WISCONSIN**

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

PROBLEMS WITH YOUR INSURANCE? - If you are having problems with us or with your agent, do not hesitate to contact us or your agent to resolve your problems.

**Guarantee Trust Life Insurance Company
Policyowner's Service Department
1275 Milwaukee Avenue
Glenview, IL 60025
1-800-338-7452
1-847-699-0600**

You can also contact the **OFFICE OF THE COMMISSIONER OF INSURANCE**, a state agency which enforces Wisconsin's insurance laws, and file a complaint. You can file a complaint electronically with the **OFFICE OF THE COMMISSIONER OF INSURANCE** at its website at <http://oci.wi.gov/>, or by contacting:

**Office of the Commissioner of Insurance
Complaints Department
P.O. Box 7873
Madison, WI 53707-7873
1-800-236-8517
1-608-266-0103**

A "complaint" is any expression of dissatisfaction expressed to Us by You, or your agent, about Us or Our providers, if any, with whom We have a direct or indirect contract.

GUARANTEE TRUST LIFE INSURANCE COMPANY PRIVACY NOTICE

At Guarantee Trust Life Insurance Company (GTL) 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 GTL 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

GTL does not disclose any nonpublic personal information about our customers or former customers to anyone without providing notice of the customer's rights to either opt out or opt in the sharing of personal information, 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.

G•T•L
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Visit us at: www.gtlic.com