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05/01/2009

GROUP BOOKLET-CERTIFICATE FOR MEMBERS OF:

ST. LOUIS SPORTS COMMISSION, INC.

ALL MEMBERS

Group Member Life Insurance

Print Date: 05/20/2009

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Your insurance has been designed to provide financial help for you when a covered loss occurs. Your employer has chosen benefits provided by a Group Policy issued by Us, Principal Life Insurance Company. To the extent that benefits are provided by that Group Policy, the administration and payment of claims will be done by Us as an insurer.

The provisions of the Group Policy determine Members' rights and benefits. This booklet briefly describes those rights and benefits. It outlines what you must do to be insured. It explains how to file claims. It is your certificate while you are insured.

The effective date of your insurance is as shown on your enrollment form. You should keep your enrollment form, any change of beneficiary or change of name forms, or other similar forms with your booklet after the form has been recorded by Us and returned to you.

NOTE: If this insurance replaces prior group life insurance provided through the Policyholder, the beneficiary named under the prior group life insurance and recorded by the Policyholder will be the beneficiary under the Group Policy unless you have named a new beneficiary. If you wish to change your beneficiary designation, you must complete a new beneficiary designation form - see the Policyholder for the necessary form.

THIS BOOKLET REPLACES ANY PRIOR BOOKLET THAT YOU MAY HAVE RECEIVED. If you have any questions about this new booklet, please contact your employer. In the event of future plan changes, you will be provided with a new booklet-certificate or a booklet-certificate rider.

If you have an electronic booklet, paper copies of this booklet-certificate are also available. Please contact your employer if you would like to request a paper copy.

PLEASE READ YOUR BOOKLET CAREFULLY. We suggest that you start with a review of the terms listed in the DEFINITIONS Section (at the back of the booklet). The meanings of these terms will help you understand the insurance.

This booklet describes all the benefits available under the Group Policy underwritten by Us. However, if you have elected to not accept any available benefits, those benefits described in this booklet will not apply to you.

The group insurance policy and your coverage under the Group Policy may be discontinued or altered by the Policyholder or Us at any time without your consent.

ACCELERATED BENEFITS - Benefits paid as shown in this booklet-certificate for Accelerated Benefits are an advance of a portion of your Life Insurance benefit. This provision:

- accelerates and reduces your benefit;
- is not intended to be used as long-term care insurance.

Effect on Government Benefits. If you receive payment of Accelerated Benefits, you may lose your right to receive certain public funds, such as Medicare, Medicaid, Social Security, Supplemental Security, Supplemental Security Income (SSI), and possibly others.

Tax Consequences. Receiving Accelerated Benefits from the Group Policy may have tax consequences for you. We cannot give you advice about this. You may wish to obtain advice from a tax professional or an attorney before you decide to receive Accelerated Benefits from the Group Policy.

The insurance provided in this booklet is subject to the laws of the state of MISSOURI.

PRINCIPAL LIFE INSURANCE COMPANY
Des Moines, IA 50392-0001

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SUMMARY OF BENEFITS
(effective May 1, 2009)

This section highlights the benefits provided under this insurance. The purpose is to give you quick access to the information you will most often want to review. **Please read the other sections of this booklet for a more detailed explanation of benefits and any limitations or restrictions that might apply.**

MEMBER LIFE INSURANCE

If you die, your beneficiary will be paid the Scheduled Benefit then in force for you (however, see the exception noted below). The Scheduled Benefit is based on your class:

Class	*Scheduled Benefit
ALL MEMBERS	The amount that is equal to 1 times your Annual Compensation (this amount will be rounded to the next higher $1,000, if it is not already an exact multiple of $1,000). The Maximum Scheduled Benefit amount will be $200,000 and the Minimum Scheduled Benefit amount will be $10,000, subject to the provisions below.

Member Life Insurance benefits are subject to all reductions provided in the Group Policy including reductions due to salary changes, age changes, and receipt of Accelerated Benefit payment.

*The Scheduled Benefit is subject to the Proof of Good Health requirements as described in the booklet on GH 110. If, because of these Proof of Good Health requirements, We approve an amount of insurance that is different than the Scheduled Benefit, the approved amount will be paid.

For the age(s) shown below, the amount of insurance will be the percentage of the Scheduled Benefit (or approved amount, if applicable) as shown below.

Age	% of Scheduled Benefit (or approved amount, whichever applies)
Age 65 but less than age 70	65%
Age 70 and Over	50%

We may rely on the Policyholder for certification of the amount of compensation or insurance.

MEMBER ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

If you are injured and otherwise qualify, We will pay the following percentages of your Scheduled Benefit (or approved amount, if applicable) in force:

- 50% if you lose a hand, a foot, or the sight of one eye; or
- 100% if more than one of the above listed losses results from the same accident; or
- 25% for loss of thumb and index finger on the same hand; or
- 100% if you lose your life.

