Starr Indemnity & Liability Company

Dallas, Texas
Administrative Office: 90 Park Avenue, 7th Floor, New York, NY 10016

Blanket Accident Insurance Policy

Policyholder: **Music City Mystique**
c/o Starr Indemnity & Liability Blanket Accident and Health Insurance Trust
616 Russell Street
Nashville, TN 37206

Policy Number: **BAP-112871-1**

Effective Date: **1/1/2010**

This Policy is a legal contract between the Policyholder and Starr Indemnity & Liability Company (herein referenced as "the Company"). The Company agrees to provide insurance to the Policyholder, in exchange for the payment of the required premium. Coverage is subject to the terms and conditions described in this Policy.

This Policy and the coverage provided by it become effective at 12:01 A.M. at the address of the Policyholder on the Policy Effective Date shown above. It continues in effect in accordance with the provisions set forth in this Policy.

This Policy is governed by the laws of the state of Delaware.

Signed for the Company as of the Effective Date above:

Richard N. Shaak, President

Honora M. Keane, General Counsel

THIS IS A BLANKET ACCIDENT INSURANCE POLICY.
THE POLICY DOES NOT PAY BENEFITS FOR LOSSES CAUSED BY SICKNESS.
PLEASE READ THE POLICY CAREFULLY.

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DEFINITIONS

The male pronoun includes the female whenever used.

For the purposes of this Policy the capitalized terms used herein are defined as follows:

ACCIDENT means a sudden, unexpected event that results in Injury to the Covered Person.

BENEFIT PERIOD means the period of time, as stated on the Schedule of Benefits, between the date of the Accident causing the Injury for which benefits are payable and the date after which no further benefits will be paid.

COVERED ACCIDENT means an Accident that occurs while coverage is in force for a Covered Person and results in a Covered Loss or Injury for which benefits are payable.

COVERED LOSS or COVERED LOSSES means an accidental death, dismemberment or other Injury covered under this Policy.

COVERED PERSON means an eligible person who is within the covered class(es) listed in the Policy Schedule of Benefits, who is a U.S citizen residing in the United States, or if not a U.S. citizen, resides permanently in the United States, and for whom the required premium is paid when due.

DEDUCTIBLE means the dollar amount of Covered Expenses that must be incurred by the Covered Person as an out-of-pocket expense for each Accident, before Accident Medical Expense Benefits paid on an expense incurred basis are payable under this Policy. Only one Deductible will apply to the Covered Person and his or her Dependents if Injured in the same Covered Accident.

HOSPITAL means an institution that:

1) operates as a Hospital pursuant to law for the care, treatment and providing in-patient services for sick or injured persons;
2) provides 24-hour nursing service by registered nurses on duty or call;
3) has a staff of one or more licensed physicians available at all times;
4) provides organized facilities for diagnosis, treatment and surgery, either
   a) on its premises; or
   b) in facilities available to it, on a pre-arranged basis;
5) is not primarily a nursing care facility, rest home, convalescent home or similar establishment, or any separate ward, wing or section of a Hospital used as such; and
6) is not a place for drug addicts, alcoholics or the aged.

We will not deny a claim for services solely because the Hospital lacks major surgical facilities and is primarily of a rehabilitative nature, if such rehabilitation is specifically for the treatment of a physical disability, and the Hospital is accredited by any one of the following:

1) the Joint Commission of Accreditation of Hospitals; or
2) the American Osteopathic Association; or
3) the Commission on the Accreditation of Rehabilitative Facilities.

IMMEDIATE FAMILY means the Covered Person's parent, grandparent, spouse, child(ren) (includes legally adopted children or step children, brother, sister, step-children, grand children, or in-laws.)

INJURY means bodily injury caused by the direct result of an Accident occurring while the Policy is in force as to the person whose injury is the basis of the claim which results, directly and independently of all other causes, in a Covered Loss.

MEDICAL EMERGENCY means a condition caused by an Injury that manifests itself by symptoms of sufficient severity that a prudent lay person possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would place the health of the person in serious jeopardy.

MEDICALLY NECESSARY means a treatment, service or supply that is:

1) required to treat an Injury;
2) prescribed or ordered by a Physician or furnished by a Hospital;
3) performed in the least costly setting required by the condition;
4) consistent with the medical and surgical practices prevailing in the area for treatment of the condition at the time rendered.

