

SERFF Tracking Number: AFDL-125593019 State: Arkansas  
Filing Company: American Public Life Insurance Company State Tracking Number: 38604  
Company Tracking Number: MEDLINK III  
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other  
Product Name: MEDlink III  
Project Name/Number: MEDlink III/MEDlink III

## Filing at a Glance

Company: American Public Life Insurance Company

Product Name: MEDlink III SERFF Tr Num: AFDL-125593019 State: ArkansasLH  
TOI: H21 Health - Other SERFF Status: Closed State Tr Num: 38604  
Sub-TOI: H21.000 Health - Other Co Tr Num: MEDLINK III State Status: Approved-Closed  
Filing Type: Form Co Status: Reviewer(s): Rosalind Minor  
Authors: Janice Famer, Shari Vick Disposition Date: 07/02/2008  
Date Submitted: 04/03/2008 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name: MEDlink III Status of Filing in Domicile: Authorized  
Project Number: MEDlink III Date Approved in Domicile: 03/27/2008  
Requested Filing Mode: Review & Approval Domicile Status Comments: Approved  
Explanation for Combination/Other: Market Type: Group  
Submission Type: New Submission Group Market Size: Small and Large  
Overall Rate Impact: Group Market Type: Employer, Association  
Filing Status Changed: 07/02/2008  
State Status Changed: 07/02/2008 Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

American Fidelity Assurance Company is filing the above listed forms for approval with your Department on behalf of American Public Life Insurance Company. A letter of authorization is enclosed.

These are new forms and are not intended to replace any forms previously approved or declined by your department. This is a group supplemental policy and certificate with optional riders, along with the master application and individual application to be used in applying for this coverage. The issue ages for these policies is age 17 and older. This policy/certificate will be marketed by American Public Life Insurance Company licensed agents and appointed brokers.

SERFF Tracking Number: AFDL-125593019 State: Arkansas  
Filing Company: American Public Life Insurance Company State Tracking Number: 38604  
Company Tracking Number: MEDLINK III  
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other  
Product Name: MEDlink III  
Project Name/Number: MEDlink III/MEDlink III

The product will be marketed to employer groups and association groups previously approved by your Department. This group policy was Approved in our domicile state of Oklahoma on March 27, 2008.

In order to be eligible to be insured under this plan the applicant must currently be insured under a basic major medical or comprehensive medical plan, which includes managed care. This MEDlink III policy pays a coinsurance percentage of the difference between the out-of-pocket in-hospital expenses incurred as an Inpatient in a Hospital and the amount payable by the primary medical plan, up to the benefit amount applied for. Benefit amounts available range from \$1,000 to \$10,000 on the base policy.

There are two optional benefit riders available. GM/GC MEDlink III OP (1/08) Outpatient Hospital Benefit Rider pays a coinsurance percentage of the difference between the out-of-pocket expenses incurred and the amount paid by the primary medical plan for outpatient treatment in a hospital emergency room, outpatient surgery in a hospital outpatient facility or outpatient surgical center, and diagnostic tests in a hospital outpatient facility or MRI facility. Benefit amounts available are 50% of the amount chosen for the base policy or 80% of the amount chosen for the base policy. The Outpatient Hospital Benefit rider has annual deductible amounts available in the amounts of \$100, \$250, \$500, \$750 or \$1,000.

GM/GC MEDlink™ III PhysT (1/08) Physician's Outpatient Treatment Rider will pay up to \$25.00 per out of hospital visit to a physician as a result of Sickness or injury due to an Accident. The maximum number of visits is 4 per covered person per calendar year up to 8 visits per family per calendar year.

The policyholder application is form MEDlink III Master App (1/08) and the employee application is MEDlink III CERTAPP(1/08).

The Flesch scores are: GM MEDlink III (1/08), master policy, 50; GC MEDlink III (1/08) certificate, 50; GM/GC MEDlink III OP (1/08) Outpatient Hospital Benefit Rider, 53; GM/GC MEDlink III PhysT (1/08) Physician Outpatient Treatment Benefit Rider, 55; MEDlink III Master App (1/08) master application, 52; and MEDlink III CERTAPP(1/08) employee application, 50.

These forms may eventually be issued from an automated system. We will make every attempt to produce the automated version to duplicate this final printed format; however, fonts and word wrap can vary when going from one system or printer to another. We will not alter the wording and will try to duplicate all pages, including keeping the



SERFF Tracking Number: AFDL-125593019 State: Arkansas  
 Filing Company: American Public Life Insurance Company State Tracking Number: 38604  
 Company Tracking Number: MEDLINK III  
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other  
 Product Name: MEDlink III  
 Project Name/Number: MEDlink III/MEDlink III

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	07/02/2008	07/02/2008
Approved-Closed	Rosalind Minor	04/17/2008	04/17/2008

### Amendments

Item	Schedule	Created By	Created On	Date Submitted
Employer Application	Form	Shari Vick	06/26/2008	06/26/2008

*SERFF Tracking Number:*      *AFDL-125593019*                      *State:*                      *Arkansas*  
*Filing Company:*              *American Public Life Insurance Company*      *State Tracking Number:*      *38604*  
*Company Tracking Number:*      *MEDLINK III*  
*TOI:*                      *H21 Health - Other*                      *Sub-TOI:*                      *H21.000 Health - Other*  
*Product Name:*              *MEDlink III*  
*Project Name/Number:*      *MEDlink III/MEDlink III*

## **Disposition**

Disposition Date: 07/02/2008

Implementation Date:

Status: Approved-Closed

Comment: This file has been reopened to replace the Employer application. The employer application is being approved effective on this date. The remainder of the filing will remain approved effective 4/17/08.

Rate data does NOT apply to filing.

SERFF Tracking Number: AFDL-125593019 State: Arkansas  
 Filing Company: American Public Life Insurance Company State Tracking Number: 38604  
 Company Tracking Number: MEDLINK III  
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other  
 Product Name: MEDlink III  
 Project Name/Number: MEDlink III/MEDlink III

<b>Item Type</b>	<b>Item Name</b>	<b>Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Certification/Notice	Approved-Closed	Yes
<b>Supporting Document</b>	Application	Approved-Closed	Yes
<b>Supporting Document</b>	Health - Actuarial Justification	Approved-Closed	No
<b>Supporting Document</b>	Outline of Coverage	Approved-Closed	Yes
<b>Supporting Document</b>	Authorization	Approved-Closed	Yes
<b>Form</b>	MEDlink III Master Policy	Approved-Closed	Yes
<b>Form</b>	MEDlink III Certificate	Approved-Closed	Yes
<b>Form</b>	Outpatient Hospital Benefit Rider	Approved-Closed	Yes
<b>Form</b>	Physician Outpatient Treatment Benefit Rider	Approved-Closed	Yes
<b>Form</b>	Policyholder Application	Approved-Closed	Yes
<b>Form (revised)</b>	Employer Application		Yes
<b>Form</b>	Employer Application	Withdrawn	Yes

*SERFF Tracking Number:*      *AFDL-125593019*                      *State:*                      *Arkansas*  
*Filing Company:*              *American Public Life Insurance Company*      *State Tracking Number:*      *38604*  
*Company Tracking Number:*      *MEDLINK III*  
*TOI:*                      *H21 Health - Other*                      *Sub-TOI:*                      *H21.000 Health - Other*  
*Product Name:*              *MEDlink III*  
*Project Name/Number:*      *MEDlink III/MEDlink III*

## **Disposition**

Disposition Date: 04/17/2008

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: AFDL-125593019 State: Arkansas  
 Filing Company: American Public Life Insurance Company State Tracking Number: 38604  
 Company Tracking Number: MEDLINK III  
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other  
 Product Name: MEDlink III  
 Project Name/Number: MEDlink III/MEDlink III

<b>Item Type</b>	<b>Item Name</b>	<b>Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Certification/Notice	Approved-Closed	Yes
<b>Supporting Document</b>	Application	Approved-Closed	Yes
<b>Supporting Document</b>	Health - Actuarial Justification	Approved-Closed	No
<b>Supporting Document</b>	Outline of Coverage	Approved-Closed	Yes
<b>Supporting Document</b>	Authorization	Approved-Closed	Yes
<b>Form</b>	MEDlink III Master Policy	Approved-Closed	Yes
<b>Form</b>	MEDlink III Certificate	Approved-Closed	Yes
<b>Form</b>	Outpatient Hospital Benefit Rider	Approved-Closed	Yes
<b>Form</b>	Physician Outpatient Treatment Benefit Rider	Approved-Closed	Yes
<b>Form</b>	Policyholder Application	Approved-Closed	Yes
<b>Form (revised)</b>	Employer Application		Yes
<b>Form</b>	Employer Application	Withdrawn	Yes

SERFF Tracking Number: AFDL-125593019 State: Arkansas  
 Filing Company: American Public Life Insurance Company State Tracking Number: 38604  
 Company Tracking Number: MEDLINK III  
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other  
 Product Name: MEDlink III  
 Project Name/Number: MEDlink III/MEDlink III

**Amendment Letter**

Amendment Date:  
 Submitted Date: 06/26/2008

**Comments:**

Thank you for reopening this filing. As I stated in our telephone conversation, this application has not yet been used. The only change I am making to this application is the addition of the line, "I acknowledge I have received the following brochure: \_\_\_\_\_" in the acknowledgement section of the Group Enrollment Form MEDlink III CERTAPP(1/08)AR.

