GROUP STUDENT ACCIDENT TERM INSURANCE
NON-RENEWABLE

SECURITYLIFE
INSURANCE COMPANY OF AMERICA
10901 Red Circle Drive, Minnetonka, Minnesota 55343-9137

Hereby insures persons (hereinafter called the Insured) who are regularly enrolled in the School for which the required premium has been paid, and agrees to pay all benefits, as specifically described in the Policy, for expenses resulting from accidental bodily injury, independent of all other causes and incurred while the Policy is in force with respect to each Insured person and while the coverage is in force for the Insured person as explained on Page 2.

This is a group policy issued to the policy holder identified on the Policy Schedule. The insured must be a member of the group to be eligible for coverage. Individuals are not issued a policy. Please review the policy and notify the company if you have questions.

EXECUTED by the Security Life Insurance Company of America at its Home Office in Minnetonka, Minnesota, on the Date of Issue.

Daniel R. Bauer
Secretary

Mark A. Zesbaugh
President/CEO

POLICY SCHEDULE

POLICYHOLDER:	**Providence Christian College** **1539 E Howard Street** **Pasadena, CA 91104**
EFFECTIVE DATE:	**08-15-2014**
EXPIRATION DATE:	**08-14-2015**
POLICY NUMBER:	**04-56-0031-016-077-4**
MAXIMUM MEDICAL BENEFIT:	**$50,000 per Injury**
DEDUCTIBLE:	**$1,000 per Injury**
PRINCIPAL SUM:	**$1,000**
ENDORSEMENTS:	**GHE-935-CA; GH-939**

PREMIUMS:

	ANNUAL
Full-Time Coverage – per student	$ 53.00

100% Participation – Group coverage – Premium is not prorated
All full-time students and student athletes participating in Cross Country are eligible. Students must be physically and actively attending classes on campus.

POLICY CONTENTS

Page

INFORCE COVERAGE - Coverage is in force for each insured person under the following conditions:

FULL TIME COVERAGE

Each person for whom the required FULL TIME premium has been paid as set forth in this policy, shall be insured, subject to Exclusions, on a 24-hour per day basis; does not include coverage for sports except as indicated on the Policy Schedule on page 1.

SECTION I – BENEFITS FOR MEDICAL EXPENSES

When injury covered by this policy results in treatment by a Licensed Physician within 120 days from the date of accident, the Company will pay the Usual and Customary Charges (U&C) incurred for necessary Services and Supplies as listed below, for charges actually incurred within one year from the date of injury up to the specified Maximum Medical Benefit per injury.

This policy will pay benefits regardless of Other Valid Coverage if the covered claim expense is less than $100. If the covered claim expense exceeds $100, benefits shall be paid first by Other Valid Coverage.

SECTION I(A) – SERVICES AND SUPPLIES

1. Physician's Services (other than x-ray)
   (a) Surgical Operations (fractures, dislocations or repair of lacerations) - U&C
   (b) Assistant Surgeon - U&C
   (c) Anesthesiologist - U&C
   (d) Non-surgical Care (includes physical therapy treatments) - U&C
   (e) Consultant Physician (when requested by the attending physician) - U&C

2. Hospital Care (benefits for hospital miscellaneous charges are limited to services not scheduled elsewhere under Services and Supplies)
   (a) Room and board - U&C
   (b) Inpatient Miscellaneous Charges - U&C
   (c) Outpatient Surgery (facility charges for outpatient day surgery) - U&C
   (d) Emergency Room - U&C
   (e) Nurse Services (In-hospital) - U&C

3. Radiology Services (including charges for reading) - U&C

4. Diagnostic Imaging (MRI, CAT scan, and bone scan) - U&C

5. Dental Treatment (benefits are limited to repair and/or replacement of each sound and natural tooth) - $200 per tooth

6. Ambulance Services (ground service only) - U&C

SECTION I(B) - EXCLUSIONS

This policy does not provide benefits for:

1. Any sickness, disease, infection (unless caused by an open cut or wound), 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, or orthodontics.

