GROUP STUDENT BLANKET ACCIDENT INSURANCE
TERM INSURANCE - NON-RENEWABLE

SECURITYLIFE
INSURANCE COMPANY OF AMERICA

10901 Red Circle Drive, Minnetonka, Minnesota 55343-9137

THIS IS A LIMITED BENEFIT POLICY- READ YOUR POLICY CAREFULLY

Security Life Insurance Company of America of Minnetonka, Minnesota (the "Company") insures persons (hereinafter called "Insureds") who are regularly enrolled in the School (the "Policyholder") for which the required premium has been paid. The Company agrees to pay all benefits, as specifically described in this Policy, for Covered Services which result from Injury that is independent of all other causes, and which are incurred while this Policy is in force with respect to each Insured.

This Policy takes effect and terminates in accordance with the dates and at the address of the Policyholder stated below. Executed by Security Life Insurance Company of America in Minnetonka, Minnesota.

Heather Anschutz	Bruce E. Mieth
Secretary	President

POLICY SCHEDULE

POLICYHOLDER: Pearl Public School District
500 Pirate Cove
Pearl, MS 39208

POLICY NUMBER: 23-16-1538-480-104-6

POLICY EFFECTIVE DATE: 08-01-2016 at 12:01 a.m.
POLICY EXPIRATION DATE: School-Time: 07-31-2017 at 11:59 p.m.
Full-Time: First Day of School Next Year
Football: 07-31-2017

AMENDMENTS/ENDORSEMENTS: GHE-2200(MS); GHE-2201

MAXIMUM MEDICAL BENEFIT: $50,000 per Injury for School-Time, Full-Time, Interscholastic Sports and Football Coverage

DEDUCTIBLE: None

PREMIUM:

Coverage (Per Insured)	Basic	Premier
School-Time with Interscholastic Sports Coverage - PK-8 (*excludes Fall Football Coverage)	$ 15	$ 28
School-Time with Interscholastic Sports Coverage – 9-12 (*excludes Fall Football Coverage)	$ 48	$ 90
Full-Time with Interscholastic Sports Coverage - PK-12 (*excludes Fall Football Coverage)	$ 85	$152
Football Coverage - 10-12 (includes grades 7-9 practicing or participating with grades 10-12)	$ 97	$240
Extended Dental Coverage - PK-12	$ 8	$ 8

*Football Coverage is for students in grades 10-12 and grades 7-9 practicing or participating with grades 10-12

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IN FORCE COVERAGE

Each Insured is eligible for the in force coverage described below, subject to receipt of the premium and the terms, conditions, limitations, exclusions of this Policy.

SCHOOL TIME COVERAGE (includes interscholastic sports coverage for grades PK-12) **-** Coverage is in force for each person for whom the School Time Coverage premium has been paid as set forth in this Policy for students in grades PK-12:

a) while on the School premises during the hours and on the days School is in regular session, and during the hours and on the days when School is not in session while the Insured is participating in or attending any Sponsored and Supervised Activity. Excludes Fall Football Coverage for students in grades 10-12 or for students in grades 7-9 practicing or participating with grades 10-12; and
b) while away from the School premises other than traveling, if participating in a Sponsored and Supervised Activity. Excludes Fall Football Coverage for students in grades 10-12 or for students in grades 7-9 practicing or participating with grades 10-12; and
c) while traveling directly to or from the Insured's residence and School for regular School sessions, or for any Sponsored and Supervised Activity in School provided transportation. Excludes Fall Football Coverage for students in grades 10-12 or for students in grades 7-9 practicing or participating with grades 10-12.

FULL TIME COVERAGE (includes interscholastic sports coverage for grades PK-12) **-** Coverage is in force for each person for whom the Full Time Coverage premium has been paid as set forth in this Policy on a twenty-four (24) hour per day basis for students in grades PK-12. Excludes Fall Football Coverage for students in grades 10-12 or for students in grades 7-9 practicing or participating with grades 10-12. The School Time Coverage provision will not apply**.**

FOOTBALL COVERAGE - Coverage is in force for each person for whom the Football Coverage premium has been paid as set forth in this Policy for students in grades 10-12 or for students in grades 7-9 practicing or participating with grades 10-12:

a) while practicing for or competing in football which is exclusively sponsored by the Policyholder, as a representative of the School, and while under the direct and immediate supervision of an employee of the Policyholder; and
b) while traveling directly to or from such practice or competition in School provided transportation.