The purchasing or renting of air conditioners; air purifiers, motorized transportation equipment, escalators or elevators in private homes, swimming pools or supplies for them; and general exercise equipment are not considered Medically Necessary.

A service or supply may not be Medically Necessary if a less intensive or more appropriate diagnostic or treatment alternative could have been used. We may, at Our discretion, consider the cost of the alternative to be the Covered Expense.

PHYSICIAN means a person who is a qualified practitioner of the healing arts, including a chiropractor and a dental practitioner. As such, he or she must be acting within the scope of his/her license under the laws in the state in which he or she practices and providing only those medical services which are within the scope of his/her license or certificate. It does not include a Covered Person or a Covered Person's Immediate Family.

SUBSCRIBER means a legal entity that is a participating organization under the Trust.

USUAL AND CUSTOMARY CHARGES means the average amount charged by most providers for treatment, service or supplies in the geographic area where the treatment, service or supply is provided.

WE, OUR, US means Starr Indemnity & Liability Company underwriting this insurance.

YOU, YOUR, YOURS, HE or SHE means the Covered Person who meets the eligibility requirements of the Policy and whose insurance under the Policy is in force.

ELIGIBILITY FOR INSURANCE

If the Covered Person is in one of the classes of Eligible Persons shown on the Policy Schedule of Benefits, He or She is eligible to be covered under the Policy. We retain the right to investigate eligibility status and attendance records to verify eligibility requirements are met. If We discover the eligibility requirements are not met, Our only obligation is to refund any premium paid for that person.

EFFECTIVE DATE OF INSURANCE

Policy Effective Date. This Policy begins on the Policy Effective Date shown in the Schedule of Benefits at 12:01 A.M. at the address of the Policyholder.

Covered Person's Effective Date

A Covered Person's coverage under this Policy begins on the later of:

1) the Policy Effective Date;
2) the date such person becomes eligible as described in the Schedule of Benefits; or
3) His Subscriber’s Effective Date.

TERMINATION DATE OF INSURANCE

Policy Termination Date

Termination takes effect at 12:01 A.M. time at the address of the Policyholder on the date of termination. Termination by the Policyholder or by the Company will be without prejudice to any claims originating prior to the date of termination.

This Policy terminates automatically on the earlier of:

1) The Policy Termination Date shown in this Policy; or
2) The premium due date if premiums are not paid when due subject to any grace period provided.

Failure by the Policyholder to pay all required premiums due by the last day of the grace period shall be deemed notice by the Policyholder to the Company to terminate this Policy on the last day of the period for which premiums have been paid.

This Policy may be terminated by the Policyholder or the Company as of any premium due date or Policy Anniversary Date by giving written notice to the other at least 31 days prior to such date.

The Policyholder and the Company may terminate this Policy at any time by written mutual consent.

If premiums have been paid beyond the termination date, the Company will refund the excess; or if premiums have been paid short of the termination date, the Policyholder will owe the Company the difference.

Covered Person's Termination Date

A Covered Person's coverage under this Policy ends on the earliest of:

1) The date this Policy terminates;
2) The date the Covered Person enters full-time active duty in the armed forces of any country or international authority;
3) The date the Covered Person ceases to be eligible as described in the Policy provided all required premiums are paid;
4) The last day of the period for which premiums have been paid; or
5) The date His Subscriber ceases to be a participating organization under the Trust.

PREMIUMS

The Company provides insurance in return for premium payments. The premium showed in the Schedule of Benefits is payable to the Company in the manner described and is based on rates currently in force, the plan, and the amount of insurance in force. Premium is due on the Policy Effective Date. After that premium will be due monthly unless otherwise stated in the Policy.

The Company has the right to rely upon the accuracy of the Subscriber's calculations and to require the Subscriber to furnish a census from time to time but not more than twice in a 12-month period. If, at any time, it is determined that additional premium or a premium credit is due, the Subscriber will pay the additional premium or apply the premium credit at the next premium due date.

If any premium payment is not paid when due, the Policy will be cancelled as of the premium due date, except as provided under the Grace Period section.