**Changed Items:**

**Form Schedule Item Changes:**

**Form Schedule Item Changes:**

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
MEDlink III CERTAPP (1/08)AR	Application/EEmployer nrollment Form	Application	Initial				50	MEDlink III Cert.APP (6-08).AR.pdf

SERFF Tracking Number: AFDL-125593019 State: Arkansas  
 Filing Company: American Public Life Insurance Company State Tracking Number: 38604  
 Company Tracking Number: MEDLINK III  
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other  
 Product Name: MEDlink III  
 Project Name/Number: MEDlink III/MEDlink III

## Form Schedule

**Lead Form Number:** GM MEDlink III (1/08)AR

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	GM MEDlink III (1/08)AR	Policy/Cont ract/Fratern al Certificate	MEDlink III Master Policy	Initial		50	MEDlink III.Master.AR.pdf
Approved-Closed	GC MEDlink III (1/08)AR	Certificate	MEDlink III Certificate	Initial		50	MEDlink III.Cert.AR.pdf
Approved-Closed	GM/GC MEDlink III OP (1/08)	Policy/Cont ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Outpatient Hospital Benefit Rider	Initial		53	MEDlink III OP Rider(1-08).Final.pdf
Approved-Closed	GM/GC MEDlink III PhysT (1/08)	Policy/Cont ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Physician Outpatient Treatment Benefit Rider	Initial		55	MEDlink III PhysTRider(1-08).Final.pdf
Approved-Closed	MEDlink III Master App (1/08)	Application/ Policyholder Enrollment Form	Application	Initial		52	MEDlink III Master App (1-08).Final.pdf
	MEDlink III CERTAPP (1/08)AR	Application/ Employer Enrollment Form	Application	Initial		50	MEDlink III Cert.APP (6-08).AR.pdf



# American Public Life Insurance Company

A member of the American Fidelity Group

2305 Lakeland Drive, Flowood, Mississippi 39232  
(800) 256-8606

**POLICYHOLDER:**

**ADDRESS:**

**POLICY NUMBER:**

**EFFECTIVE DATE:**

**ISSUE DATE:**

**POLICY ANNIVERSARY DATE:**

In consideration of the application for this group Policy and the timely payment of premiums, American Public Life Insurance Company (herein called the Company) agrees to pay the benefits of this Policy, subject to all of its terms and conditions.

The Policy takes effect on the Effective Date shown above, 12:01 a. m., Standard Time at the address of the Policyholder.

Signed for American Public Life Insurance Company.

Assistant Secretary

Vice President

THIS POLICY PROVIDES LIMITED BENEFITS AND IS DESIGNED TO SUPPLEMENT OTHER INSURANCE  
COVERAGE.

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

## TABLE OF CONTENTS

### Schedule of Benefits

Section 1 .....	Defined Terms
Section 2 .....	Eligibility and Effective Date
Section 3 .....	What We Will Pay
Section 4 .....	What We Will Not Pay
Section 5 .....	When Coverage Ends
Section 6 .....	Premiums
Section 7 .....	General Policy Provisions
Section 8 .....	Claim Provisions

### Application

**Policy MEDlink® III  
Supplemental Medical Expense Insurance Plan**

Certificate Number:	Policy Number:	Effective Date:
Policyholder:		Age of Primary Insured:
Type of Coverage:		Premium:
Method of Payment:		Frequency:

**SCHEDULE OF BENEFITS**

**THE FOLLOWING SHALL APPLY TO EACH COVERED PERSON**

**COINSURANCE PERCENTAGE:** [50% to 100%]

<b>BENEFIT DESCRIPTION</b>	<b>BENEFIT AMOUNT AND LIMITATIONS</b>
----------------------------	---------------------------------------

---

<b>Maximum Benefit Per Calendar Year</b>	[\$1,000 to \$10,000] per Covered Person for Covered In-Hospital and Outpatient Services combined. Maximum of [\$3,000-\$30,000] per Calendar Year for all persons covered.
<b>Maximum In-Hospital Benefit</b>	[\$1,000 to \$10,000] per Covered Person per Calendar Year. Maximum of [\$3,000-\$30,000] per Calendar Year for all persons covered.

**OPTIONAL BENEFIT RIDERS**

**Outpatient Hospital Benefit Rider,  
Form # MEDlink III OP:  
Maximum Outpatient Benefit**

[\$500-\$4000] per Covered Person per Calendar Year for Covered Outpatient Services. Maximum of [\$1,500-\$12,000] per Calendar Year for all persons covered.

**Outpatient Deductible:**

[\$100-\$1,000] per Covered Person Per Calendar Year  
[Waived for Accident]

**Covered Outpatient Services**

- Hospital Emergency Room treatment
- Outpatient Surgery in Hospital Outpatient Facility or Freestanding Outpatient Surgery Center
- Diagnostic Testing in Hospital Outpatient Facility or MRI Facility
- Outpatient Treatment for a Mental or Emotional Disorder in a Hospital Outpatient Facility

Maximum of 2 Hospital Emergency Room visits per Covered Person and 4 Hospital Emergency Room visits per family, per Calendar Year.

Maximum of 30 days of treatment per Calendar Year

**Physician Outpatient Treatment Benefit Rider,  
Form # MEDlink III PhysT:**

- Treatment in Hospital Outpatient Facility, Freestanding Emergency Care Clinic or Physician Office

\$25 per visit; Maximum of 4 visits per Covered Person and 8 visits per family, per Calendar Year

**PRE-EXISTING PERIOD:**

**12 Months**

**PRE-EXISTING CONDITION EXCLUSION PERIOD:**

**[0 or 12] Months**

## Section 1 DEFINED TERMS

The following terms are used in this Policy and will be capitalized wherever used.

**Accident** means sudden, unexpected and unintended injury:

- (a) which is independent of any Sickness;
- (b) over which the Covered Person has no control; and
- (c) that takes place while the Covered Person's coverage is in force.

**Active Service** means that You are:

- (a) doing in the usual manner all of the regular duties of Your employment on a full-time basis on a scheduled work day; and
- (b) these duties are being done at one of the places of business where You normally do such duties or at some location to which Your employment sends You.

You will be said to be on Active Service on a day which is not a scheduled work day only if You would be able to perform in the usual manner all of the regular duties of Your employment if it were a scheduled work day.

**Calendar Year** means the period from January 1 through December 31 of the same year.

**Certificate** means the individual Certificate issued to You. It describes the coverage under the Policy.

**Coinsurance Percentage** mean the applicable percentage specified in the Schedule of Benefits that the Company will use in computing the amount payable for Covered Charges.

**Covered Charges** means those charges that:

- (a) are incurred by a Covered Person because of an Accident or Sickness;
- (b) are for necessary treatment, services and medical supplies and recommended by a Physician;
- (c) are not more than any dollar limit set forth in the Schedule;
- (d) are incurred while insured under the Policy, subject to any Extension of Benefits; and
- (e) are not excluded under Section 4.

**Covered Person(s)** means You and Your Dependents who are insured under the Policy.

**Dependent** means Your:

- (a) married spouse who is under age 70 and who lives with You; or
- (b) unmarried child (natural, step or adopted) who is not eligible as a primary insured under a group health plan and who:
  - (1) is less than 26 years old and who lives with You; or
  - (2) is less than 26 years old and going to an accredited school full time. Such child must be dependent on You for principal support and maintenance; or
  - (3) becomes incapable of self-sustaining employment because of mental or physical incapacity while covered under the Policy and prior to reaching the limiting age for dependent children. The child must be dependent on You for support and maintenance. The Company must receive notification of the incapacity. Coverage will then continue as long as Your insurance stays in force and the child remains incapacitated. You must notify Us if this incapacity is removed or terminated at a later date. The premium will remain at the dependent rate; or
  - (4) is not living with You, but You are legally required to support such child, and the child would otherwise qualify under (1), (2), or (3) above.

The term Dependent does not include:

- (a) Your grandchild (unless required by law); or
- (b) a child who engages for compensation, profit or gain in any employment or business for 30 or more hours per week, unless such child is a full-time student as described in (b) (2) above.

**Effective Date** means the date described in the Policy. The date shown in Your Certificate is Your Effective Date. The "Effective Date" will start at 12:01 a.m. at the main place of business of the Policyholder.

**Hospital** means a licensed institution that:

(a) has on its premises:

- (1) laboratory, x-ray equipment and operating rooms where major surgical operations may be performed by licensed Physicians;
- (2) permanent and full-time facilities for the care of overnight resident bed patients under the supervision of a licensed Physician;
- (3) 24-hour-a-day nursing service by graduate registered nurses; and
- (4) the patient's written history and medical records;

or:

(b) is accredited by the Joint Commission on Accreditation of Hospitals.