BENEFITS FOR MEDICAL EXPENSES

When injury covered by this Policy results in treatment by a Licensed Physician within sixty (60) days from the date of Accident, the Company shall pay Eligible Expenses for necessary Covered Services - Supplies, subject to all maximums, deductibles, coinsurance percentages and benefit limits listed below. Benefits shall be payable for charges actually incurred within one year from the date of Injury up to the specified Maximum Medical Benefit as stated in the Policy Schedule.

This Policy shall pay benefits regardless of Other Valid Coverage, if the covered claim expense is less than $200. If the covered claim expense exceeds $200, benefits shall be paid first by any other valid and collectible insurance or group plan including an ERISA or self-funded group policy.

SCHEDULE OF COVERED SERVICES – SUPPLIES AND BENEFIT LIMITS

(unless otherwise stated all amounts are per Injury)

1. Inpatient Benefits

(a) Hospital Room and Board .... Semi-private room charges, up to $150 per day
(b) Intensive Care (in lieu of 1.a.) .... U&C, up to $300 per day
(c) Hospital Miscellaneous Services .... U&C, up to $500 per day
(all other hospital charges except room and board or intensive care)
(d) Physician's Non-Surgical Visits (does not include physiotherapy) .... U&C, up to $40 first visit, subsequent visits $25; maximum 10 visits
(e) Physiotherapy .... Paid under 1.(c)
(f) Radiology services (including charges for reading) .... Paid under 1.(c)
(g) Registered Nurse .... 70% U&C

2. Outpatient Surgery Benefits

(a) Day Surgery .... U&C, up to $500
(facility charge includes room supplies and all other expenses for outpatient surgery)

3. Other Outpatient Benefits

(a) Hospital Emergency Room Charges .... U&C, up to $150
(b) Radiology Services (including x-rays and charges for reading) .... 70% U&C, up to $200
(c) Diagnostic Imaging .... U&C, up to $300
(includes CT scans, MRI and bone scans and charges for reading)
(d) Physician's Non-Surgical Visits .... U&C, up to $40 first visit, subsequent visits $25; maximum 10 visits
(e) Physiotherapy .... Paid under 3.(d)
(f) Orthopedic Appliances .... U&C, up to $100
(when prescribed by a physician for healing)
(g) Durable Medical Equipment .... No Benefit
(h) Prescription Drugs .... U&C, up to $100
(i) Ambulance .... U&C, up to $300
(j) Laboratory Services (outpatient) .... 70% U&C

4. Other Physician Services

(a) Dental Treatment .... U&C, up to $150 per tooth
(in lieu of all other medical benefits; including x-rays of sound and natural teeth)
(b) Physician Surgical Care (inpatient or outpatient) .... 60% U&C; up to $1,000
(c) Assistant Surgeon Charges (inpatient or outpatient) .... 25% of the surgeon's allowance
(d) Anesthesia Charges (inpatient or outpatient) .... 25% of the surgeon's allowance
(e) Physician Consultation (when referred by attending physician) .... U&C, up to $100

5. Miscellaneous Supplies, Services, Limitations

(a) Motor Vehicle Injury (subject to covered services limits) .... Same as any Injury, up to $1,000
(b) Eyeglass and Hearing Aid Replacement .... U&C, up to $100
(when medical treatment is required for a covered Injury)

BENEFITS FOR MEDICAL EXPENSES

When injury covered by this Policy results in treatment by a Licensed Physician within sixty (60) days from the date of Accident, the Company shall pay Eligible Expenses for necessary Covered Services - Supplies, subject to all maximums, deductibles, coinsurance percentages and benefit limits listed below. Benefits shall be payable for charges actually incurred within one year from the date of Injury up to the specified Maximum Medical Benefit as stated in the Policy Schedule.

This Policy shall pay benefits regardless of Other Valid Coverage, if the covered claim expense is less than $200. If the covered claim expense exceeds $200, benefits shall be paid first by any other valid and collectible insurance or group plan including an ERISA or self-funded group policy.