Changes in Premium Rate

The Company may change the premium rates from time to time with at least 31 days advanced written or authorized electronic notice. No change in rates will be made until 12 months after the Policy Effective Date. However, the Company reserves the right to change rates at any time if any of the following events occur:

1) A change in the terms of the Policy.
2) A subsidiary, division, affiliated organization or eligible class is added or deleted to the Policy.
3) A change in any federal or state law or regulation affecting this Policy and Our benefit obligation.
4) A change in the factors bearing on the risk assumed.
5) A misrepresentation in the information relied on in establishing the rate for this Policy.

If an increase or decrease in rates takes place on a date that is not a Premium Due Date, a prorated adjustment will apply from the date of the change to the next Premium Due Date.

Grace Period

After the payment of the first premium, this Policy will have a 31 day grace period. This means that if premium is not paid on or before the date it is due, it may be paid during the 31 day grace period. During this time, this Policy will stay in force provided all the premiums due are paid by the last day of the grace period. This Policy will terminate on the last day of the period for which all premiums have been paid if all premiums due are not paid by the last day of the grace period.

HAZARDS INSURED AGAINST

We will pay benefits described in this Policy when a Covered Person suffers a loss or Injury as a result of a Covered Accident during one of the Covered Activities listed in the Schedule of Benefits. Unless otherwise specified, We pay benefits only once for any one Covered Accident, even if it is covered by more than one Hazard.

SPORTS COVERAGE

We will pay the benefits described in the Policy for an Accident which occurs while a Covered Person is:

(1) taking part in:
- (a) a regularly scheduled athletic game or competition; or
- (b) a practice session for an athletic team or club; or

(2) traveling to or from such a game, competition or practice session provided he is;
- (a) traveling with the athletic team or club; and
- (b) under the direct and immediate supervision of:
  - (i) the athletic team or club; or
  - (ii) an adult authorized by the athletic team or club;
- (c) in a vehicle which is:
  - (i) designated or furnished by the athletic team or club;
  - (ii) operated by a properly licensed, adult driver, or
  - (iii) under the direct supervision of the athletic team or club; or
- (d) in a vehicle other than that described in (3)(c) when operated by a properly licensed driver

Travel time includes the time:
- (1) to or from a scheduled game, competition or practice session;
- (2) before required attendance time;
- (3) after the Covered Person is dismissed; and
- (4) after the Covered Person completes extra duties assigned by the Subscriber.

Conditions which result over a period of time (including but not limited to blisters, tennis elbow, heat exhaustion, hernia, repetitive stress injury), and which are a normal, foreseeable result of the sport, are not covered. These items are considered a sickness and are not covered.

Unless otherwise stated in the Schedule of Benefits, We will pay benefits for a Covered Loss, only once, even if coverage was provided under more than one Hazard.

DESCRIPTION OF BENEFITS

All benefits payable are shown in the Schedule of Benefits.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

If Injury to the Covered Person results in any of the Covered Losses shown below, within the Loss Period as shown in the Schedule of Benefits from the date of the Covered Accident that caused the Injury, the Company will pay the percentage of the Principal Sum/Amount of Insurance shown below for that Loss. The Principal Sum/Amount of Insurance is shown in the Schedule of Benefits. If multiple losses occur, only one Benefit, the largest, will be paid for all Losses due to the same Covered Accident.

Loss of:	Benefit:
	(Percentage of Principal Sum/Amount of Insurance)
Life.....	100%
Two or More Members	100%
One Member	50%
Thumb and Index Finger of the Same Hand	25%

"Member" means Loss of Hand or Foot and Loss of Sight. "Loss of a hand or foot" means complete severance through or above the wrist or ankle joint. "Loss of sight" means total and permanent loss of sight of one/both eyes that is irrecoverable, including by surgical and artificial means. "Loss of thumb and index finger of the same hand" means complete severance of each through or above the metacarpophalangeal joint of both digits of the same hand. Severance means the complete separation and dismemberment of the part from the body.

ACCIDENT MEDICAL AND DENTAL EXPENSE BENEFIT

We will pay Accident Medical and Dental Expense Benefits for Covered Expenses that result directly, and from no other cause, from a Covered Accident. These benefits are subject to the Deductibles, Coinsurance Factors, Co-payments, Benefit Periods, Benefit Maximums and other terms or limits shown below and in the Schedule of Benefits.