The term Hospital shall not include any institution used by the Covered Person as:

- (a) a place for rehabilitation;
- (b) a place for rest, or for the aged;
- (c) a nursing or convalescent home;
- (d) a long term nursing unit or geriatrics ward; or
- (e) an extended care facility for the care of convalescent, rehabilitative or ambulatory patients.

**Inpatient** means confinement in a Hospital for at least 18 continuous hours in duration.

**Insured (You, Your)** means any person who is eligible for insurance under Section 2 and is insured under the Policy by virtue of:

- (a) employment by the Policyholder; or
- (b) employment by a member company who is a member of an association who holds the Master Policy.

**Late Enrollee** means any person who enrolls for coverage past the first 31 days of first becoming eligible.

**Maximum Benefit Per Calendar Year** is equal to the amount of the Maximum In-Hospital Benefit Calendar Year maximum. The Maximum Benefit Per Calendar Year is the maximum amount payable in a Calendar Year for In-Hospital Covered Charges and Outpatient Hospital Covered Charges combined, as shown in the Schedule of Benefits. In-Hospital Covered Charges and Outpatient Hospital Covered Charges are also subject to their individual Calendar Year maximums as shown in the Schedule of Benefits.

**Mental or Emotional Disorder** means a neurosis, psychoneurosis, psychopathy, psychosis or mental or emotional disease or disorder of any kind.

**Other (or Another) Medical Plan** means any basic major medical or comprehensive medical or managed care policy provided through the Policyholder through which a Covered Person has coverage. The term Other Medical Plan does not include TRICARE, Medicare, or Medicaid.

**Physician** means a practitioner of the healing arts who:

- (a) is practicing within the scope of his or her license in the state where so licensed; and
- (b) is not related to the Covered Person.

**Policy** means the Policy issued to the Policyholder which covers the Covered Persons.

**Policyholder** means the association or employer who holds the Policy.

**Pre-Existing Condition** means a disease, Accident, Sickness, or physical condition for which the Covered Person:

- (a) had treatment;
- (b) incurred expense;
- (c) took medication; or
- (d) received a diagnosis or advice from a Physician;

during that period of time immediately before the Effective Date of the Covered Person's coverage shown under "Pre-Existing Period" on the Schedule. The term "Pre-Existing Condition" will also include conditions which are related to such disease, Accident, Sickness or physical condition.

**Schedule of Benefits (or Schedule)** means the benefit schedule set forth in the Policy or Certificate.

**Sickness** means illness or disease which starts while the Covered Person's coverage is in force and is the direct cause of the loss.

**We, Our, or Us** means American Public Life Insurance Company.

**Section 2**  
**ELIGIBILITY AND EFFECTIVE DATE**

**Your Eligibility:** You are eligible to be insured under this Policy if You:

- (a) are on Active Service as an employee of the Policyholder, or an employee of a member of the Policyholder; and,
- (b) qualify as an eligible Insured, as defined in the Policyholder's application; and,
- (c) are covered under Another Medical Plan; and,
- (d) are under age 70 (if You are employed by an employer employing less than 20 employees).

Evidence of coverage under Another Medical Plan may be required.

**Your Effective Date:** If You are eligible, Your insurance will take effect on:

- (a) the requested Effective Date; or
- (b) the Effective Date assigned by Us upon approval of Your written application, whichever is later, if:
  - (1) Our underwriting rules are met;
  - (2) You are on Active Service;
  - (3) You are covered under Another Medical Plan; and
  - (4) premium has been paid.

If You are not on Active Service due to an Accident or Sickness when Your coverage is to take effect, it will take effect on the first day of the calendar month after the date You return to Active Service.

**Dependent Eligibility:** If Dependent coverage is available under the Policy, You will be eligible for such coverage on:

- (a) the day You become eligible for coverage; or
- (b) the day You acquire Your first Dependent;

whichever is later, provided the Dependent(s) to be insured is/are covered under Another Medical Plan.

Dependent coverage may be elected by:

- (a) completing and signing an application within 31 days of the date the Dependent becomes eligible; and
- (b) by completing any required form of payroll deduction authorization.

**Dependent Effective Date:** The Effective Date of coverage for each eligible Dependent will be the first of the month following:

- (a) Our acceptance of the application; and
- (b) receipt of the first premium.

However, if on such date Your coverage has not yet taken effect, the Effective Date for Dependent coverage will be the same as Your Effective Date.

A newborn child will become covered for Accident and Sickness automatically on the day he or she is born as long as Your coverage was in force on that date. Accident or Sickness includes prematurity, congenital defects and birth abnormalities of a newborn child. The newborn child's coverage will not continue past the 90-day period following his or her birth unless:

- (a) We are notified by the end of the 90-day period of the addition of such newborn child; and
- (b) any applicable additional premium is paid.

Coverage for newborn children will also include coverage for:

- (a) a newly-born child adopted by You, from the moment of birth if a petition for adoption was filed within 60 days of the birth of the child; and
- (b) a child adopted by You from the date of petition for adoption.

Coverage for the adopted child will not continue past 60 days after the date of filing the petition for adoption unless:

- (a) We are notified by the end of the 60-day period of the addition of such adopted child; and
- (b) any applicable additional premium is paid.

**Section 3**  
**WHAT WE WILL PAY**

**In-Hospital Benefit:** We will pay the Coinsurance Percentage for Covered Charges incurred by a Covered Person if:  
(a) the Covered Person is covered by Another Medical Plan when such Covered Charges are incurred, except as provided in the Absence of Other Medical Plan provision, described in this Section; and  
(b) such Covered Charges are incurred while the Covered Person is an Inpatient.

Benefits payable are limited to the Coinsurance Percentage of:  
(a) any out-of-pocket deductible amount incurred under the Other Medical Plan;  
(b) any out-of-pocket co-payment or coinsurance amounts the Covered Person actually incurs under the Other Medical Plan;  
(c) any out-of-pocket amount the Covered Person actually incurs under the Other Medical Plan for treatment of a Mental or Emotional Disorder, limited to 30 days per Calendar Year;

up to the Maximum In-Hospital Benefit shown in the Schedule.

Benefits are limited to the Maximum Benefit Per Calendar Year listed on the Schedule for any In-Hospital Covered Charges and Outpatient Hospital Covered Charges, combined.

**Absence of Other Medical Plan:** In the event a Covered Person has no Other Medical Plan in force when out-of-pocket expense is incurred:

(a) benefits will be derived using the Assumed Other Medical Plan, as described below; and  
(b) coverage under the Policy will be terminated for such Covered Person, and any other person in the same family unit whose Other Medical Plan coverage is not in effect. Such Covered Person(s) will not be entitled to any Extensions or Continuations described in Section 5, except COBRA Continuation, where applicable.

**MAXIMUM IN-HOSPITAL BENEFIT**

**ASSUMED OTHER MEDICAL PLAN**

\$2,000 or less	\$100 deductible, then 20% co-insurance for the first \$5,000 of Covered Charges per Calendar Year per person.
\$2,001 - \$2,750	\$250 deductible, then 20% co-insurance for the first \$10,000 of Covered Charges per Calendar Year per person.
\$2,751 - \$4,250	\$500 deductible, then 20% co-insurance for the first \$10,000 of Covered Charges per Calendar Year per person.
\$4,251 or more	\$1,000 deductible, then 20% co-insurance for the first \$10,000 of Covered Charges per Calendar Year per person.

## Section 4

### WHAT WE WILL NOT PAY

We will pay no benefits for any expenses incurred during any period the Covered Person does not have coverage under Another Medical Plan, except as provided in the Absence of Other Medical Plan provision, described in Section 3 or which result from:

- (a) suicide or any attempt, thereof, while sane or insane;
- (b) any intentionally self-inflicted injury or Sickness;
- (c) rest care or rehabilitative care and treatment;
- (d) voluntary abortion except, with respect to You or Your covered Dependent spouse:
  - (1) where Your or Your Dependent spouse's life would be endangered if the fetus were carried to term; or
  - (2) where medical complications have arisen from abortion;
- (e) pregnancy of a Dependent child;
- (f) participation in a riot, civil commotion, civil disobedience, or unlawful assembly. This does not include a loss which occurs while acting in a lawful manner within the scope of authority;
- (g) commission of a felony;
- (h) participation in a contest of speed in power driven vehicles, parachuting, or hang gliding;
- (i) air travel, except:
  - (1) as a fare-paying passenger on a commercial airline on a regularly scheduled route; or
  - (2) as a passenger for transportation only and not as a pilot or crew member;
- (j) Accident that occurs while intoxicated or Sickness that results from intoxication; (Whether or not a person is intoxicated is determined and defined by the laws and jurisdiction of the geographical area in which the loss occurred.)
- (k) alcoholism or drug use, unless such drugs were taken on the advice of a Physician and taken as prescribed;
- (l) sex changes;
- (m) experimental treatment, drugs (except of FDA approved cancer drugs), or surgery;
- (n) Pre-Existing Conditions, unless the Covered Person has satisfied the Pre-Existing Condition Exclusion Period shown on the Schedule;
- (o) an act of war, whether declared or undeclared, or while performing police duty as a member of any military or naval organization; (This exclusion includes Accident sustained or Sickness contracted while in the service of any military, naval, or air force of any country engaged in war. We will refund the pro rata unearned premium for any such period the Covered Person is not covered due to military service.)
- (p) Accident or Sickness arising out of and in the course of any occupation for compensation, wage or profit; (This does not apply to those sole proprietors or partners not covered by Workers' Compensation.)
- (q) dental or vision services, including treatment, surgery, extractions, or x-rays, unless:
  - (1) resulting from an Accident occurring while the Covered Person's coverage is in force and if performed within 12 months of the date of such Accident; or
  - (2) due to congenital disease or anomaly of a covered newborn child.
- (r) routine examinations, such as health exams, periodic check-ups, or routine physicals;
- (s) any expense for which benefits are not payable under the Covered Person's Other Medical Plan; or
- (t) air or ground ambulance;
- (u) elective cosmetic surgery;
- (v) drugs (prescription and non-prescription);
- (w) sterilization and reversal of sterilization;
- (x) an expense that does not meet the definition of Covered Charges;
- (y) expense or service that exceeds the maximum benefit amount, as shown in the Policy Schedule of Benefits, or number of visits that exceed the maximum number of visits, as shown in the Policy Schedule of Benefits.

## Section 5 WHEN COVERAGE ENDS

**Your Coverage:** Your insurance coverage will end on the earliest of these dates:

- (a) the date You no longer qualify as an Insured;
- (b) the end of the last period for which premium has been paid;
- (c) the date the Policy is discontinued;
- (d) the date You retire;
- (e) the date You attain age 70 (if You work for an employer employing less than 20 employees);
- (f) the date You cease to be on Active Service, as defined in Section 1;
- (g) the date Your coverage under Another Medical Plan ends; or
- (h) the date You cease employment with the employer through whom You originally became insured under the Policy.

**Coverage On Your Dependent(s):** Insurance coverage on a Dependent will end on the earliest of these dates:

- (a) the date Your coverage terminates;
- (b) the end of the last period for which premium has been paid;
- (c) the date the Dependent no longer meets the definition of Dependent, as defined in Section 1;
- (d) the date the Dependent's coverage under Another Medical Plan ends; or
- (e) the date the Policy is modified so as to exclude Dependent coverage.

We may end the coverage of any Covered Person who submits a fraudulent claim.

**Extension of Coverage:** Coverage under the Policy will continue for 31 days following termination of a Covered Person's coverage under this section, unless during such period the Covered Person otherwise becomes entitled to similar coverage from some other source.

This provision will not apply if:

- (a) the Covered Person's Other Medical Plan does not provide a similar Extension of Coverage provision;
- (b) Another Medical Plan was not in effect during the period of time the Covered Person was insured under the Policy; or
- (c) coverage under the Covered Person's Other Medical Plan was terminated more than 30 days prior to termination of coverage under the Policy.

**Extension of Benefits:** Whenever termination of coverage under this section occurs because of termination of Your employment, such termination shall be without prejudice to any Hospital confinement, which commenced while this Policy was in force; provided, however, that the Covered Person is and continues to be Hospital confined as an Inpatient. Such Extension of Benefits shall continue for up to three months.

This provision will not apply if:

- (a) the Covered Person's Other Medical Plan does not provide a similar Extension of Benefits provision;
- (b) Another Medical Plan was not in effect during the period of time the Covered Person was insured under the Policy; or
- (c) coverage under the Covered Person's Other Medical Plan was terminated more than 30 days prior to termination of coverage under the Policy.

**Continuation of Coverage During a Sabbatical Leave:** Coverage for You and Your covered Dependent(s) may be continued during Your Sabbatical Leave:

- (a) until the date Your Sabbatical Leave ends; or
- (b) for up to 12 months, whichever is earlier.

Sabbatical Leave means a leave of absence granted in writing by Your employer for the purpose of Your pursuit of education, research or teaching.

This provision will not apply if:

- (a) Your Other Medical Plan does not provide a similar Continuation of Coverage provision;
- (b) Another Medical Plan was not in effect during the period of time You were insured under the Policy; or
- (c) coverage under Your Other Medical Plan was terminated more than 30 days prior to termination of coverage under the Policy.

**Continuation of Coverage During a Layoff or Leave of Absence:** Coverage for You and Your covered Dependent(s) may be continued during a Layoff or Leave of Absence for up to a maximum period of three months.

If:

- (a) Your Layoff or Leave of Absence continues for more than three months; or
- (b) You do not return to work for the same employer,

Your coverage will be said to have ended the last day of Active Service and no coverage will be provided during the Layoff or Leave of Absence period.

Layoff means:

- (a) involuntary termination of Active Service (for reasons other than cause); or
- (b) a reduction of work hours to the point where You are no longer eligible for coverage under the Policy.

Leave of Absence must be granted in writing by Your employer.

This provision will not apply if Your Other Medical Plan does not provide a similar Continuation of Coverage provision.

**Continuation of Coverage Privilege:** An Insured whose coverage under the Policy ends due to termination of employment or membership or change in marital status, will have the right to continuation of coverage for You and Your Dependent(s). The continuation of coverage period will extend to 120 days providing You have been continuously insured under the group Policy for three months prior to termination of coverage.

The continuation coverage will end:

- (a) the end of the period You paid premium;
- (b) the premium due date following the date You become eligible for Medicare; and
- (c) the date of which the group Policy is terminated.

Written application for the continued coverage and the required premium must be submitted to Us by the Covered Person within 10 days following termination of coverage.

You will not be eligible for continued coverage if:

- (a) any required premium or contribution was not paid;
- (b) such person is eligible for Medicare;
- (c) such person is eligible for full coverage under any other group disability policy which covers Pre-Existing conditions; and
- (d) such person discontinued their coverage under the Other Medical Plan.

Upon termination of such continued coverage, You may elect the conversion coverage. However, any Covered Person utilizing the conversion coverage will waive the right to the continuation privilege or may skip the continuation privilege in order to receive the conversion coverage.

**Conversion Privilege:** Any Covered Person whose insurance under the group Policy ends for any reason except:

- (a) failure to pay any required premium, such person will have the right to coverage under a conversion policy.
- (b) Replacement of the terminating policy by similar group coverage within 31 days, such person will have the right to coverage under a conversion policy.

The conversion coverage will be issued without any Pre-Existing limitations or waiting periods other than those remaining unfulfilled under the Policy which conversion is made, and will cover pregnancy and maternity benefits.

Application and the required premium for the conversion coverage must be made within 30 days of the date prior coverage was terminated. Premiums for the converted policy will be determined in accordance with Our table of premium rates applicable to the age, class of risk and the type / amount of coverage provided for each Covered Person, and are subject to change at the end of every annual policy anniversary.

Conversion coverage will not be issued or renewed for any person:

- (a) who is or could be covered by Medicare;
- (b) whose coverage ended because the required premium was not paid
- (c) who is eligible for similar benefits under another group disability plan; and
- (d) who does not elect to keep in force conversion coverage under their basic Major Medical / Comprehensive policy.

**COBRA Continuation of Coverage:** This plan may be continued in accordance with the Consolidated Omnibus Reconciliation Act of 1986.

**Insurer's Right to Terminate Policy:** We have the right to terminate coverage under the Policy on any Premium due date on or after the 1<sup>st</sup> Anniversary Date of the Policy. We will give the Policyholder at least 60 days advance written notice of such termination.

## **Section 6 PREMIUMS**

The first premium is due on or before the Effective Date of Your Coverage. Thereafter, premiums are due on or before the premium due date. Premiums may be remitted to:

- (a) Our Home Office; or
- (b) an authorized insurance producer of Ours.

The premium rates may be changed by Us. If the rates are changed, the Company will give You at least 45 days advance written notice. If a change in benefits increases the Company's liability, premium rates may be changed on the date the Company's liability is increased.

## **Section 7 GENERAL POLICY PROVISIONS**

**Entire Contract-Changes:** The entire contract shall include:

- (a) the Policy;
- (b) the application of the Policyholder;
- (c) Your application, attached to the Certificate; and
- (d) all endorsements and amendments.

Statements made by the Policyholder or You are representations and not warranties, if fraud was not intended. No such statements will be used to avoid the insurance, reduce benefits, or defend a claim under the Policy unless:

- (a) the statement is in writing; and
- (b) a copy of that statement is given to You, Your beneficiary, or Your personal representative.

The terms of the Policy can be changed only by endorsement or amendment signed by one of the Company's executive officers. No insurance producer may change the Policy or waive its provisions.

**Time Limit on Certain Defenses:** After two years from the Effective Date of coverage for a Covered Person, no statements in the application, except fraudulent misstatements, can be used to:

- (a) avoid the coverage; or
- (b) deny a claim for loss incurred that starts after such two-year period.