SCHEDULE OF COVERED SERVICES – SUPPLIES AND BENEFIT LIMITS

(unless otherwise stated all amounts are per Injury)

1. Inpatient Benefits
   - (a) Hospital Room and Board .... Semi-private room charges, up to $500 per day
   - (b) Intensive Care (in lieu of 1.a.) .... U&C, up to $500 per day
   - (c) Hospital Miscellaneous Services .... U&C, up to $1,000 per day
     (all other hospital charges except room and board or intensive care)
   - (d) Physician's Non-Surgical Visits (does not include physiotherapy) .... U&C, up to $60 first visit, subsequent visits $40; maximum 10 visits
   - (e) Physiotherapy .... Paid under 1.(c)
   - (f) Radiology services (including charges for reading) .... Paid under 1.(c)
   - (g) Registered Nurse .... 80% U&C

2. Outpatient Surgery Benefits
   - (a) Day Surgery .... U&C, up to $1,000
     (facility charge includes room supplies and all other expenses for outpatient surgery)

3. Other Outpatient Benefits
   - (a) Hospital Emergency Room Charges .... U&C, up to $300
   - (b) Radiology Services (including x-rays and charges for reading) .... 80% U&C, up to $500
   - (c) Diagnostic Imaging .... U&C, up to $700
     (includes CT scans, MRI and bone scans and charges for reading)
   - (d) Physician's Non-Surgical Visits .... U&C, up to $60 first visit, subsequent visits $40; maximum 10 visits
   - (e) Physiotherapy .... Paid under 3.(d)
   - (f) Orthopedic Appliances .... U&C, up to $200
     (when prescribed by a physician for healing)
   - (g) Durable Medical Equipment .... No Benefit
   - (h) Prescription Drugs .... U&C, up to $200
   - (i) Ambulance .... U&C, up to $500
   - (j) Laboratory Services (outpatient) .... 80% U&C

4. Other Physician Services
   - (a) Dental Treatment .... U&C, up to $300 per tooth
     (in lieu of all other medical benefits; including x-rays of sound and natural teeth)
   - (b) Physician Surgical Care (inpatient or outpatient) .... 80% U&C; up to $2,000
   - (c) Assistant Surgeon Charges (inpatient or outpatient) .... 25% of the surgeon's allowance
   - (d) Anesthesia Charges (inpatient or outpatient) .... 25% of the surgeon's allowance
   - (e) Physician Consultation (when referred by attending physician) .... U&C, up to $200

5. Miscellaneous Supplies, Services, Limitations
   - (a) Motor Vehicle Injury (subject to covered services limits) .... Same as any Injury, up to $1,000
   - (b) Eyeglass and Hearing Aid Replacement .... U&C, up to $300
     (when medical treatment is required for a covered Injury)

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

When Injury covered by this Policy results in the following specific Losses within 180 days from the date of Accident, the Company shall pay the benefit amount below listed opposite to the specific Loss, and shall be in addition to any other benefits payable under this Policy for such Accident. If the Insured sustains more than one Loss as a result of one Accident, the Company shall pay only one amount, the largest to which the Insured is entitled. Loss of a Hand or Foot means loss by severance at or above the wrist or ankle joint. Loss of Sight must be entire and irrecoverable.

Loss	Benefit
Loss of Life	$ 2,500
Loss of both Hands, both Feet or Sight of both Eyes	$10,000
Loss of one Hand, one Foot or Sight of one Eye	$ 5,000

EXCLUSIONS

This Policy does not provide benefits for expenses resulting from:

1. Any sickness, disease, infection (unless caused by an open cut or wound), including but not limited to: aggravation of a congenital condition, blisters, headaches, hernia of any kind, mental or physical infirmity, Osgood-Schlatter disease, osteochondritis, osteochondritis dissecans, osteomyelitis, spondylolysis, slipped femoral capital epiphysis, orthodontics.
2. Injuries for which benefits are payable under Workerss' Compensation or Employer's Liability Laws.
3. Any Injury involving a two or three-wheeled motor vehicle or snowmobile or any motorized or engine driven vehicle not designed primarily for use on public streets and highways, unless the insured is participating in an activity sponsored by the Policyholder.
4. Treatment for re-Injury, EXCEPT when the Insured is treatment free for a period of 180 days prior to the Policy Effective Date.
5. Replacement of contact lenses or prescriptions or examinations thereof.
6. The practice or play of tackle football for students in grades 10-12 (or students in grades 7-9 practicing or participating in grades 10-12 football), including travel to or from such activity, practice, or play, unless such premium is paid.