Payment for loss of life will be to your beneficiary or as otherwise provided in the Death Benefit provision. Payment for any other loss will be to you. Your Scheduled Benefit is based on your class:

Class	***Scheduled Benefit**
ALL MEMBERS	The amount that is equal to 1 times your Annual Compensation (this amount will be rounded to the next higher $1,000, if it is not already an exact multiple of $1,000). The Maximum Scheduled Benefit amount will be $200,000 and the Minimum Scheduled Benefit amount will be $10,000, subject to the provisions below.

*The Scheduled Benefit is subject to the Proof of Good Health requirements as described in the booklet on GH 110. If, because of these Proof of Good Health requirements, We approve an amount of insurance that is different than the Scheduled Benefit, the approved amount will be paid.

For the age(s) shown below, the amount of insurance will be the percentage of the Scheduled Benefit (or approved amount, if applicable) as shown below.

Age	**% of Scheduled Benefit (or approved amount, whichever applies)**
Age 65 but less than age 70	65%
Age 70 and Over	50%

We may rely on the Policyholder for certification of the amount of compensation or insurance.

HOW TO BE INSURED - MEMBERS

MEMBER LIFE INSURANCE
MEMBER ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

Eligibility

To be eligible for insurance you must be a Member.

You will be eligible for insurance on the latest of:

- May 1, 2009; or
- for full-time employees hired prior to May 1, 2009, the first of the Insurance Month coinciding with or next following the date you complete 30 consecutive days of continuous Active Work; or
- for full-time employees hired on or after May 1, 2009, the first of the Insurance Month coinciding with or next following the date you complete 30 consecutive days of continuous Active Work.

In no circumstance will you be eligible for Member Life Insurance under the Group Policy if you are eligible under any other Group Term Life Insurance policy underwritten by Us.

Effective Dates - Actively at Work

If you are not Actively at Work on the date your insurance would otherwise be effective, your insurance will not be in force until the day you return to Active Work.

This Actively at Work requirement will be waived for you if:

- you are absent from Active Work because of a regularly scheduled day off, holiday, or vacation day; and
- you were Actively at Work on your last scheduled work day before the date of your absence; and
- you were capable of Active Work on the day before the scheduled effective date of your insurance or change in your insurance, whichever is applicable.

This Actively at Work requirement may also be waived as described below.

When insurance under the Group Policy replaces coverage under a Prior Policy, the Active Work requirement may be waived for those Members who:

- are eligible and enrolled under the Group Policy on the date the Group Policy is effective; and
- were covered under the Prior Policy on the date of its termination.

In no event will the Active Work requirement be waived for those Members who, on the date of termination of the Prior Policy, either:

- had the option, under the terms of the Prior Policy, to convert their coverage under the Prior Policy to an individual policy; or
- were eligible under the terms of the Prior Policy to have their premiums waived due to Total Disability.

NOTE: When insurance under the Group Policy replaces coverage under a Prior Policy and the Active Work requirement

is waived, any benefits payable will be the lesser of the Scheduled Benefit of the Group Policy or the amount that would have been paid by the Prior Policy had it remained in force.

Individual Incontestability

All statements made by any insured person (you or one of your Dependents) will be representations and not warranties. In the absence of fraud, these statements may not be used to contest an insured person's insurance unless:

- the insurance has been in force for less than two years during the insured person's lifetime; and
- the statement is in Written form Signed by the insured person; and
- a copy of the form, which contains the statement, is given to the insured person or the insured person's beneficiary at the time insurance is contested.

However, the above will not preclude the assertion at any time of defenses based upon the person not being eligible for insurance under the Group Policy or upon other provisions of the Group Policy.

In addition, if a person's age is misstated, We may, at any time, adjust premium and benefits to reflect the correct age.

Assignments

No assignments of Member Life Insurance will be allowed under the Group Policy.

Proof of Good Health

In some instances, Proof of Good Health will be required to place your insurance in force. We will determine the type and form of required proof. You will need to file Proof of Good Health:

- If you request insurance more than 31 days after the date you are eligible including any insurance you refuse and later request.
- If you request insurance under the Group Policy and you were eligible under the Prior Policy, but elected to waive coverage under the Prior Policy.
- If you have failed to provide required Proof of Good Health or you have been refused insurance under the Group Policy at any prior time.
- If you elect to terminate insurance and, more than 31 days later, you request to be insured again.
- If, on the date you are eligible, fewer than ten Members are insured.
- If, on the date you are eligible for any increased or additional Scheduled Benefit amount, fewer than ten Members are insured.
- To make effective any Scheduled Benefits amounts for you that are, initially or through later increases, in excess of:
    - $100,000 if you are under age 65; and
    - $100,000 if you are age 65 or over but under age 70; and
    - *$100,000 if you are age 70 or over.

    *If you are insured on the date the Group Policy is effective and this insurance replaces insurance in force on the day immediately before the effective date of the Group Policy: the lesser of the amount shown above or the amount for which you were insured under the replaced insurance.

Effective Date for Initial Insurance
(Proof of Good Health Not Required)

You must request initial insurance in a form provided by Us.

If you are required to contribute toward the cost of your insurance, your insurance will normally be in force on:

- the date you are eligible, if you make your request on or before that date; or

- the first of the Insurance Month coinciding with or next following the date of your request, if you make your request within 31 days after the date you are eligible.