**Grace Period:** A Grace Period of 31 days will be allowed for each premium payment after the first premium. Coverage will stay in force during this time. The coverage under the Policy will terminate at the end of the Grace Period if the premium has not been paid.

The Policyholder or You may, by writing to Us, cancel Your coverage under the Policy:

- (a) on any future premium due date; or
- (b) on any date during the Grace Period.

If coverage is cancelled on a premium due date, the Grace Period will not apply. If cancellation is during the Grace Period and a claim is filed for expenses incurred during the Grace Period for which benefits are payable, We will deduct the premium for the Grace Period from the claim payment. This will not further extend the Grace Period.

**Legal Actions:** No legal action may be brought to recover under the Policy:

- (a) within 60 days after written proof of loss has been furnished as required; or
- (b) more than three (3) years from the time written proof of loss is required to be furnished.

**Conformity With State Laws:** A provision of the Policy that conflicts with a law of the state of issue is hereby changed to meet the minimum standards of that law.

**Certificates:** We will supply You a Certificate. This Certificate will describe:

- (a) the insurance benefits;
- (b) to whom benefits will be paid;
- (c) any limitations of the Policy; and
- (d) all other essential features of the Policy.

If You are issued more than one Certificate under the Policy, only the last one issued will be in effect.

**Misstatement of Age:** If the age of the Covered Person has been misstated, the amounts payable shall be such as the premium paid would have purchased at the correct age.

**Refund of Premium:** Upon the death of a Covered Person, any proceeds payable will include any premiums for that person for any period beyond the end of the month in which death occurred.

## **Section 8 CLAIM PROVISIONS**

You should notify Us, in writing, within 30 days after You or one of Your covered Dependents incurs a loss covered by the Policy. (If it is not reasonably possible to give notice within this time period, Your claim will not be denied or reduced due to the delay.) Written notice should be sent to Us at the following address:

American Public Life Insurance Company  
P. O. Box 925  
Jackson, Mississippi 39205-0925

Use a claim form for filing proof of loss. We will send You claim forms within 15 days after We receive Your notice of claim. If We do not supply You claim forms within this stated period of time, You can give proof by sending, in writing, a description of the loss regarding the nature and extent of the loss. Proof of loss must be given to Us within 90 days after the loss. We will accept late proof if:

- (a) it was not reasonably possible to give proof in that time; and
- (b) the proof is given within one (1) year from the date proof is otherwise required to be furnished. This one (1) year limit will not apply in the absence of legal capacity.

The explanation of benefits from the carrier of the Other Medical Plan must be submitted with claim forms for all Inpatient and outpatient claims. With respect to the benefits under the Physician Outpatient Treatment Benefit Rider, no explanation of benefits is required; however, the Physician's statement must be submitted.

**Time of Payment of Claims:** Benefits for a covered loss will be paid immediately as soon as the Company receives written proof of loss.

**Payment of Benefits:** All benefits will be paid to You. Benefits payable under the Policy will be paid to You or the providers of services and supplies, if You so direct in writing. Any benefits unpaid at Your death will be paid to Your Estate.

Accrued benefits that are not paid at Your death will be paid to Your beneficiary or estate. If a benefit is to be paid to Your estate, or, if You or Your beneficiary are not competent to give a valid release, We may pay up to \$1,000 of such benefit to one of Your relatives who is deemed by Us to be justly entitled to it. Such payment, made in good faith, fully discharges Us to the extent of the payment.

**Physical Examination:** We have the right to have a Covered Person examined as often as is reasonably necessary while a claim is pending. We will pay for such examination.

## **NOTICE OF THE RIGHT TO APPEAL**

Any denial of a claim for benefits will be explained in writing and the explanation will include:

- (a) the specific reason for the denial;
- (b) reference to the Plan provision upon which the denial was based;
- (c) a description of any additional information You may be required to provide and an explanation of why it is needed; and
- (d) an explanation of the Plan's claim review procedure.

You and Your beneficiary, or a duly authorized representative may appeal any denial of a claim for benefits by filing a written request to Us. In connection with such a request, documents pertinent to the administration of the Plan may be reviewed, and issues outlining the basis of the appeal may be submitted. You may have representation throughout this review procedure.

Your request for review must be filed within 90 days after receipt of the written notice of denial of a claim. A decision will be rendered by Us, no later than 90 days after receipt of Your request for review. If there are special circumstances, the decision shall be rendered as soon as possible, but no later than 120 days after receipt of the request for review. The decision, after the review, shall be in writing and shall include specific reasons for the decision. This decision shall also include specific references to the pertinent Plan provisions on which the decision was based.

## **[STATEMENT OF ERISA RIGHTS**

As a participant in the Plan, the Insured is 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:

- (a) examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all Plan documents, including insurance contracts and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.
- (b) obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- (c) 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.

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 the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of Your and other Plan participants and beneficiaries. No one, including Your employer, or any other person, may discharge You or otherwise discriminate against You in any way to prevent You from obtaining a welfare benefit or exercising Your rights under ERISA. If Your claim for a welfare benefit is denied in whole or in part, You must receive a written explanation of the reason for the denial. You have the right to have the Plan review and consider Your claim.

Under ERISA, there are steps You can take to enforce the above rights. For instance, if You request materials from the Plan and do not receive them within 30 days, You may file suit in a federal court. In such 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 to You because of reasons beyond the control of the Plan 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. 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 court costs and fees. If You lose, the court may order You to pay these costs and fees, for example, if it finds Your claim frivolous.

If You have any questions about the Plan, You should contact the Plan Administrator. If You have any questions about this statement or about Your rights under ERISA, You should contact the nearest Area Office of the Pension Welfare Benefits Administration, U.S. Department of Labor.]



# American Public Life Insurance Company

**A member of the American Fidelity Group**

2305 Lakeland Drive, Flowood, Mississippi 39232  
(800) 256-8606

## CERTIFICATE OF INSURANCE

American Public Life Insurance Company (We, Us, Our) hereby certifies that it has issued and delivered to the Policyholder a group Policy, described on the Schedule of Benefits page attached hereto. The group Policy covers certain eligible persons, as described in the Policy.

This Certificate describes the benefits and provisions of the group Policy and becomes Your Certificate of insurance only if:

- (a) You are eligible for the insurance;
- (b) You are on Active Service on the date it is to take effect; and
- (c) You become insured and remain insured in accordance with all of the provisions of the Policy.

Further, the insurance is to be effective only if the required premium payments are made by You or on Your behalf to Us. (See Section 2, Eligibility and Effective Date.)

No insurance producer may change the Policy or waive any of its provisions.

This Certificate takes the place of any other Certificate previously issued to You under the group Policy. It should be kept in a safe place.

IN WITNESS WHEREOF, We cause this Certificate to take effect on the Effective Date.

Handwritten signature of Sharon N. Starnes in black ink.

Assistant Secretary

Handwritten signature of William F. Weems in black ink.

Vice President

### **PLEASE READ YOUR CERTIFICATE CAREFULLY.**

THE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED PROVIDES LIMITED BENEFITS AND IS  
DESIGNED TO SUPPLEMENT OTHER INSURANCE COVERAGE.  
THIS COVERAGE SHOULD NOT BE REPRESENTED AS YOUR PRIMARY COVERAGE.

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

**TABLE OF CONTENTS**

Schedule of Benefits

Section 1..... Defined Terms  
Section 2..... Eligibility and Effective Date  
Section 3..... What We Will Pay  
Section 4..... What We Will Not Pay  
Section 5..... When Coverage Ends  
Section 6..... Premiums  
Section 7..... General Policy Provisions  
Section 8..... Claim Provisions

Application

**Certificate of Insurance  
MEDlink® III**

**Supplemental Limited Benefit Medical Expense Insurance**

Certificate Number:	Policy Number:	Effective Date:
Policyholder:		Age of Primary Insured:
Type of Coverage:		Premium:
Method of Payment:		Frequency:

**Insured:** **John C. Doe**  
**123 First Avenue**

**SCHEDULE OF BENEFITS**

**THE FOLLOWING SHALL APPLY TO EACH COVERED PERSON**

**COINSURANCE PERCENTAGE:** [50% to 100%]

<b>BENEFIT DESCRIPTION</b>	<b>BENEFIT AMOUNT AND LIMITATIONS</b>	<b>PREMIUM</b>
<b>Maximum Benefit Per Calendar Year</b>	[\$1,000 to \$10,000] per Covered Person for Covered In-Hospital and Outpatient Services combined. Maximum of [\$3,000-\$30,000] per Calendar Year for all persons covered.	
<b>Maximum In-Hospital Benefit</b>	[\$1,000 to \$10,000] per Covered Person per Calendar Year. Maximum of [\$3,000-\$30,000] per Calendar Year for all persons covered.	

**OPTIONAL BENEFIT RIDERS**

**Outpatient Hospital Benefit Rider,  
Form # MEDlink III OP:  
Maximum Outpatient Benefit**

[\$500 to \$4,000] per Covered Person per Calendar Year for Covered Outpatient Services. Maximum of [\$1,500-\$12,000] per Calendar Year for all persons covered.