DEFINITIONS

Accident - means an unexpected, external and sudden event that is independent of any other cause.

Anesthesia - Benefits are payable for the administration of anesthesia when performed by a Physician or Certified Registered Nurse Anesthetist.

Company - means Security Life Insurance Company of America.

Covered Services - Supplies - means the services and supplies which are 1) Medically Necessary, 2) prescribed or performed by a Physician or Hospital, 3) not excluded by this Policy, and 4) listed or named in this Policy's Schedule of Covered Services – Supplies.

Deductible - means the dollar amount subtracted from Eligible Expenses the Insured must pay before benefits are considered.

Dental Treatment – means Dentist's fees for surgery, x-rays, and other necessary dental services as a result of Injury to a Sound and Natural Tooth.

Diagnostic Imaging - means the images of the body created using other forms of radiology that does not include x-ray radiographs (films), including but not limited to: computerized axial tomography (CT); magnetic resonance imaging (MRI); radionuclid imaging (nuclear medicine); bone scans; and ultrasound (US). Benefit includes the fees for interpretation or reading of imaging results and the administration of contrast material.

Durable Medical Equipment – means medical equipment or device which can be rented, leased or purchased and which 1) is prescribed by a Physician; 2) is primarily and customarily used to serve a medical purpose; 3) can withstand repeated use; 4) generally is not useful to a person in the absence of Injury; and 5) is used exclusively by the Insured. Replacement equipment and devices are not covered. No benefits will be paid for rental charges in excess of purchase price. Durable Medical Equipment does not include non-prescription therapy devices or medical supplies; comfort and convenience items; corrective shoes; exercise and sports equipment. A written prescription must accompany the claim when submitted. It includes, but is not limited to: CPM machines; drug pumps; and H2O pumps.

Eligible Expenses - means the Usual and Customary (U&C) Charges incurred for Covered Services – Supplies as a result of Injury or the amount as set forth in the Schedule of Covered Services - Supplies.

Hospital - means an institution which 1) is licensed by the state (if required) or other laws of jurisdiction; 2) is operated for the medical care and treatment of injured persons on an inpatient basis; 3) provides 24-hour nursing services or supervised by a graduate registered nurse; 4) has medical, diagnostic and treatment facilities with major surgical facilities on its premises or available to it on prearranged basis; 5) has a staff of one or more Physicians available at all times. It is not primarily a clinic, sanitarium, nursing home, skilled nursing facility, rest home or used for custodial or educational care, or an institution that mainly provides treatment for mental illness or substance abuse.

Injury - means an accidental bodily Injury or injuries directly caused by specific accidental contact with another body or object while the Insured is covered under this Policy. It is unrelated to any pathological, functional, or structural disorder. The Accident must result in an Injury which begins while the Insured is covered under this Policy.

The term Injury also means a re-Injury sustained while the Insured is covered under this Policy, for which the Insured has remained treatment free for a period of 180 days prior to the Policy Effective Date.

If benefits have been paid under this Policy for an Injury, a re-injury will be considered new if:
a) the re-Injury occurs while the Insured is covered under this Policy; and
b) the Insured remains treatment free for a period of 180 days between the date of last treatment for the original Injury and the date of the re-Injury.

A re-Injury that is incurred within 180 days of the original Injury, will be considered a continuation of the original Injury.

Inpatient – means confinement in a Hospital for at least eighteen (18) or more consecutive hours.

Insured – An eligible person of the Policyholder participating in the In Force coverage for whom the proper premium has been paid.

Medically Necessary – means a Covered Service – Supply which is: 1) consistent with symptoms and diagnosis or treatment of Injury; 2) in accordance with standards of generally accepted medical practice; 3) not primarily for the convenience of the patient or Physician; and 4) most appropriate supply or level of service which can be safely provided.

Orthopedic Appliances – means a supportive appliance or device designed specifically for use in the correction or prevention of human deformities, defects of the skeleton, joints, or spine and which: 1) is prescribed by a Physician; 2) is primarily and customarily used to serve a medical purpose; 3) can withstand repeated use; 4) generally is not useful to a person in the absence of Injury; and 5) is used exclusively by the Covered Person. Replacement braces and appliances are not covered. A written prescription must accompany the claim when submitted.