If you are not required to contribute toward the cost of your insurance, your insurance will normally be in force on the date you are eligible.

However, if you are not Actively at Work on the date insurance would otherwise be effective, your insurance will not be in force until the day you return to Active Work.

Effective Date for Initial Insurance
(Proof of Good Health Required)

If Proof of Good Health is required, your insurance will normally be in force on the later of:

- the date insurance would have been effective had Proof of Good Health not been required; or

- the first of the Insurance Month coinciding with or next following the date Proof of Good Health is approved by Us.

However, if you are not Actively at Work on the date insurance would otherwise be effective, your insurance will not be in force until the day you return to Active Work.

Effective Date for Benefit Changes Due to Change in Annual Compensation

A change in your Scheduled Benefit amount because of a change in your Annual Compensation for which Proof of Good Health is not required (see above) will normally be effective on the Policy Anniversary that next follows the date of the change. However, if you are not Actively at Work on the date the Scheduled Benefit change would otherwise be effective, the Scheduled Benefit change will not be in force until the day you return to Active Work. Exception: Any decrease Scheduled Benefit amounts due to a change in your Annual Compensation will be effective on the date of the change, whether or not you are Actively at Work.

Any termination of Scheduled Benefit amounts due to a change in your Annual Compensation will be effective on the date of the change, whether or not you are Actively at Work.

A change in your Scheduled Benefit amount due to a change in your Annual Compensation for which Proof of Good Health is required (see above), will be effective on the later of:

- the date the change would otherwise be effective if Proof of Good Health had not been required; or

- the first of the Insurance Month coinciding with or next following the date Proof of Good Health is approved by Us.

Effective Date for Benefit Changes Due to Change in Insurance Class

A change in your Scheduled Benefit amount because of a change in your insurance class for which Proof of Good Health is not required (see above) will normally be effective on the first of the Insurance Month coinciding with or next following the date of the change. However, if you are not Actively at Work on the date the Scheduled Benefit change

would otherwise be effective, the Scheduled Benefit change will not be in force until the day you return to Active Work. Exception: Any decrease in Scheduled Benefit amounts due to a change in your insurance class will be effective on the date of the change, whether or not you are Actively at Work.

Any termination of Scheduled Benefit amounts due to a change in your insurance class will be effective on the date of the change, whether or not you are Actively at Work.

A change in your Scheduled Benefit amount due to a change in your insurance class for which Proof of Good Health is required (see above), will be effective on the later of:

- the date the change would otherwise be effective if Proof of Good Health had not been required; or
- the first of the Insurance Month coinciding with or next following the date Proof of Good Health is approved by Us.

Effective Date for Benefit Changes Due to Changes by Policy Amendment

A change in your Scheduled Benefit amount because of a change in the Schedule of Insurance (as described on GH 109) by amendment to the Group Policy for which Proof of Good Health is not required (see above) will be effective on the date of change. However, if you are not Actively at Work on the date an increase in the Scheduled Benefit would otherwise be effective, the Scheduled Benefit in force will continue to apply to you until the day you return to Active Work. When you return to Active Work, the Scheduled Benefit increase will then be in force for you. Exception: Any decrease in Scheduled Benefit amounts due to a change by amendment to the Group Policy will be effective on the date of change, whether or not you are Actively at Work.

A change in your Scheduled Benefit amount because of a change in the Schedule of Insurance (as described on GH 109) by amendment to the Group Policy for which Proof of Good Health is required (see above) will be effective on the later of:

- the date the change would otherwise be effective if Proof of Good Health had not been required; or
- the first of the Insurance Month coinciding with or next following the date Proof of Good Health is approved by Us.

Effective Date for Benefit Changes Due to Changes Requested by the Member

A change in your Scheduled Benefit amount due to your request for which Proof of Good Health is not required (see above), will be effective on the Policy Anniversary that next follows the date of the request. However, if you are not Actively at Work on the date the Scheduled Benefit change would otherwise be effective, the Scheduled Benefit change will not be in force until the day you return to Active Work. Exception: Any decrease in Scheduled Benefit amounts will be effective on the date of the change, whether or not you are Actively at Work.

A change in your Scheduled Benefit amount due to your request for which Proof of Good Health is required (see above), will be effective on the later of:

- the date the change would otherwise be effective if Proof of Good Health had not been required; or
- the first of the Insurance Month coinciding with or next following the date Proof of Good Health is approved by Us.

Termination

Your insurance under the Group Policy will cease on the earliest of:

- the date the Group Policy terminates; or

- the end of the Insurance Month for which the last premium is paid for your insurance; or
- the end of any Insurance Month, if requested by you before that date; or
- the end of the Insurance Month in which you cease to be a Member; or
- the end of the Insurance Month in which you cease to belong to a class for which insurance is provided; or
- the date you retire; or
- the end of the Insurance Month in which you cease Active Work.