Accident Medical Expense Benefits are only payable:

1) for Usual and Customary Charges incurred after the Deductible has been met;
2) for those Medically Necessary Covered Expenses incurred by or on behalf of the Covered Person;
3) for Covered Expenses incurred within 365 days after the date of the Covered Accident.

No benefits will be paid for any expenses incurred that are in excess of Usual and Customary Charges.

Covered Medical Expenses, from a Covered Accident, include:

1) Hospital room and board expenses: the daily room rate when a Covered Person is Hospital confined and general nursing care is provided and charged for by the Hospital. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge.
2) Ancillary Hospital expenses: services and supplies including operating room, laboratory tests, anesthesia and medicines (excluding take home drugs) when Hospital confined.
3) Daily Intensive Care Unit/Cardiac Care Unit Expenses: the daily room rate when a Covered Person is Hospital confined in a bed in the Intensive Care Unit/Cardiac Care Unit and nursing services other than private duty nursing services.
4) Registered nurse services expenses for private duty nursing while a Covered Person is Hospital confined, when services are ordered by a Physician.
5) Medical Emergency Care (room and supplies) expenses incurred within 72 hours of a Covered Accident and including the attending Physician's charges, x-rays, laboratory procedures, use of the emergency room and supplies.
6) Outpatient surgery expenses, including an ambulatory surgical center.
7) Outpatient surgical room and supply expenses for use of the surgical facility.
8) Outpatient diagnostic x-rays, laboratory procedures and test expenses.
9) Physician non-surgical treatment/examination expenses (excluding medicines) including the Physician's initial visit, each necessary follow-up visit and consultation visits when referred by the attending Physician.
10) Second surgical opinion expenses.
11) Physician surgical expenses. If an Injury requires multiple surgical procedures through the same incision, We will pay only one benefit, the largest of the procedures performed. If multiple surgical procedures are performed during the same operative session, but through different incisions, We will pay for the most expensive procedure and 50% of Covered Expenses for the additional surgeries.
12) Assistant surgeon expenses when Medically Necessary.
13) Anesthesiologist expenses for pre-operative screening and administration of anesthesia during a surgical procedure whether on an inpatient or outpatient basis.
14) Outpatient laboratory test expenses.
15) Physiotherapy (physical medicine) expenses on an inpatient or outpatient basis limited to one visit per day; expenses include treatment and office visits connected with such treatment when prescribed by a Physician, including diathermy, ultrasonic, whirlpool, heat treatments, chiropractic, adjustments, manipulation, massage or any form of physical therapy.
16) Post surgical physical medicine expenses and office visits connected with such treatment when prescribed by a Physician.
17) X-ray expenses (including reading charges) not including dental x-rays.
18) Diagnostic imaging expenses including magnetic resonance imaging (MRI) and CAT scans.
19) Dental expenses including dental x-rays for the repair or treatment of each injured tooth that is whole, sound and a natural tooth at the time of the Covered Accident.
20) Outpatient registered nurse services if ordered by a Physician.
21) Ambulance expenses for transportation from the Accident site to the Hospital.

22) Rehabilitative braces or appliances prescribed by a Physician. It must be durable medical equipment that is primarily and customarily used to serve a medical purpose and can withstand repeated use and generally is not useful to a person in the absence of Injury. No benefits will be paid for rental charges in excess of the purchase price.
23) Prescription drug expenses prescribed by a Physician and administered on an outpatient basis.
24) Medical equipment rental expenses for a wheelchair or other medical equipment that has therapeutic value for the Covered Person. We will not cover computers, motor vehicles or modifications to a motor vehicle, ramps and installation costs.
25) Medical services and supplies for blood and blood transfusions; oxygen and its administration.
26) Eyeglasses, contact lenses and hearing aids when damage occurs in a Covered Accident that requires medical treatment.
27) Artificial limbs, eyes and larynx for initial acquisition and fitting. We will not pay for repair or replacement of artificial limbs, eyes or larynx.