Other Valid Coverage - means any plan providing benefits or services for medical or dental care or treatment, where such benefits or services are provided on a group basis by or under: group insurance; coverage provided by hospital or medical service organizations such as Blue Cross or Blue Shield or similar pre-paid medical service organizations; union welfare or trust plans including ERISA or self-funded group policies; employer or employee benefit plans or arrangements, whether on an insured or uninsured basis; Medicare as established by Title XVIII of the United States Social Security Act of 1965, as amended; any medical benefits coverage in group, group-type and individual automobile "no-fault" and traditional automobile "fault" type coverage; HMO (health maintenance organization); or PPO(preferred provider organization); group type contracts which are not available to the general public and can be maintained only because of membership in or connection with a particular organization or group. These types of contracts include but are not limited to; associations, franchise, or blanket policies of accident, disability or health insurance.

This policy will not cover expenses which are payable under the Insured's HMO or PPO. This Policy will pay benefits in excess of coverage provided by the Insured's HMO or PPO. If the Insured chooses not to use a preferred provider (under HMO or PPO), or does not obtain the required pre-authorization, the Company will only pay benefits for expenses incurred in excess of those expenses that would have been paid by the HMO or PPO plan, had the Insured used a preferred provider or obtained pre-authorization.

"Other Valid Coverage" does not include a state plan under Medicaid, or any plan whereby law that plan's benefits are excess to those of any private insurance plan or other nongovernmental plan.

Physician - means a doctor of medicine or osteopathy, or any other licensed health care provider that state law requires to be recognized as a Physician, other than You or Your relative by blood or marriage, who is acting within the scope of such license.

Physiotherapy - means any form of therapeutic or manual treatment provided by a Physician, including but not limited to: physical or mechanical therapy, diathermy, ultrasonic treatment, EMS, whirlpool, heat treatments or manipulation. Includes office visit connected with the physiotherapy.

Policyholder – means the legal entity or sponsoring organization to whom the policy is issued, as stated in the Policy Schedule.

Prescription Drug – means a drug which has been determined to be safe and effective by the Food and Drug Administration and which can, under federal or state law, only be dispensed when ordered by a Physician who is duly licensed to prescribe such medication.

Radiology Services - Covered Services includes x-ray and radiology examination, consultation and fees for interpretation or reading of X-rays and other radiology results. Diagnostic X-rays are obtained from an x-ray machine and images are recorded on radiographs (films). This benefit does not include Diagnostic Imaging if listed as a separate benefit in the Schedule of Covered Services – Supplies.

Residence - means the building and grounds where the Insured lives.

Sound and Natural Tooth - means the major portion of the individual tooth, formed by the human body, is present. Does not include teeth that are carious, abscessed, or defective.

Sponsored and Supervised Activity - means any activity which is exclusively sponsored by the Policyholder and which is under the direct and immediate supervision of an employee of the Policyholder.

Surgical Care – means Physician's fees for surgery. Surgical procedures are identified in the Surgery section of the Physicians' Current Procedural Terminology (CPT). If two or more procedures are performed through the same incision or at the same operative session, the maximum amount payable for the subsequent procedure(s) will not exceed 50% of the Usual and Customary Charges for the subsequent procedure(s).

Usual and Customary Charges (U&C) - means charges for medical services or supplies for which the Insured is legally liable and which do not exceed the average rate charged for the same or similar services or supplies in the geographic region where the services or supplies are received.

Usual and Customary Charges for Covered Services - Supplies are determined by referencing the 75th percentile of the most current survey published by FAIR Health, Inc. for such Covered Service.

GENERAL POLICY PROVISIONS

ENTIRE CONTRACT CHANGES

This Policy, including the endorsements and attached papers, if any, and the Policyholder's application constitute the entire contract of insurance. All statements made by the Policyholder shall, in the absence of fraud, be deemed representations and not warranties. No such statements will be used in defense to a claim under this Policy unless it is contained in the written application signed by, and furnished to, the Policyholder. No changes in this Policy shall be valid until approved by an executive officer of the Company and unless such approval be endorsed hereon and attached hereto. No agent has authority to change this Policy or to waive any of its provisions.

ADDITIONAL INSUREDS

All new persons eligible for coverage under this Policy may be added to those persons originally insured under this Policy.