Termination for Fraud

We may at any time terminate your eligibility under the Group Policy:

- in Writing and with 31-day notice, if you submit any claim that contains false or fraudulent elements under state or federal law which constitutes acts or admissions by you and such information is contained in a Written instrument Signed by the person making such statement;
- in Writing and with 31-day notice, upon finding in a civil or criminal case that you have submitted claims that contain false or fraudulent elements under state or federal law and such information is contained in a Written instrument Signed by the person making such statement;
- in Writing and with 31-day notice, when you have submitted a claim, which you knew contains false or fraudulent elements under state or federal law and such information is contained in a Written instrument Signed by the person making such statement.

Insurance While Outside of the United States

If you are temporarily outside the United States, you may choose to continue insurance, subject to premium payment for a period of six months or less for one of the following reasons:

- travel; or
- a business assignment; or
- full-time student status, provided you are either:
  - enrolled and attending an accredited school in a foreign country; or
  - participating in an academic program in a foreign country, for which the institution of higher learning at which you are enrolled in the U.S. grants academic credit;

The six-month period will not be reduced for any time covered under a Prior Policy.

If you are outside the United States for any other reason than those listed above, insurance for the person concerned will automatically terminate.

Continuation

If you cease Active Work because of sickness or injury, you may be eligible for limited continuation of insurance.

If you cease Active Work because of layoff or leave of absence, insurance may be continued on a limited basis.

Your insurance may also be continued under the continuation provisions described on GH 118 and GH 118 A MO and

subject to the provisions of the Group Policy.

If you are interested in continuing your insurance beyond the date it would normally terminate, you should consult with the Policyholder before your insurance terminates.

Reinstatement

If coverage under the Group Policy lapses as a result of unpaid premium, coverage in the form in which it existed on the date the coverage lapsed may be reinstated provided:

- not more than five (5) years have elapsed since the coverage lapsed; and
- Proof of Good Health is submitted and approved by Us; and
- We receive a payment of all premiums in arrears and the payment of interest during the period of lapse, assessed per annum and compounded annually, on all premium in arrears and on each unpaid premium from its due date.

The reinstated coverage will become effective on the first of the next month coinciding with or next following the date We receive and approve Proof of Good Health.

CONTINUATION

Federal Family and Medical Leave Act (FMLA)

Federal law requires that Eligible Employees be provided a continuation period in accordance with the provisions of the Federal Family and Medical Leave Act (FMLA).

This is a general summary of the FMLA and how it affects the Group Policy. See your employer for details on this continuation provision.

FMLA and Other Continuation Provisions

If your employer is an Eligible Employer and if the continuation portion of the FMLA applies to your insurance, these FMLA continuation provisions:

- are in addition to any other continuation provisions of the Group Policy, if any; and
- will run concurrently with any other continuation provisions of the Group Policy for sickness, injury, layoff, or approved leave of absence, if any.

If continuation qualifies for both state and FMLA continuation, the continuation period will be counted concurrently toward satisfaction of the continuation period under both the state and FMLA continuation periods.

Eligible Employer

Eligible Employer means any employer who is engaged in commerce or in any industry or activity affecting commerce who employs 50 or more employees for each working day during each of 20 or more calendar workweeks in the current or preceding calendar year.

Eligible Employee

Eligible Employee means an employee who has worked for the Eligible Employer:

- for at least 12 months; and
- for at least 1,250 hours (approximately 24 hours per week) during the year preceding the start of the leave; and
- at a work-site where the Eligible Employer employs at least 50 employees within a 75-mile radius.

For this purpose, "employs" has the meaning provided by the Federal Family and Medical Leave Act (FMLA).

Mandated Unpaid Leave

Eligible Employers are required to allow 12 workweeks of unpaid leave during any 12-month period to Eligible Employees for one or more of the following reasons:

- the birth of a child of an Eligible Employee and in order to care for the child;
- the placement of a child with the Eligible Employee for adoption or foster care;
- to care (physical or psychological care) for the spouse, child, or parent of the Eligible Employee, if they have a "serious health condition";

- a "serious health condition" that makes the Eligible Employee unable to perform the functions of his or her job; or

- because of a "qualifying exigency" arising out of a spouse, son , daughter or parent on active duty or having been notified of a call to active duty.

Eligible Employers are required to allow up to a total of 26 workweeks of unpaid leave during any 12 month period to eligible employees to care for a "covered service member" with a "serious injury or illness".

Reinstatement

An Eligible Employee's terminated insurance may be reinstated in accordance with the provisions of the Federal Family and Medical Leave Act (FMLA), subject to the Actively at Work requirements of the Group Policy.

Reinstatement of Insurance for you When Insurance Ends due to Living Outside of the United States

If insurance for you terminates because you are outside of the United States you may become eligible again for insurance under the Group Policy, but only if:

- you return to the United States within six months of the date on which insurance terminated because the person is outside of the United States; and

- in your case, you return to Active Work in the United States for the Policyholder for a period of at least 30 consecutive days. You will be eligible for insurance on the day immediately following completion of the 30 consecutive days of Active Work.