Terms of Payment for Accident Medical and Dental Expense Benefit

Full Excess:

If a Covered Person incurs Covered Expenses, We will pay the applicable benefit, subject to any applicable Deductible and Benefit Period shown on the Schedule of Benefits that are in excess of expenses payable by any other Health Care Plan, regardless of any Coordination of Benefits provision contained in such Health Care Plan. The first expense must be incurred within the Loss Period stated on the Schedule of Benefits. The Total Benefit Maximum payable under the Policy are shown on the Schedule of Benefits.

Failure by a Covered Person to follow the terms and conditions of His primary coverage will result in a benefit reduction of Eligible Expense to 50% of the amount otherwise payable under the Policy. This limitation will not apply to emergency treatment required within 24 hours after an Accident when the Accident occurs outside the geographic area served by His primary plan's HMO, PPO or other similar arrangement for provision of benefits or services, if applicable.

For the purposes of this provision, "Health Care Plan" means any contract, policy or other arrangement for benefits or services for medical or dental care or treatment under:
(1) group or blanket insurance, whether on an insured or self-funded basis;
(2) Hospital or medical service organizations on a group basis;
(3) Health Maintenance Organizations on a group basis;
(4) group labor management plans;
(5) employee benefit organization plan;
(6) professional association plans on a group basis;
(7) any other group employee welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974 as amended; or
(8) automobile no-fault coverage (unless prohibited by law).

EXCLUSIONS

This Policy does not cover any loss resulting in whole or part from, or contributed to by, or as a natural or probable consequence of, any of the following even if the immediate cause of the loss is an accidental bodily injury:

- Suicide, self-destruction, attempted self-destruction or intentional self-inflicted injury while sane or insane.
- War or any act of war, declared or undeclared, not including terrorism.
- Sickness, disease or any bacterial infection, except one that results from an accidental cut or wound or pyogenic infections that result from accidental ingestion of contaminated substances.
- Voluntarily taking any drug or narcotic unless the drug or narcotic is prescribed by a Physician.
- Covered Expenses for which the Covered Person would not be responsible in the absence of this Policy.
- Injuries paid under workers' compensation, employer's liability laws or similar occupational benefits or while engaging in activity for monetary gain from sources other than the Subscriber.
- Injury caused by, contributed to or resulting from the Covered Person's use of alcohol, illegal drugs or medicines that are not taken in the dosage or for the purpose as prescribed by the Covered Person's Physician.
- Service or active duty in the armed forces, National Guard, military, naval or air service or organized reserve corps of any country or international organization.
- Services or treatment rendered by a Physician, nurse or any other person who is employed or retained by the Subscriber; or an Immediate Family member of the Covered Person.
- Treatment of a hernia, Osgood-Schlatter's disease, osteochondritis, appendicitis, osteomyelitis, cardiac diseaseor conditions, pathological fractures, congenital weakness, whether or not caused by a Covered Accident.
- Damage to or loss of dentures or bridges or damage to existing orthodontic equipment, except as specifically provided in this Policy.
- Eyeglasses, contact lenses, hearing aids.
- Travel or flight in or on any vehicle for aerial navigation, including boarding or alighting from: While riding as a passenger in any aircraft not intended or licensed for the transportation of passengers.

CLAIMS PROVISIONS

NOTICE OF CLAIM: Written notice of death or Injury must be given to the Company within 30 days after a Covered Loss begins or as soon as reasonably possible. Notice can be given to the Company at Starr Indemnity & Liability Company, 90 Park Avenue, 7th Floor, New York, NY 10016, Attn: Claims Department. Notice should include the Covered Person's name and address as well as this Policy Number. If written notice is not received within 30 days, the claim may be reduced or invalidated. However, the claim will not be reduced or invalidated if:

1) it can be shown that it was not possible within reason to submit notice within the 30 day period; and
2) it is further shown that notice was given as soon as possible.

CLAIM FORMS: When the Company receives a notice of claim, the Company will send forms for filing proof of loss. If claim forms are not sent within 15 days after receipt of such notice, Proof of Loss requirements stated below will be deemed to have been met if, within the Proof of Loss time period specified below, written proof of the nature and extent of the loss is submitted.