NOTICE OF CLAIM

Written notice of claim must be given to the Company's Administrative Office within thirty (30) days after the occurrence or commencement of any loss covered by this Policy, or as soon thereafter as is reasonably possible. Notice given on behalf of the Insured or the beneficiary to the Company's Administrative Office, 333 North Main Street, Suite 300, Stillwater, MN 55082, or its authorized agent, with information sufficient to identify the Insured, shall be deemed notice to the Company.

CLAIM FORMS

The Company, upon receipt of a 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 fifteen (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 proofs of loss, written proofs covering the occurrence, the character and the extent of loss for which claim is made.

PROOFS OF LOSS

Written proof of loss must be furnished to The Company's Administrative Office, 333 North Main Street, Suite 300, Stillwater, MN 55082 within ninety (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, later than one year from the time proof is otherwise required.

TIME PAYMENT OF CLAIMS

Indemnities payable under this Policy will be paid as they accrue immediately upon receipt of due written proof of such loss.

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 indemnities will be payable to the Insured, except that if the Insured is a minor, said indemnities may be payable to the Insured's parents, guardian, or other person actually

supporting the Insured. Unless the Company is requested otherwise in writing not later than the time of filing proofs of loss, such indemnities may be paid directly to the Hospital or person rendering such services; but it is not required that the services be rendered by a particular Hospital or person. Payment so made shall discharge the Company's liability with respect to the amount of insurance so paid.

PHYSICAL EXAMINATION AND AUTOPSY
The Company at its own expense shall have the right and opportunity to examine the person of the Insured when and so often as it may reasonably require during the pendency of claim hereunder and also the right and opportunity to make an autopsy in case of death, where it is not prohibited by law.

OTHER INSURANCE WITH THIS COMPANY
Insurance effective at any one time on the Insured under a like policy or policies of the Company is limited to the one such policy elected by the Insured, or Insured's beneficiary or estate, as the case may be.

LEGAL ACTIONS
No action at law or in equity shall be brought to recover on this Policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this Policy and no such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished in accordance with the requirements of this Policy.

CONFORMITY WITH STATE STATUTES
Any provision of this Policy which, on its effective date, is in conflict with the statutes of the state in which the Policyholder is located on such date is hereby amended to conform to the minimum requirements.

NON-PARTICIPATING
This Policy and Certificates issued under it are non-participating. No dividends will be paid.

ADDITIONAL POLICY PROVISIONS

EFFECTIVE DATE
Voluntary coverage under this Policy with respect to each Insured shall become effective on the later of the following dates:

a) 12:01 a.m. following the date on which the required premium is actually received and dated by the Policyholder, the Company's Administrative Office, or its authorized agent; or
b) 12:01 a.m. following the date the envelope containing the enrollment form and premium payment is postmarked by the U.S. Postal Service if not dated as specified in a) above; or
c) the Policy Effective Date.

Group coverage under this Policy with respect to each Insured shall become effective on the later of the following dates:

a) 12:01 a.m. following the date the application and premium payment is received by the Company's Administrative Office or its authorized agent; or
b) the Policy Effective Date.

The effective date of coverage for voluntary interscholastic sports that begin prior to the first day of the regular School year is the Policy Effective Date, if the premium is received by the Company's Administrative Office, the Policyholder or its authorized agent within ten (10) days of the Policy Effective Date.

EXPIRATION DATE
Coverage under this Policy with respect to each Insured will end on the earliest of the following dates:

a) 11:59 p.m. on the date on which the Insured ceases to be enrolled in the School if the School-Time or Interscholastic sports coverage is purchased; or
b) 11:59 p.m. on the last date of the period of coverage for which the premium was paid; or
c) 11:59 p.m. on the last date of the authorized season or activity for the Interscholastic or Intercollegiate Sports, Football or Special Risk Activity of the current Policy period; or
d) 11:59 p.m. on the Policy Expiration Date.

NON-INTERRUPTION OF COVERAGE
Notwithstanding any provision contained in this Policy to the contrary, each Insured under this Policy, who would be eligible for coverage under a new policy at the commencement of the new School term, shall be protected by this Policy without interruption of coverage until ten (10) days after the new term commences or until the premium for the new policy is paid, whichever is earlier.