The reinstated insurance will be on the same basis as that being provided on the date insurance is reinstated. However, any restrictions on this insurance, which were in effect before reinstatement, will continue to apply. If you do not complete the 30 consecutive days of residence, the insurance for such person concerned will not be reinstated.

See your employer for details on this reinstatement provision.

CONTINUATION OF INSURANCE

Member (State Required - Missouri)

If you cease Active Work because you are Totally Disabled, you may continue your Life Insurance until the earlier of:

- the date six months after the end of the Insurance Month in which your Total Disability began; or
- the date the Group Policy terminates. However, if the Total Disability began prior to attainment of age 60 and while you are insured, you may continue your insurance after termination of the Group Policy until the date six months after the Total Disability began.

DESCRIPTION OF BENEFITS

MEMBER LIFE INSURANCE

Death Benefit

If you die while insured for Member Life Insurance, We will pay your beneficiary the Scheduled Benefit (or approved amount, if applicable) in force on the date of your death, less any Accelerated Benefit payment as discussed later in this section. If your beneficiary does not survive you, We will make your payment in the following order of precedence:

- to your spouse;
- to your children born to or legally adopted by you;
- to your parents;
- to your brothers and sisters; or
- if none of the above, to the executor or administrator of your estate or other persons as provided in the Group Policy.

However, if a beneficiary is suspected or charged with your death, the Death Benefit may be withheld until additional information has been received or the trial has been held. If a beneficiary is found guilty of your death, such beneficiary may be disqualified from receiving any benefit due. Payment may then be made to any contingent beneficiary or to the executor or administrator of your estate.

No payment will be made before We receive Written proof of your death.

Upon your death, the Scheduled Benefit (or approved amount, if applicable) in force on the date of your death, less any Accelerated Benefit payment as discussed later in this section will be placed in an interest-bearing draft account at an interest rate determined by Us, unless a lump sum or other settlement option has been elected. With the interest-bearing draft account, the balance will be available to your beneficiary at any time, in total or in part, as provided in the Group Policy.

See the Policyholder if you would like more information on the Interest Draft Account or on any of the other settlement options that are available to your beneficiary upon your death.

In the event the Interest Draft Account is not available or otherwise does not apply, We reserve the right to make payment of proceeds according to other settlement options if agreed to, in Writing, by Us.

Beneficiary

You should name a beneficiary at the time you enroll for insurance. You may name or later change your beneficiary by sending a Written request to Us. See the Policyholder for change request forms. A change in your beneficiary will not be in force until We record(s) the change. Once recorded, the change will apply as of the date the request was Signed. If We properly pay any benefit before a change request is received, that payment may not be contested

Continuation (Member Life Insurance - Coverage During Disability)

If you cease Active Work for any reason, your insurance will normally terminate. However, if you cease Active Work because you are Totally Disabled, you might qualify to continue your Member Life Insurance and Member Accidental Death and Dismemberment Insurance . This continuation is called Coverage During Disability.

To be qualified for Coverage During Disability, you must:

- become Totally Disabled while insured for Member Life Insurance; and

- become Totally Disabled before the earlier of retirement or age 60; and

- remain Totally Disabled continuously; and

- be under the regular care and attendance of a Physician if appropriate for the particular Total Disability, as determined by Us; and

- send proof of Total Disability to Us within one year of the date Total Disability starts and as often thereafter as We may require; and

- return, without claim, any individual policy issued under your purchase rights as described below. Upon return of such policy, We will refund premiums paid, less dividends and less any outstanding policy loan balance; and

- submit to examinations by a Physician when We require (We will pay for these examinations and will choose the Physician).

If you qualify, Coverage During Disability will be in force on the earlier of:

- the day 180 days after the date your Total Disability began; or

- the date of your death.

Premium will not be charged for Member Life Insurance and Member Accidental Death and Dismemberment Insurance while your Coverage During Disability is in force.

Once Coverage During Disability becomes effective, all premiums paid by you from the date of Total Disability will be waived retrospectively.

Coverage During Disability will cease on the earliest of:

- the date your Total Disability ends; or

- the date you fail to send Us any required proof of Total Disability; or

- the date you cease to be under the regular care and attendance of a Physician if such regular care and attendance of a Physician is appropriate for the particular Total Disability, as determined by Us; or

- the date you fail to submit to a required Physician's examination; or

- the date you are age 65.

If you die while Coverage During Disability is in force, We will pay your beneficiary the Member Life Insurance benefit, if any, that would have been paid had you remained insured under the Schedule of Insurance in force on the date your Total Disability began. Member Life Insurance benefits are subject to all reductions provided in the Group Policy including reductions due to salary changes, age changes, and receipt of Accelerated Benefit payment.

Note that Coverage During Disability will not be in force and NO BENEFIT WILL BE PAID if Written proof of Total Disability is not sent to Us within ONE YEAR of the date Total Disability starts. However, failure to give Written proof within the time specified will not invalidate or reduce any claim if Written proof is given as soon as reasonably possible.