2. Injuries for which benefits are payable under Workmen's Compensation or Employer's Liability Laws.

3. Repair or replacement of eyeglasses or contact lenses.

4. The services of a second or subsequent Licensed Physician when not requested in writing by the attending Physician.

6. Any injury involving a two or three wheeled motor vehicle or snowmobile. Injuries involving any other motor vehicle are covered up to a maximum medical benefit as shown in the Schedule of Benefits.

SECTION II -DEFINITIONS

Wherever used in this Master Policy:

1. **“Accident”** means an unexpected, external and sudden event that is independent of any other cause.

2. **“Company**” means the Security Life Insurance Company at its Home Office in Minnetonka, Minnesota.

3. **“Hospital”,** means an institution licensed by the State (if required), which is operated for the care of resident inpatients and has a graduate nurse on duty, has a laboratory and operating room where surgery is performed, has a staff of one or more Licensed Physicians available at all times, and is not primarily a clinic, sanitarium, nursing home, or rest home.

4. **"Injury"** means an injury to the body of the Insured directly caused by specific accidental contact with another body or object during the Insured's term of coverage under the Master Policy. It is unrelated to any pathological, functional, or structural disorder. The accident must result in a loss beginning during the Insured's term of coverage under the Master Policy.

   The term "Injury" also means a reinjury incurred while the policy is in force with respect to the Insured, for which the Insured has remained treatment free for a period of 180 days prior to the effective date of the Master Policy.

   If benefits have been paid under the Master Policy for an injury incurred while the Master Policy is in force with respect to the Insured, a reinjury will be considered a new injury if:

   a. the reinjury occurs while the Master Policy is in force with respect to the Insured; 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 reinjury.

   A reinjury that is incurred within 180 days of the original injury, will be considered a continuation of the original injury.

5. **"Inpatient Care"** resulting in hospital confinement means a stay as a resident bed patient in a hospital for eighteen (18) or more consecutive hours.

6. **"Licensed Physician"** means any medical practitioner, other than a member of the Insured's immediate family, licensed to practice medicine in the State in which he practices.

7. **"Other Valid Coverage"** means any plan providing benefits or services for medical 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; 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 type of contracts include but are not limited to; associations, franchise or blanket insurance.

   This policy will not cover expenses which are payable under the Insured's HMO or PPO. The 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 for alternative care, the Company will pay the expense incurred that would have been covered had the Insured used a preferred provider.

   "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.

SECTION II -DEFINITIONS CONT.

8. **"Radiology Services"** means any procedure or service performed for the diagnosis or detection of an injury or condition that is covered under the terms of the policy, by means of x-rays and radiation. It does not include MRIs (magnetic resonance imaging); CAT Scans; or bone scans.

9. **"Residence"** means the building and ground where the Insured resides.

10. "**School Sponsored and Supervised Activity"** means any activity which is exclusively sponsored by the Policyholder and which is under the immediate supervision of an employee of the Policyholder.

11. "**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 are determined by using the 75th percentile of the most current value published by FAIR Health, Inc. for such services or supplies.

SECTION III -ACCIDENTAL DEATH & DISMEMBERMENT BENEFITS

When injury covered by this policy, results in the following specific losses within 180 days from the date of accident, the Company will pay indemnity in the amount (the largest applicable thereto) as specified below for any one injury, and shall be in addition to any other benefits for such accident. 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 of Life -	The Principal Sum
Loss of both Hands, both Feet or Sight of both Eyes -	Two times the Principal Sum
Loss of one Hand, one Foot or Sight of one Eye -	The Principal Sum

SECTION IV - 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.

NOTICE OF CLAIM: Written notice of claim must be given to The Company within thirty (30) days after the occurrence or commencement of any loss covered by the Policy, or as soon thereafter as is reasonably possible. Notice given in behalf of the Insured or the beneficiary to the Company at its Home Office, in Minnetonka, Minnesota, or to any authorized agent of the Company, with information sufficient to identify the Insured, shall be deemed notice to the Company.