RIGHT OF SUBROGATION: If the Company provides payment for benefits under this Policy in an amount greater than $100.00, the Company will have a right to be reimbursed from any payments an Insured obtains or has right to obtain from any third party. The Company may require an assignment from the Insured of the Insured's right to recover to the extent of payments by the Company, or for the reasonable value of benefits and services provided by the Company; The Company's subrogation rights will be valid only if an Insured is fully compensated for the loss for which benefits are provided under this Policy.

RIGHT OF RECOVERY: Payments made by the Company which exceed the Benefits payable under this Policy may be recovered by the Company from or among any persons, firms, or corporations to or for whom such payments were made or from any insurance organizations who are obligated to pay benefits for any covered Injury or Sickness.

GENERAL ENDORSEMENT FOR MISSISSIPPI

This Endorsement is made a part of the Policy to which it is attached.

SECTION - EXCLUSIONS is revised as follows:

Intentionally self-inflicted Injuries; Injuries sustained while fighting or brawling, or violating or attempting to violate any existing city, state, or federal law; Injuries sustained or contracted in consequence of being intoxicated or under the influence of any narcotic unless administered on the advice of physician.

SECTION – GENERAL POLICY PROVISIONS is revised as follows:

TIME LIMIT ON CERTAIN DEFENSES is added: After 2 years from the Policy Effective Date no misstatements, except fraudulent misstatements, can be used to void the policy or to deny a claim for Loss incurred or disability (as defined in the Policy) commencing after the expiration of such two-year period.

TIME PAYMENT OF CLAIMS is revised:
All benefits payable under this Policy for any Loss shall be paid within twenty-five (25) days after receipt of due written Proof of Loss in the form of a clean claim where claims are submitted electronically, and will be paid within thirty-five (35) days after receipt of due written proof of such loss in the form of clean claim where claims are submitted in paper format. Benefits due under the policies and claims are overdue if not paid within twenty-five (25) days or thirty-five (35) days, whichever is applicable, after the Company receives a clean claim.

A "clean claim" means a claim received by the Company for adjudication and which requires no further information, adjustment or alteration by the provider of the services or the Insured in order to be processed and paid by the Company. A claim is clean if it has no defect or impropriety, including any lack of substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this provision. A clean claim includes resubmitted claims with previously identified deficiencies corrected.

A clean claim does not include any of the following:
a. A duplicate claim, which means an original claim and its duplicate when the duplicate is filed within thirty (30) days of the original claim;
b. Claims which are submitted fraudulently or that are based upon material misrepresentations;
c. Claims that require information essential for the Company to administer Policy provisions; or
d. Claims submitted by a provider more than thirty (30) days after the date of service; if the provider does not submit the claim on behalf of the Insured, then a claim is not clean when submitted more than thirty (30) days after the date of billing by the provider to the Insured.

Not later than twenty-five (25) days after the date the Insurer actually receives an electronic claim, the Company shall pay the appropriate benefit in full, or any portion of the claim that is clean, and notify the provider (where the claim is owed to the provider) or the Insured (where the claim is owed to the insured) of the reasons why the claim or portion thereof is not clean and will not be paid and what substantiating documentation and information is required to adjudicate the claim as clean. Not later than thirty-five (35) days after the date the Company actually receives a paper claim, the Company shall pay the appropriate benefit in full, or any portion of the claim that is clean, and notify the provider (where the claim is owed to the provider) or the Insured (where the claim is owed to the insured) of the reasons why the claim or portion thereof is not clean and will not be paid and what substantiating documentation and information is required to adjudicate the claim as clean. Any claim or portion thereof resubmitted with the supporting documentation and information requested by the Company shall be paid within twenty (20) days after receipt.

For purposes of this provision, the term "pay" means that the Insurer shall either send cash or a cash equivalent by United States mail, or send cash or a cash equivalent by other means such as electronic transfer, in full satisfaction of the appropriate benefit due the provider (where the claim is owed to the provider) or the Insured (where the claim is owed to the insured). To calculate the extent to which any benefits are overdue, payment shall be treated as made on the date a draft or other valid instrument was placed in the United States mail to the last known address of the provider (where the claim is owed to the provider) or the Insured (where the claim is owed to the Insured) in a properly addressed, postpaid envelope, or, if not so posted, or not sent by United States mail, on the date of delivery of payment to the provider or Insured.