No benefits will be paid for any disability that:

- results from willful self-injury or self-destruction, while sane or insane; or

- results from war or act of war; or

- results from voluntary participation in an assault, felony, criminal activity, insurrection, or riot.

Accelerated Benefit

An Accelerated Benefit is an advance (before death) payment of a part of your Member Life Insurance benefit. To qualify for an Accelerated Benefit, you must:

- be insured for a Member Life Insurance benefit of at least $10,000; and

- be Terminally Ill (expected to die within 12 months); and

- send a request for Accelerated Benefit payment to Us; and

- send proof, satisfactory to Us, of your Terminal Illness.

Proof of Terminal Illness will consist of a statement from your Physician, and any other medical information that We believe is needed to confirm your status.

If you qualify, We will pay you any amount you request, except that:

- only one Accelerated Benefit payment will be made during your lifetime; and

- you must request a payment of at least $5,000; and

- we will not pay you more than the lesser of (1) 75% of your Member Life Insurance benefit; or (2) $250,000.

We will pay you the Accelerated Benefit payment in a lump sum.

If an Accelerated Benefit is paid, the Member Life Insurance benefit otherwise payable to your beneficiary upon your death will be reduced by any Accelerated Benefit payment.

Following is an EXAMPLE of how this benefit affects the final death benefit.

BENEFIT EXAMPLE		
Member Life Insurance Benefit Amount	$	100,000
Accelerated Benefit Amount Requested (Member would receive $75,000)	$	75,000
Payment to Member's Beneficiary ($100,000 - $75,000)	$	25,000

During the two-year period following payment of an Accelerated Benefit:

- termination of Active Work because of your Terminal Illness will not result in termination of your Member Life Insurance; and

- your Member Life and Member Accidental Death and Dismemberment Insurance will be provided without premium charge.

Individual Purchase Rights

You will have the right to buy an individual life insurance policy without submitting Proof of Good Health:

- If your total Member Life Insurance, or any portion of it, terminates because you end Active Work or cease to be in a class eligible for insurance. In these instances, the maximum amount you may buy will be your Member Life Insurance amount in force on the date of termination or the portion of your Member Life Insurance that has terminated, less any individual amount purchased earlier under these rights, and less any Accelerated Benefit as discussed earlier in this Section and less any amount for which you become eligible under any group policy within 31 days.

- If the Group Policy terminates or is amended to exclude your insurance class after you have been insured for at least five years. In these instances, the maximum amount you may buy will be the smaller of: (1) $10,000; or (2) your Member Life Insurance amount in force on the date of termination, less any Accelerated Benefit payment as discussed earlier in this Section and less any amount for which you become eligible under any group policy within 31 days.

- If your Coverage During Disability ceases because Total Disability ends and you do not then become insured under the Group Policy within 31 days. In this instance, the maximum amount you may buy will be the Coverage During Disability benefit amount in force on the date Total Disability ends, less any individual amount purchased earlier under these rights, and less any Accelerated Benefit as discussed earlier in this Section.

- If your Accelerated Benefit Premium Waiver Period ceases and you do not qualify for Coverage During Disability. In this instance, the maximum amount you may buy will be the Member Life Insurance benefit amount in force on the date you cease Active Work, less any individual amount purchased earlier under these rights, and less any Accelerated Benefit as discussed earlier in this Section.

You must apply for individual purchase and pay the first premium to Us within 31 days after your insurance or Coverage During Disability under the Group Policy ceases.

See the Policyholder for the proper forms. Any individual policy issued will be effective on the 32nd day.

The individual policy will be for life insurance only (other than term insurance). No Disability or other benefits will be included. The premium you pay will be at Our normal rate for your age and for the risk class to which you belong on the individual policy's date of issue.

If you die within the 31-day purchase period, your beneficiary will be paid the life insurance amount, if any, you had the right to buy. This payment will be made whether or not you have applied for an individual policy.

DESCRIPTION OF BENEFITS

MEMBER ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

Benefit Qualification

To qualify for benefit payment, all of the following must occur:

- You must be injured while insured for Member Accidental Death and Dismemberment Insurance.
- Your injury must be caused by accident.
- Your injury must be the direct and sole cause of a loss listed in Benefit Payable below.
- Your loss must occur within 365 days of your injury.
- The limitations listed below must not apply.
- You must satisfy the requirements listed in the CLAIM PROCEDURES Section.
- All medical evidence must be satisfactory to Us.

Benefit Payable

If all of the above qualifications are met, We will pay the following percentages of your Scheduled Benefit (or approved amount, if applicable) in force:

- 50% if one hand is severed at or above the wrist; or
- 50% if one foot is severed at or above the ankle; or
- 50% if the sight of one eye is permanently lost (For this purpose, vision not correctable to better than 20/200 will be considered loss of sight.); or
- 100% if more than one of the above listed losses occurs; or
- 25% for loss of thumb and index finger on the same hand; or
- 100% if you lose your life.

Total payment for all losses under Benefits Payable that result from the same accident will not exceed 100% of your Scheduled Benefit (or approved amount, if applicable). Payment for loss of life will be to the beneficiary you named for Member Life Insurance. Payment for any other loss will be to you.