PROOF OF LOSS: Written proof of loss must be given to the Company within 90 days after the date of loss. If the proof of loss is not submitted within 90 days, the claim may be reduced or invalidated. However, the claim will not be reduced or invalidated if:

1) it can be shown that it was not possible within reason to submit notice within the 90 day period; and
2) it is further shown that notice was given as soon as possible, and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

TIME OF PAYMENT OF CLAIMS: Benefits for loss covered by this Policy, other than benefits that require periodic payment, will be paid not more than 60 days after the Company receives proper written proof of such loss. Benefits for loss covered by this Policy that require periodic payment shall be paid monthly provided that the Company receives proper written proof of such loss.

PAYMENT OF CLAIMS: All benefits will be paid in United States currency. Loss of life benefits will be paid to the beneficiary as described in the Designation or Change of Beneficiary provision of this Policy entitled 'General Policy Provisions. To receive proceeds, a beneficiary must be living on the earlier of the following dates: the date the Company receives proof of the loss of life; or the 10^{th} day after the death.

All other benefits will be paid to the Covered Person suffering the loss. If the Covered Person dies before all payments due have been made, the amount still payable will be paid to his/her beneficiary as described in the Designation and Change of Beneficiary provision of this Policy entitled 'General Policy Provisions.'

PHYSICAL EXAMINATIONS AND AUTOPSY: We have the right to have a Physician of Our choice examine the Covered Person as often as is reasonably necessary. This section applies when a claim is pending or while benefits are being paid. We also have the right to request an autopsy in the case of death, unless the law forbids it. We will pay the cost of the examination or autopsy.

RECOVERY OF OVERPAYMENT: If benefits are overpaid, or paid in error, We have the right to recover the amount overpaid or paid in error by any of the following methods:

1) A request for lump sum payment of the amount overpaid or paid in error, or
2) Reduction of any proceeds payable under this Policy by the amount overpaid or paid in error.

SUBROGATION: The Subscriber is required to investigate and prosecute all valid claims that it may have against third parties arising out of any claim for which benefits were paid by this Policy. The Subscriber shall account to the Company for all amounts recovered. If the Subscriber fails to pursue any action against a third party and the Company has made benefit payments under this Policy, the Company will be subrogated to all of the Subscriber's rights to make recoveries. However, the Company's subrogation right is secondary to the Subscriber's right to be fully compensated for its damages. The Subscriber is required to cooperate fully and do all things necessary and required for the Company to pursue any action to recover against the third party. The Company agrees to pay its portion of the Subscriber's reasonable attorneys' fees or other costs associated with a claim or lawsuit to the extent that the Company recovers any portion of the benefits paid under this Policy pursuant to its subrogation right.

GENERAL POLICY PROVISIONS

ENTIRE CONTRACT/CHANGES: This Policy, with the Policyholder's Master Application and all Subscription Agreements, endorsements, amendments and attached papers is the entire contract between the parties. Changes to this Policy may be made at any time by an endorsement or amendment and must be agreed upon, in writing, between the Policyholder and the Company. The Company may also, upon 31 days written notice to the Policyholder, change or modify the provisions of this Policy to comply with any applicable requirements of the Internal Revenue Service and/or any state or other federal law or regulation. No agent may change this Policy or waive any of its provisions.

TIME LIMIT ON CERTAIN DEFENSES: In the absence of fraud, all statements made by the Policyholder, Subscriber or by a Covered Person shall be deemed representations and not warranties. No such statement shall be used to contest this Policy or reduce benefits unless contained in a signed, written application, a copy of which has been provided to the person who made the statement, or to their beneficiary or representative. No such statement will be used to contest this Policy after this Policy has been in force for two years.

CERTIFICATES OF INSURANCE: The Company will issue to the Subscriber certificates of insurance for delivery to each Covered Person covered by this Policy, where required by law. Certificates will list the benefits, conditions and limits of this Policy and to whom benefits will be paid.

CLERICAL ERROR: Clerical error in keeping any records pertaining to the coverage, whether by the Policyholder, Subscriber or by the Company, will not invalidate coverage otherwise validly in force nor continue coverage otherwise validly terminated, provided such clerical error is not prejudicial to the Company and is rectified promptly upon discovery.

CONFORMITY WITH STATE STATUTES: Any provision of this Policy in conflict on its effective date with the laws of the state where the Covered Person lives is amended to conform to the minimum requirements of such laws.