If the claim is not denied for valid and proper reasons by the end of the applicable time period prescribed in this provision, the Company must pay the provider (where the claim is owed to the provider) or the Insured (where the claim is owed to the Insured) interest on accrued benefits at the rate of one and one-half percent (1-1/2%) per month accruing from the day after payment was due on the amount of the benefits that remain unpaid until the claim is finally settled or adjudicated.

Whenever interest due pursuant to this provision is less than One Dollar ($ 1.00), such amount shall be credited to the account of the person or entity to whom such amount is owed.

In the event the Company fails to pay benefits when due, the person entitled to such benefits may bring action to recover such benefits, any interest which may accrue, and any other damages as may be allowable by law.

PHYSICAL EXAMINATION is revised: The Company at its own expense shall have the right and opportunity to examine the person of the Insured when and so often as it may reasonably require during the pendency of claim hereunder.

CHANGE OF BENEFICIARY is added: The right to change the beneficiary is reserved to the Insured, and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this Policy, or to any change of beneficiary or beneficiaries, or to any other changes in this Policy.

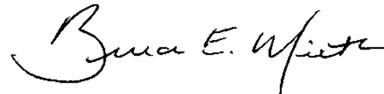
SECTION – ADDITIONAL POLICY PROVISIONS is revised as follows:

GRACE PERIOD: A grace period of seven (7) days for weekly premium notices, ten (10) days for monthly premium policies and thirty-one (31) days for all other policies will be granted for the partial payment of each premium due, except the first premium. Coverage will continue in force during the grace period, unless the Insured Person has given prior written notice or discontinuance of coverage in advance of the date of discontinuance. However, the Insured person will be liable for payment of premium during the time coverage remains in force during the grace period.

Nothing contained in this endorsement shall be held to alter, extend, vary or waive any other terms of the Policy, except as stated above. All such other terms of the Policy apply.

Signed for Security Life Insurance Company of America.

Heather Anschutz
Secretary



Bruce E. Mieth
President

EXTENDED DENTAL COVERAGE ENDORSEMENT

This endorsement is made a part of this Policy to which it is attached. It provides benefits for loss resulting from an Accidental injury to a tooth or teeth, incurred while coverage under this Policy is in force. Coverage is subject to the Benefits and Limitations of this endorsement and all such other applicable terms, conditions, limitations and exclusions of this Policy.

IN FORCE COVERAGE – An Insured for whom the required Extended Dental Coverage premium has been paid, as set forth in this Policy, will have coverage in force on a 24-hour per day basis.

BENEFITS – Treatment must begin within 60 days from the date of Accident causing the dental Injury. When dental Injury results in treatment by a Dentist, the Company will pay the Usual and Customary (U&C) Charges for covered Dental Services and Supplies listed below incurred within one year from the date of the Injury. Benefits are paid up to a Maximum Benefit of $5,000 per Injury. Benefits are payable for expenses which are not covered by Other Valid Coverage.

SERVICES AND SUPPLIES – Covered dental services and supplies related to an Accidental Injury include:

1. Hospital services and supplies.

2. Necessary dental care to the tooth, including root canal treatment, examination and x-rays.

3. Benefits for dental prosthesis, including procedures performed to install them, are payable up to $500 per Injury. Dental prosthesis includes but are not limited to: crowns; dentures; bridges, and implants.

4. Benefits are payable up to $200 per tooth for the estimated cost of necessary deferred dental treatment. The Insured's attending Dentist must certify within the one year period following the date of Accident that dental treatment and/or replacement must be deferred beyond the one year period. Benefits for deferred dental prosthesis is not payable if the dental prosthesis maximum benefit limit in 3. above has been paid for the same Accident.

EXCLUSIONS – the Extended Dental Coverage does not provide benefits for any expense or loss resulting or complicated by:

1. Orthodontics treatment for any purpose.

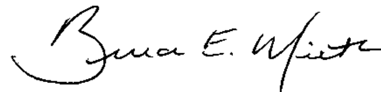
2. Dental disease, including but not limited to treatment of cavities, removal of abscessed, diseased, decayed or impacted teeth or periodontal treatment.

3. Benefits for estimated deferred dental prosthesis that exceeds the dental prosthesis maximum benefit limit.

Nothing contained in this endorsement shall be held to alter, extend, vary or waive any other terms of the Policy, except as stated above.

Signed for Security Life Insurance Company of America on the Policy Date.

Heather Anschutz
Secretary



Bruce E. Mieth
President