Limitations

Payment will not be made for any loss to which a contributing cause is:

- willful self-injury or self-destruction, while sane; or
- disease, medical or surgical treatment of disease, or complications following the surgical treatment of disease (except for bacterial infection due to the accidental ingestion of a contaminated substance or pyogenic infection which results from an accidental bodily injury); or

- voluntary participation in a riot, assault, felony, criminal activity, or insurrection; or

- participating in flying, ballooning, parachuting, parasailing, bungee jumping or other aeronautic activities, except as a passenger on a commercial aircraft or as a passenger in a Policyholder-owned or leased aircraft on company business; or

- duty as a member of a military organization; or

- war or act of war; or

- the use of alcohol if, at the time of the injury, your alcohol concentration exceeds the legal limit allowed by the jurisdiction where the injury occurs; or

- the operation by you of a motor vehicle or motor boat if, at the time of the injury, your alcohol concentration exceeds the legal limit allowed by jurisdiction where the injury occurs; or

- the use of any drug, narcotic, or hallucinogen not prescribed for you by a licensed Physician.

CLAIM PROCEDURES

These provisions apply only to the Accidental Death and Dismemberment benefits. They do not apply to Life Insurance.

Notice of Claim

Written notice of claim must be given to Us within 20 days after the date of loss. Failure to give notice within the time specified will not invalidate or reduce any claim if notice is given as soon as reasonably possible.

Claim Forms

Claim forms and other information needed to prove loss must be filed with Us in order to obtain payment of benefits. The Policyholder will provide forms to assist you in filing claims. If the forms are not provided within 15 days after We receive such notice, you will be considered to have complied with the requirements of the Group Policy upon submitting, within the time specified below for filing proof of loss, Written proof covering the occurrence, character, and extent of the loss.

Proof of Loss

Completed claim forms and other information needed to prove loss should be filed promptly. Written proof of loss should be sent to Us within 90 days after the date of loss. Proof required includes the date, nature, and extent of the loss. We may request additional information to substantiate your loss or require a Signed unaltered authorization to obtain that information from the provider. Your failure to comply with such request could result in declination of the claim.

Failure to furnish such proof within the time required will not invalidate or 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 date proof is otherwise required.

Payment, Denial, and Review

ERISA permits up to 45 days from receipt of claim for processing the claim. If a claim cannot be processed due to incomplete information, We will send a Written explanation prior to the expiration of the 45 days. A claimant is then allowed up to 45 days to provide all additional information requested. We are permitted two 30-day extensions for processing an incomplete claim. Written notification will be sent to a claimant regarding the extension.

In actual practice, benefits under the Group Policy will be payable immediately after We receive complete and proper proof of loss. Further, if a claim is not payable or cannot be processed, We will promptly explain why.

A claimant may request an appeal of a claim denial by Written request to Us within 180 days of the receipt of notice of the denial. We will make a full and fair review of the claim. We may require additional information to make the review. We will notify you in Writing of the appeal decision within 45 days after receipt of the appeal request. If the appeal cannot be processed within the 45-day period because We did not receive the requested additional information, We are permitted a 45-day extension for the review. Written notification will be sent to a claimant regarding the extension. After exhaustion of the formal appeal process, the claimant may request an additional appeal. However, this appeal is voluntary and does not need to be filed before asserting rights to legal action.

For purposes of this section, "claimant" means Member, Dependent, or Beneficiary.

State Time Limits: Unless otherwise preempted by the Employee Retirement Income Security Act (ERISA), state time limits will apply. State law requires that benefits payable under the Group Policy will be payable not more than 30 days

after receipt of proof and subject to the proof of loss.

Medical Examinations

We may have you, whose loss is the basis for claim, examined by a Physician during the course of a claim. We will pay for these examinations and will choose the Physician to perform them.

Autopsy

If payment for loss of life is claimed, We may require an autopsy. We will pay for any such autopsy.

Legal Action

Legal action to recover benefits under the Group Policy may not be started earlier than 60 days after proof of loss is filed and before the appeal procedures have been exhausted. Further, no legal action may be started later than three years after that proof is required to be filed.

Time Limits

All time limits listed in this section will be adjusted as required by law.

STATEMENT OF RIGHTS

Federal law requires that this section be included in your booklet:

As a participant in this plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon Written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits, which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

DEFINITIONS

Several words and phrases used to describe your insurance are capitalized whenever they are used in this booklet. These words and phrases have special meanings as explained in this section.

Active Work; Actively at Work means you will be considered Actively at Work if you are able and available for active performance of all of your regular duties. Short term absence because of a regularly scheduled day off, holiday, vacation day, jury duty, funeral leave, or personal time off is considered Active Work provided you are able and available for active performance of all of your regular duties and were working the day immediately prior to the date of your absence.