**Outpatient Deductible:**

[\$100 to \$1,000] per Covered Person Per Calendar Year  
[Waived for Accident]

**Covered Outpatient Services**

- Hospital Emergency Room treatment
- Outpatient Surgery in Hospital Outpatient Facility or Freestanding Outpatient Surgery Center
- Diagnostic Testing in Hospital Outpatient Facility or MRI Facility
- Outpatient Treatment for a Mental or Emotional Disorder in a Hospital Outpatient Facility

Maximum of 2 Hospital Emergency Room visits per Covered Person and 4 Hospital Emergency Room visits per Family, per Calendar Year.

Maximum of 30 days of treatment per Calendar Year

**Physician Outpatient Treatment Benefit Rider,  
Form # MEDlink III PhysT:**

- Treatment in Hospital Outpatient Facility, Freestanding Emergency Care Clinic or Physician Office

\$25 per visit; Maximum of 4 visits per Covered Person and 8 visits per Family, per Calendar Year

**PRE-EXISTING PERIOD:**

**12 Months**

**PRE-EXISTING CONDITION EXCLUSION PERIOD:**

**[0-12] Months**

## Section 1 DEFINED TERMS

The following terms are used in this Policy and will be capitalized wherever used.

**Accident** means sudden, unexpected and unintended injury:

- (a) which is independent of any Sickness;
- (b) over which the Covered Person has no control; and
- (c) that takes place while the Covered Person's coverage is in force.

**Active Service** means that You are:

- (a) doing in the usual manner all of the regular duties of Your employment on a full-time basis on a scheduled work day; and
- (b) these duties are being done at one of the places of business where You normally do such duties or at some location to which Your employment sends You.

You will be said to be on Active Service on a day which is not a scheduled work day only if You would be able to perform in the usual manner all of the regular duties of Your employment if it were a scheduled work day.

**Calendar Year** means the period from January 1 through December 31 of the same year.

**Certificate** means the individual Certificate issued to You. It describes the coverage under the Policy.

**Coinsurance Percentage** mean the applicable percentage specified in the Schedule of Benefits that We will use in computing the amount payable for Covered Charges.

**Covered Charges** means those charges that:

- (a) are incurred by a Covered Person because of an Accident or Sickness;
- (b) are for necessary treatment, services and medical supplies and recommended by a Physician;
- (c) are not more than any dollar limit set forth in the Schedule;
- (d) are incurred while insured under the Policy, subject to any Extension of Benefits; and
- (e) are not excluded under Section 4.

**Covered Person(s)** means You and Your Dependents who are insured under the Policy.

**Dependent** means Your:

- (a) married spouse who is under age 70 and who lives with You; or
- (b) unmarried child (natural, step or adopted) who is not eligible as a primary insured under a group health plan and who:
  - (1) is less than 26 years old and who lives with You; or
  - (2) is less than 26 years old and going to an accredited school full time. Such child must be dependent on You for principal support and maintenance; or
  - (3) becomes incapable of self-sustaining employment because of mental or physical incapacity while covered under the Policy and prior to reaching the limiting age for dependent children. The child must be dependent on You for support and maintenance. We must receive notification of the incapacity. Coverage will then continue as long as Your insurance stays in force and the child remains incapacitated. You must notify Us if this incapacity is removed or terminated at a later date. The premium will remain at the dependent rate; or
  - (4) is not living with You, but You are legally required to support such child, and the child would otherwise qualify under (1), (2), or (3) above.

The term Dependent does not include:

- (a) Your grandchild (unless required by law); or
- (b) a child who engages for compensation, profit or gain in any employment or business for 30 or more hours per week, unless such child is a full-time student as described in (b)(2) above.

**Effective Date** means the date described in the Policy. The date shown in Your Certificate is Your Effective Date. The "Effective Date" will start at 12:01 a.m. at the main place of business of the Policyholder.

**Hospital** means a licensed institution that:

(a) has on its premises:

- (1) laboratory, x-ray equipment and operating rooms where major surgical operations may be performed by licensed Physicians;
- (2) permanent and full-time facilities for the care of overnight resident bed patients under the supervision of a licensed Physician;
- (3) 24-hour-a-day nursing service by graduate registered nurses; and
- (4) the patient's written history and medical records;

or:

(b) is accredited by the Joint Commission on Accreditation of Hospitals.

The term Hospital shall not include any institution used by the Covered Person as:

- (a) a place for rehabilitation;
- (b) a place for rest, or for the aged;
- (c) a nursing or convalescent home;
- (d) a long term nursing unit or geriatrics ward; or
- (e) an extended care facility for the care of convalescent, rehabilitative or ambulatory patients.

**Inpatient** means confinement in a Hospital for at least 18 continuous hours in duration.

**Insured (You, Your)** means any person who is eligible for insurance under Section 2 and is insured under the Policy by virtue of:

- (a) employment by the Policyholder; or
- (b) employment by a member company who is a member of an association who holds the Master Policy.

**Late Enrollee** means any person who enrolls for coverage past the first 31 days of first becoming eligible.

**Maximum Benefit Per Calendar Year** is equal to the amount of the Maximum In-Hospital Benefit Calendar Year maximum. The Maximum Benefit Per Calendar Year is the maximum amount payable in a Calendar Year for In-Hospital Covered Charges and Outpatient Hospital Covered Charges combined, as shown in the Schedule of Benefits. In-Hospital Covered Charges and Outpatient Hospital Covered Charges are also subject to their individual Calendar Year maximums as shown in the Schedule of Benefits.

**Mental or Emotional Disorder** means a neurosis, psychoneurosis, psychopathy, psychosis or mental or emotional disease or disorder of any kind.

**Other (or Another) Medical Plan** means any basic major medical, comprehensive medical, or managed care policy provided through the Policyholder through which a Covered Person has coverage. The term Other Medical Plan does not include TRICARE, Medicare, or Medicaid.

**Physician** means a practitioner of the healing arts who:

- (a) is practicing within the scope of his or her license in the state where so licensed; and
- (b) is not related to the Covered Person.

**Policy** means the Policy issued to the Policyholder which covers the Covered Persons.

**Policyholder** means the association or employer who holds the Policy.

**Pre-Existing Condition** means a disease, Accident, Sickness, or physical condition for which the Covered Person:

- (a) had treatment;
- (b) incurred expense;
- (c) took medication; or
- (d) received a diagnosis or advice from a Physician;

during that period of time immediately before the Effective Date of the Covered Person's coverage shown under "Pre-Existing Period" on the Schedule. The term "Pre-Existing Condition" will also include conditions which are related to such disease, Accident, Sickness or physical condition.

**Schedule of Benefits (or Schedule)** means the benefit schedule set forth in the Policy or Certificate.

**Sickness** means illness or disease which starts while the Covered Person's coverage is in force and is the direct cause of the loss.

**Section 2**  
**ELIGIBILITY AND EFFECTIVE DATE**

**Your Eligibility:** You are eligible to be insured under this Policy if You:

- (a) are on Active Service as an employee of the Policyholder, or an employee of a member of the Policyholder; and,
- (b) qualify as an eligible Insured, as defined in the Policyholder's application; and,
- (c) are covered under Another Medical Plan; and,
- (d) are under age 70 (if You are employed by an employer employing less than 20 employees).

Evidence of coverage under Another Medical Plan may be required.

**Your Effective Date:** If You are eligible, Your insurance will take effect on:

- (a) the requested Effective Date; or
- (b) the Effective Date assigned by Us upon approval of Your written application, whichever is later, if:
  - (1) Our underwriting rules are met;
  - (2) You are on Active Service;
  - (3) You are covered under Another Medical Plan; and
  - (4) premium has been paid.

If You are not on Active Service due to an Accident or Sickness when Your coverage is to take effect, it will take effect on the first day of the calendar month after the date You return to Active Service.

**Dependent Eligibility:** If Dependent coverage is available under the Policy, You will be eligible for such coverage on:

- (a) the day You become eligible for coverage; or
- (b) the day You acquire Your first Dependent;

whichever is later, provided the Dependent(s) to be insured is/are covered under Another Medical Plan.

Dependent coverage may be elected by:

- (a) completing and signing an application within 31 days of the date the Dependent becomes eligible; and
- (b) by completing any required form of payroll deduction authorization.

**Dependent Effective Date:** The Effective Date of coverage for each eligible Dependent will be the first of the month following:

- (a) Our acceptance of the application; and
- (b) receipt of the first premium.

However, if on such date Your coverage has not yet taken effect, the Effective Date for Dependent coverage will be the same as Your Effective Date.

A newborn child will become covered for Accident and Sickness automatically on the day he or she is born as long as Your coverage was in force on that date. Accident or Sickness includes prematurity, congenital defects and birth abnormalities of a newborn child. The newborn child's coverage will not continue past the 90-day period following his or her birth unless:

- (a) We are notified by the end of the 90-day period of the addition of such newborn child; and
- (b) any applicable additional premium is paid.