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

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 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 in this insurer 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.

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

SECTION V -ADDITIONAL POLICY PROVISIONS

EFFECTIVE DATE: The insurance with respect to each Insured person shall become effective on the later of the following dates:

(a) the date on which the required premium is actually received by the Policyholder, the Company or its authorized agent; or
(b) the Master Policy effective date.

The effective date of coverage for interscholastic sports that begin prior to the first day of the regular school year is the Effective Date of the Master Policy, if the premium is received by the Policyholder or agent within ten (10) days of the Effective Date of the Master Policy.

EXPIRATION DATE: The insurance with respect to each Insured person shall expire on the earlier of the following dates:

(a) the date on which the Insured ceases to be enrolled in the school if the SCHOOL-TIME COVERAGE is purchased; or at the close of the period for which the premium is paid; or
(b) the Expiration Date shown on the Policy Schedule if the Interscholastic Sports coverages are purchased; or
(c) the Master 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.

FACILITY OF PAYMENT: If Other Valid Coverage makes benefit payments that should have been made by the Company pursuant to the Master Policy, the Company may make payment to the Other Valid Coverage to satisfy its obligation under the Master Policy.

RIGHT OF RECOVERY: If the amount of any benefit payment made by the Company is more than the amount needed to satisfy its obligation under the Master Policy, the Company may exercise its rightly to recover such excess payments from: any person(s) to or form whom or with respect to whom the payment were made; or any organization providing Other Valid Coverage.

Countersigned by:

_____

Licensed Resident Agent

GENERAL ENDORSEMENT

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

SECTION IV – GENERAL POLICY PROVISIONS is revised by adding the following:

TIME LIMIT ON CERTAIN DEFENSES:

(a) After two years from the date of issue of this policy, no misstatement of the Policyholder, except a fraudulent misstatement, made in his 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.

(b) No claims for loss incurred or disability (as defined in the policy) commencing after six months from the effective date of the insurance coverage with respect to which the claim is made shall be reduced or denied on the grounds that a disease or physical condition, not excluded from the coverage by name or specific description effective on the date of loss, had existed during the six months immediately prior to the effective date of coverage with respect to which the claim is made.

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

CHANGE OF BENEFICIARY: The right to change of beneficiary is reserved to the Insured person, and the consent of the beneficiary or beneficiaries shall not be requisite to any change in beneficiary.

In all other respects the terms of this policy remain unchanged.

Signed for us at our Home Office on the Policy Date.

Secretary

President

SECURITY LIFE INSURANCE COMPANY OF AMERICA

Anti-Duplication Disclosure Notice

The Notice is required by State of California. The benefits payable under the Policy may be reduced, subject to the policy limits, if an insured person is entitled to benefits from "other valid coverage" for the expenses stated below.

The benefits paid under the Policy may be reduced when an insured receives benefits on a indemnity basis or on a provision of service basis for hospital, medical, dental or surgical expenses under any other valid and collectible individual, group, or blanket insurance policy or contract, or group practice prepayment plan, except automobile medical payments insurance.

The policy will pay up to $100 of covered claim expenses incurred by the insured, regardless of "other valid coverage" when the covered claim expenses are less than $100. If the covered claim expense is equal to or greater than $100, benefits shall be paid first by "Other Valid Coverage." The policy will then pay benefits up to the policy limits, for those covered expenses not paid by "Other Valid Coverage."

"Other Valid Coverage" means any plan providing benefits or services for medical 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; 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; association, franchise or blanket insurance.

The Policy will not cover expenses that are payable under the insured's HMO or PPO plan. The Policy will pay benefits in excess of coverage provided by the insured's HMO or PPO plan. If the insured chooses not to use a preferred provider (under HMO or PPO), or does not obtain the required pre-authorization for alternative care, the company will pay the expense incurred that would have been covered had the insured used a preferred provider.

"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 non-governmental plan.