DESIGNATION OR CHANGE OF BENEFICIARY: Each Covered Person may designate a beneficiary to whom loss of life benefits are payable. The designation shall be as follows in descending order of preference:

1) Beneficiaries designated in writing by the Covered Person for this Policy on file with the Subscriber, if any, otherwise;
2) In equal shares to the members of the first surviving class of those that follow, if any:
   a) a Covered Person's lawful spouse, if not legally separated or divorced;
   b) a Covered Person's natural Child, adopted Child, foster Child, step Child, or other Child for whom the Covered Person has or had legal guardianship (proof will be required); or
   c) a Covered Person's parents, whether natural, step or adoptive; otherwise;
3) The estate of the Covered Person.

A Covered Person may change his/her beneficiary designation from time to time without the consent of the designated beneficiary by giving notice, in writing, to the Subscriber. When a request for designation or change is received by the Subscriber, it will take effect on the date of its execution, whether or not the Covered Person is living on the date it is received by the Subscriber. Any interest created by the request will be subject to any payment made or action taken before its receipt.

ASSIGNMENT: No assignment of interest in loss of life benefits shall be binding on the Company until the original or duplicate thereof is received by the Company. The Company assumes no responsibility for the validity of such assignment.

INSOLVENCY: The insolvency, bankruptcy, financial impairment, receivership, voluntary plan of arrangement with creditors, or dissolution of the Policyholder or Subscriber will not impose upon the Company any liability other than the liability defined in this Policy. The insolvency of the Policyholder or Subscriber will not make the Company liable to the creditors of the Policyholder or Subscriber, including Covered Persons under the Plan.

LEGAL ACTION: All Policy terms will be interpreted under the laws of the state in which this Policy was issued. No legal action may be brought to recover on this Policy within 60 days after written Proof of Loss has been furnished, No legal action may be brought after three (3) years from the time written Proof of Loss is required to be furnished.

MISSTATED DATA: The Company has relied upon the underwriting information provided by the Subscriber, its Third Party Administrator or other Agent in the issuance of this Policy. Should subsequent information become known which, if known prior to issuance of this Policy, would have affected the rates, Deductibles, terms or conditions for coverage, the Company will have the right to revise the rates, Deductibles, terms or conditions as of the Effective Date of issuance, by providing written notice to the Subscriber.

WAIVER: Failure of the Company to strictly enforce its rights under this Policy at any time or under any circumstance shall not constitute a waiver of such rights by the Company at any time under the same or different circumstances.

WORKERS' COMPENSATION: This Policy is not in lieu of and does not affect any requirements for coverage by any Workers' Compensation Act or similar law.

Starr Indemnity & Liability Company

Dallas, Texas
Administrative Office: 90 Park Avenue, 7th Floor, New York, NY 10016

SCHEDULE OF BENEFITS

POLICYHOLDER/SUBSCRIBER: Music City Mystique
c/o Starr Indemnity & Liability Blanket Accident and Health Insurance Trust

POLICY NUMBER: BAP-112871-1

POLICY EFFECTIVE DATE: 1/1/2010

POLICY PERIOD: 01/01/10 - 01/01/11

CLASSES OF ELIGIBLE PERSONS:
All Participants and Staff of the Policyholder's Winterguard Activities

HAZARDS INSURED AGAINST:
Sports Coverage

Covered Activities:
Winter Guard Activities

PREMIUMS: $150.00

PREMIUM DUE DATE: Annual in advance on the Effective Date

BENEFITS:

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

Covered Person Principal Sum/Amount of Insurance:	$10,000.00
Loss Period:	365 days from the date of the Covered Accident

ACCIDENT MEDICAL AND DENTAL EXPENSE BENEFIT

Total Benefit Maximum for all Accident Medical and Dental:	$10,000.00
Loss Period (first Covered Expenses must be incurred within):	90 days after the Covered Accident
Benefit Period:	1 Year from the date of the Covered Accident
Deductible:	$250.00
Coinsurance:	100% of Usual and Customary Charges
Terms of Payment:	Full Excess

Any Deductibles, Coinsurance, Benefit Periods, and Benefit Maximums apply on a per Covered Person, per Covered Accident basis.