Coverage for newborn children will also include coverage for:

- (a) a newly-born child adopted by You, from the moment of birth if a petition for adoption was filed within 60 days of the birth of the child; and
- (b) a child adopted by You from the date of petition for adoption.

Coverage for the adopted child will not continue past 60 days after the date of filing the petition for adoption unless:

- (a) We are notified by the end of the 60-day period of the addition of such adopted child; and
- (b) any applicable additional premium is paid.

**Section 3**  
**WHAT WE WILL PAY**

**In-Hospital Benefit:** We will pay the Coinsurance Percentage for Covered Charges incurred by a Covered Person if:  
(a) the Covered Person is covered by Another Medical Plan when such Covered Charges are incurred, except as provided in the Absence of Other Medical Plan provision, described in this Section; and  
(b) such Covered Charges are incurred while the Covered Person is an Inpatient.

Benefits payable are limited to the Coinsurance Percentage of:  
(a) any out-of-pocket deductible amount incurred under the Other Medical Plan;  
(b) any out-of-pocket co-payment or coinsurance amounts the Covered Person actually incurs under the Other Medical Plan;  
(c) any out-of-pocket amount the Covered Person actually incurs under the Other Medical Plan for treatment of a Mental or Emotional Disorder, limited to 30 days per Calendar Year;

up to the Maximum In-Hospital Benefit shown in the Schedule.

Benefits are limited to the Maximum Benefit Per Calendar Year listed on the Schedule for any In-Hospital Covered Charges and Outpatient Hospital Covered Charges, combined.

**Absence of Other Medical Plan:** In the event a Covered Person has no Other Medical Plan in force when out-of-pocket expense is incurred:

(a) benefits will be derived using the Assumed Other Medical Plan, as described below; and  
(b) coverage under the Policy will be terminated for such Covered Person, and any other person in the same family unit whose Other Medical Plan coverage is not in effect. Such Covered Person(s) will not be entitled to any Extensions or Continuations described in Section 5, except COBRA Continuation, where applicable.

**MAXIMUM IN-HOSPITAL BENEFIT**

**ASSUMED OTHER MEDICAL PLAN**

\$2,000 or less	\$100 deductible, then 20% co-insurance for the first \$5,000 of Covered Charges per Calendar Year per person.
\$2,001 - \$2,750	\$250 deductible, then 20% co-insurance for the first \$10,000 of Covered Charges per Calendar Year per person.
\$2,751 - \$4,250	\$500 deductible, then 20% co-insurance for the first \$10,000 of Covered Charges per Calendar Year per person.
\$4,251 or more	\$1,000 deductible, then 20% co-insurance for the first \$10,000 of Covered Charges per Calendar Year per person.

## Section 4

### WHAT WE WILL NOT PAY

We will pay no benefits for any expenses incurred during any period the Covered Person does not have coverage under Another Medical Plan, except as provided in the Absence of Other Medical Plan provision, described in Section 3 or which result from:

- (a) suicide or any attempt, thereof, while sane or insane;
- (b) any intentionally self-inflicted injury or Sickness;
- (c) rest care or rehabilitative care and treatment;
- (d) voluntary abortion except, with respect to You or Your covered Dependent spouse:
  - (1) where Your or Your Dependent spouse's life would be endangered if the fetus were carried to term; or
  - (2) where medical complications have arisen from abortion;
- (e) pregnancy of a Dependent child;
- (f) participation in a riot, civil commotion, civil disobedience, or unlawful assembly. This does not include a loss which occurs while acting in a lawful manner within the scope of authority;
- (g) commission of a felony;
- (h) participation in a contest of speed in power driven vehicles, parachuting, or hang gliding;
- (i) air travel, except:
  - (1) as a fare-paying passenger on a commercial airline on a regularly scheduled route; or
  - (2) as a passenger for transportation only and not as a pilot or crew member;
- (j) Accident that occurs while intoxicated or Sickness that results from intoxication; (Whether or not a person is intoxicated is determined and defined by the laws and jurisdiction of the geographical area in which the loss occurred.)
- (k) alcoholism or drug use, unless such drugs were taken on the advice of a Physician and taken as prescribed;
- (l) sex changes;
- (m) experimental treatment, drugs (except of FDA approved cancer drugs), or surgery;
- (n) Pre-Existing Conditions, unless the Covered Person has satisfied the Pre-Existing Condition Exclusion Period shown on the Schedule;
- (o) an act of war, whether declared or undeclared, or while performing police duty as a member of any military or naval organization; (This exclusion includes Accident sustained or Sickness contracted while in the service of any military, naval, or air force of any country engaged in war. We will refund the pro rata unearned premium for any such period the Covered Person is not covered due to military service.)
- (p) Accident or Sickness arising out of and in the course of any occupation for compensation, wage or profit; (This does not apply to those sole proprietors or partners not covered by Workers' Compensation.)
- (q) dental or vision services, including treatment, surgery, extractions, or x-rays, unless:
  - (1) resulting from an Accident occurring while the Covered Person's coverage is in force and if performed within 12 months of the date of such Accident; or
  - (2) due to congenital disease or anomaly of a covered newborn child.
- (r) routine examinations, such as health exams, periodic check-ups, or routine physicals;
- (s) any expense for which benefits are not payable under the Covered Person's Other Medical Plan; or
- (t) air or ground ambulance;
- (u) elective cosmetic surgery;
- (v) drugs (prescription and non-prescription);
- (w) sterilization and reversal of sterilization;
- (x) an expense that does not meet the definition of Covered Charges;
- (y) expense or service that exceeds the maximum benefit amount, as shown in the Certificate Schedule of Benefits, or number of visits that exceed the maximum number of visits, shown in the Certificate Schedule of Benefits.

## Section 5 WHEN COVERAGE ENDS

**Your Coverage:** Your insurance coverage will end on the earliest of these dates:

- (a) the date You no longer qualify as an Insured;
- (b) the end of the last period for which premium has been paid;
- (c) the date the Policy is discontinued;
- (d) the date You retire;
- (e) the date you attain age 70 (if You work for an employer employing less than 20 employees);
- (f) the date You cease to be on Active Service, as defined in Section 1;
- (g) the date Your coverage under Another Medical Plan ends; or
- (h) the date You cease employment with the employer through whom You originally became insured under the Policy.

**Coverage On Your Dependent(s):** Insurance coverage on a Dependent will end on the earliest of these dates:

- (a) the date Your coverage terminates;
- (b) the end of the last period for which premium has been paid;
- (c) the date the Dependent no longer meets the definition of Dependent, as defined in Section 1;
- (d) the date the Dependent's coverage under Another Medical Plan ends; or
- (e) the date the Policy is modified so as to exclude Dependent coverage.

We may end the coverage of any Covered Person who submits a fraudulent claim.

**Extension of Coverage:** Coverage under the Policy will continue for 31 days following termination of a Covered Person's coverage under this section, unless during such period the Covered Person otherwise becomes entitled to similar coverage from some other source.

This provision will not apply if:

- (a) the Covered Person's Other Medical Plan does not provide a similar Extension of Coverage provision;
- (b) Another Medical Plan was not in effect during the period of time the Covered Person was insured under the Policy; or
- (c) coverage under the Covered Person's Other Medical Plan was terminated more than 30 days prior to termination of coverage under the Policy.

**Extension of Benefits:** Whenever termination of coverage under this section occurs because of termination of Your employment, such termination shall be without prejudice to any Hospital confinement which commenced while this Policy was in force; provided, however, that the Covered Person is and continues to be Hospital confined as an Inpatient. Such Extension of Benefits shall continue for up to three months.

This provision will not apply if:

- (a) the Covered Person's Other Medical Plan does not provide a similar Extension of Benefits provision;
- (b) Another Medical Plan was not in effect during the period of time the Covered Person was insured under the Policy; or
- (c) coverage under the Covered Person's Other Medical Plan was terminated more than 30 days prior to termination of coverage under the Policy.

**Continuation of Coverage During a Sabbatical Leave:** Coverage for You and Your covered Dependent(s) may be continued during Your Sabbatical Leave:

- (a) until the date Your Sabbatical Leave ends; or
- (b) for up to 12 months, whichever is earlier.

Sabbatical Leave means a leave of absence granted in writing by Your employer for the purpose of Your pursuit of education, research or teaching.

This provision will not apply if:

- (a) Your Other Medical Plan does not provide a similar Continuation of Coverage provision;
- (b) Another Medical Plan was not in effect during the period of time You were insured under the Policy; or
- (c) coverage under Your Other Medical Plan was terminated more than 30 days prior to termination of coverage under the Policy.

**Continuation of Coverage During a Layoff or Leave of Absence:** Coverage for You and Your covered Dependent(s) may be continued during a Layoff or Leave of Absence for up to a maximum period of three months.

If:

- (a) Your Layoff or Leave of Absence continues for more than three months; or
- (b) You do not return to work for the same employer,

Your coverage will be said to have ended the last day of Active Service and no coverage will be provided during the Layoff or Leave of Absence period.