Annual Compensation means

For Members with no ownership interest in the business entity of the Policyholder:

On any date, your annual (or annual equivalent) wage then in force, as established by the Policyholder. Basic wage does not include commissions, bonuses, tips, differential pay, housing and/or car allowance, or overtime pay. Basic wage does include any deferred earnings under a qualified deferred compensation plan, such as contributions to Internal Revenue Code Section 401(k), 403(b), or 457 deferred compensation arrangements and any amount of voluntary earnings reduction under a qualified Section 125 Cafeteria Plan.

For Members with ownership interest in the business entity of the Policyholder, such as an owner of a sole proprietorship, a partner in a partnership, a shareholder of a corporation or subchapter S-corporation, or a member of a limited liability company or limited liability partnership, Annual Compensation on any date is based on an average of the following earnings as reported for Federal Income Tax purposes for the last two calendar year(s), unless ownership interest is less than two years in which case an annual equivalent of the average of earnings for the completed months of employment will be used, assuming the owner meets all eligibility requirements:

- your share (based on ownership or contractual agreement) of the gross revenue or income earned by the Policyholder, including income earned by you and others under your supervision or direction; less

- your share (based on ownership or contractual agreement) of the usual and customary unreimbursed business expenses of the Policyholder which are incurred on a regular basis, are essential to the established business operation of the Policyholder, are deductible for Federal Income Tax purposes; plus

- the salary, benefits, and other forms of compensation which are payable to you, and any contributions to a pension or profit sharing plan made on your behalf by the Policyholder.

Annual Compensation does not include any form of unearned income such as dividends, rent, interest, capital gains, income received from any form of deferred compensation, retirement, pension plan, income from royalties, or disability benefits.

Group Policy means the policy of group insurance issued to the Policyholder by Us which describes benefits and provisions for insured Members.

Insurance Month means calendar month.

Member means any PERSON who is a full-time employee of the Policyholder and who regularly works at least 30 hours per week. The employee must be compensated by the Policyholder and either the employer or employee must be able to show taxable income on federal or state tax forms. Work must be at the Policyholder's usual place or places of business, at an alternative worksite at the direction of the Policyholder, or at another place to which the employee must travel to perform his or her regular duties. This excludes any person who is scheduled to work for the Policyholder on a seasonal, temporary, contracted, or part-time basis.

An owner, proprietor, or partner of the Policyholder's business will be deemed to be an eligible employee for purposes of the Group Policy, provided he or she is regularly scheduled to work for the Policyholder at least 30 hours per week and otherwise meets the definition of a Member.

Physician means:

- a licensed Doctor of Medicine (M.D.) or Osteopathy (D.O.); or
- any other licensed health care practitioner that state law requires be recognized as a Physician under the Group Policy.

The term Physician does not include you, one of your employees, your business or professional partner or associate, any person who has a financial affiliation or business interest with you, anyone related to you by blood or marriage, or anyone living in your household.

Policyholder means ST. LOUIS SPORTS COMMISSION, INC..

Prior Policy means the Group Term Life coverage of either:

- the Policyholder; or
- a business entity which has been obtained by the Policyholder through a merger or acquisition;

for which the Group Policy is a replacement.

Proof of Good Health means Written evidence that a person is insurable under Our underwriting standards. This proof must be provided in a form satisfactory to Us.

Qualifying Event means for Accelerated Benefits, a medical condition, which would, in the absence of extensive or extraordinary medical treatment, result in a drastically limited life span. Such conditions may include, BUT ARE NOT LIMITED TO, one or more of the following:

- coronary artery disease resulting in an acute infarction or requiring surgery;
- permanent neurological deficit resulting from cerebral vascular accident;
- end stage renal failure; or
- acquired immune deficiency syndrome (AIDS).

Signed or Signature means any symbol or method executed or adopted by a person with the present intention to authenticate a record, and which is on or transmitted by paper or electronic media, and which is consistent with applicable law and is agreed to by Us.

Terminally Ill means, for Accelerated Benefits, you have experienced a Qualifying Event and you are expected to die within 12 months of the date you request payment of Accelerated Benefits.

Total Disability; Totally Disabled means for you, your inability, as determined by Us, due to sickness or injury, to perform the material and substantial duties of any occupation for which you are qualified based on education, training, or experience.

We, Us, and Our means Principal Life Insurance Company, Des Moines, Iowa.

Written or Writing means a record which is on or transmitted by paper or electronic media, and which is consistent with applicable law.

BOOKLET-CERTIFICATE NOTICE

Missouri insurance law requires that the certificate must include the address and telephone number of the insurance company issuing the Group Policy. The information is as follows:

Principal Life Insurance Company
711 High Street
Des Moines, Iowa 50392-0001

Life claim-related inquiries:
Attn: Group Claim - Life Info Line Services
Telephone: 1-800-245-1522

For administration-related inquiries:
Attn: Group Call Center
Telephone: 1-800-843-1371

If you call or write, please provide all relevant information pertaining to your inquiry, including the group account number and your full name and address.

This notice is for your information only and does not become a part or condition of this booklet-certificate.

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Plan Arranged By

MAHER ROSENHEIM COMFORT TABASH
230 S BEMISTON STE 900
CLAYTON MO
63105

Principal Life Insurance Company
Des Moines, Iowa 50392-0002