Layoff means:

- (a) involuntary termination of Active Service (for reasons other than cause); or
- (b) a reduction of work hours to the point where You are no longer eligible for coverage under the Policy.

Leave of Absence must be granted in writing by Your employer.

This provision will not apply if Your Other Medical Plan does not provide a similar Continuation of Coverage provision.

**Continuation of Coverage Privilege:** An Insured whose coverage under the Policy ends due to termination of employment or membership or change in marital status, will have the right to continuation of coverage for You and Your Dependent(s). The continuation of coverage period will extend to 120 days providing You have been continuously insured under the group Policy for three months prior to termination of coverage.

The continuation coverage will end:

- (a) the end of the period You paid premium;
- (b) the premium due date following the date You become eligible for Medicare; and
- (c) the date of which the group Policy is terminated.

Written application for the continued coverage and the required premium must be submitted to Us by the Covered Person within 10 days following termination of coverage.

You will not be eligible for continued coverage if:

- (a) any required premium or contribution was not paid;
- (b) such person is eligible for Medicare;
- (c) such person is eligible for full coverage under any other group disability policy which covers Pre-Existing conditions; and
- (d) such person discontinued their coverage under the Other Medical Plan.

Upon termination of such continued coverage, You may elect the conversion coverage. However, any Covered Person utilizing the conversion coverage will waive the right to the continuation privilege or may skip the continuation privilege in order to receive the conversion coverage.

**Conversion Privilege:** Any Covered Person whose insurance under the group Policy ends for any reason except:

- (a) failure to pay any required premium, such person will have the right to coverage under a conversion policy.
- (b) Replacement of the terminating policy by similar group coverage within 31 days, such person will have the right to coverage under a conversion policy.

The conversion coverage will be issued without any Pre-Existing limitations or waiting periods other than those remaining unfulfilled under the Policy which conversion is made, and will cover pregnancy and maternity benefits.

Application and the required premium for the conversion coverage must be made within 30 days of the date prior coverage was terminated. Premiums for the converted policy will be determined in accordance with Our table of premium rates applicable to the age, class of risk and the type / amount of coverage provided for each Covered Person, and are subject to change at the end of every annual policy anniversary.

Conversion coverage will not be issued or renewed for any person:

- (a) who is or could be covered by Medicare;
- (b) whose coverage ended because the required premium was not paid
- (c) who is eligible for similar benefits under another group disability plan; and
- (d) who does not elect to keep in force conversion coverage under their basic Major Medical / Comprehensive policy.

**COBRA Continuation of Coverage:** This plan may be continued in accordance with the Consolidated Omnibus Reconciliation Act of 1986.

#### **Insurer's Right to Terminate Policy**

We have the right to terminate coverage under the Policy on any Premium due date on or after the 1<sup>st</sup> Anniversary Date of the Policy. We will give the Policyholder at least 60 days advance written notice of such termination.

### **Section 6 PREMIUMS**

The first premium is due on or before the Effective Date of Your Coverage. Thereafter, premiums are due on or before the premium due date. Premiums may be remitted to:

- (a) Our Home Office; or
- (b) an authorized insurance producer of Ours.

The premium rates may be changed by Us. If the rates are changed, We will give You at least 45 days advance written notice. If a change in benefits increases Our liability, premium rates may be changed on the date Our liability is increased.

### **Section 7 GENERAL POLICY PROVISIONS**

**Entire Contract-Changes:** The entire contract shall include:

- (a) the Policy;
- (b) the application of the Policyholder;
- (c) Your application, attached to the Certificate; and
- (d) all endorsements and amendments.

Statements made by the Policyholder or You are representations and not warranties, if fraud was not intended. No such statements will be used to avoid the insurance, reduce benefits, or defend a claim under the Policy unless:

- (a) the statement is in writing; and
- (b) a copy of that statement is given to You, Your beneficiary or Your personal representative.

The terms of the Policy can be changed only by endorsement or amendment signed by one of Our executive officers. No insurance producer may change the Policy or waive its provisions.

**Time Limit on Certain Defenses:** After two years from the Effective Date of coverage for a Covered Person, no statements in the application, except fraudulent misstatements, can be used to:

- (a) avoid the coverage; or
- (b) deny a claim for loss incurred that starts after such two-year period.

**Grace Period:** A Grace Period of 31 days will be allowed for each premium payment after the first premium. Coverage will stay in force during this time. The coverage under the Policy will terminate at the end of the Grace Period if the premium has not been paid.

The Policyholder or You may, by writing to Us, cancel Your coverage under the Policy:

- (a) on any future premium due date; or
- (b) on any date during the Grace Period.

If coverage is cancelled on a premium due date, the Grace Period will not apply. If cancellation is during the Grace Period and a claim is filed for expenses incurred during the Grace Period for which benefits are payable, We will deduct the premium for the Grace Period from the claim payment. This will not further extend the Grace Period.

**Legal Actions:** No legal action may be brought to recover under the Policy:

- (a) within 60 days after written proof of loss has been furnished as required; or
- (b) more than three (3) years from the time written proof of loss is required to be furnished.

**Conformity With State Laws:** A provision of the Policy that conflicts with a law of the state of issue is hereby changed to meet the minimum standards of that law.

**Certificates:** We will supply You a Certificate. This Certificate will describe:

- (a) the insurance benefits;
- (b) to whom benefits will be paid;
- (c) any limitations of the Policy; and
- (d) all other essential features of the Policy.

If You are issued more than one Certificate under the Policy, only the last one issued will be in effect.

**Misstatement of Age:** If the age of the Covered Person has been misstated, the amounts payable shall be such as the premium paid would have purchased at the correct age.

**Refund of Premium:** Upon the death of a Covered Person, any proceeds payable will include any premiums for that person for any period beyond the end of the month in which death occurred.

## Section 8

### HOW TO FILE A CLAIM / CLAIM PROVISIONS

You should notify Us, in writing, within 30 days after You or one of Your covered Dependents incurs a loss covered by the Policy. (If it is not reasonably possible to give notice within this time period, Your claim will not be denied or reduced due to the delay.) Send Your written notice to Us at the following address:

American Public Life Insurance Company  
P. O. Box 925  
Jackson, Mississippi 39205-0925

Use a claim form for filing proof of loss. We will send You claim forms within 15 days after We receive Your notice of a claim. If We do not supply You claim forms within this stated period of time, You can give proof by sending, in writing, a description of the loss regarding the nature and extent of the loss. Proof of loss must be given to Us within 90 days after the loss. We will accept late proof if:

- (a) it was not reasonably possible to give proof in that time; and
- (b) the proof is given within one (1) year from the date proof is otherwise required to be furnished. This one (1) year limit will not apply in the absence of legal capacity.

The explanation of benefits from the carrier of the Other Medical Plan must be submitted with claim forms for all Inpatient and outpatient claims. With respect to the benefits under the Physician Outpatient Treatment Benefit Rider, no explanation of benefits is required; however, You must submit the Physician's statement.

**Time of Payment of Claims:** Benefits for a covered loss will be paid immediately as soon as the Company receives written proof of loss.

**Payment of Benefits:** All benefits will be paid to You. Benefits payable under the Policy will be paid to You or the providers of services and supplies, if You so direct in writing. Any benefits unpaid at Your death will be paid to Your Estate.

Accrued benefits that are not paid at Your death will be paid to Your beneficiary or estate. If a benefit is to be paid to Your estate, or, if You or Your beneficiary are not competent to give a valid release, We may pay up to \$1,000 of such benefit to one of Your relatives who is deemed by Us to be justly entitled to it. Such payment, made in good faith, fully discharges Us to the extent of the payment.

**Physical Examination:** We have the right to have a Covered Person examined as often as is reasonably necessary while a claim is pending. We will pay for such examination.

## **NOTICE OF THE RIGHT TO APPEAL**

Any denial of a claim for benefits will be explained in writing and the explanation will include:

- (a) the specific reason for the denial;
- (b) reference to the Plan provision upon which the denial was based;
- (c) a description of any additional information You may be required to provide and an explanation of why it is needed; and
- (d) an explanation of the Plan's claim review procedure.

You and Your beneficiary, or a duly authorized representative may appeal any denial of a claim for benefits by filing a written request to Us. In connection with such a request, documents pertinent to the administration of the Plan may be reviewed, and issues outlining the basis of the appeal may be submitted. You may have representation throughout this review procedure.

Your request for review must be filed within 90 days after receipt of the written notice of denial of a claim. A decision will be rendered by Us, no later than 90 days after receipt of Your request for review. If there are special circumstances, the decision shall be rendered as soon as possible, but no later than 120 days after receipt of the request for review. The decision, after the review, shall be in writing and shall include specific reasons for the decision. This decision shall also include specific references to the pertinent Plan provisions on which the decision was based.

## **[STATEMENT OF ERISA RIGHTS**

As a participant in the 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:

- (a) examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all Plan documents, including insurance contracts and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.
- (b) obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- (c) 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.

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 the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of Your and other Plan participants and beneficiaries. No one, including Your employer, or any other person, may discharge You or otherwise discriminate against You in any way to prevent You from obtaining a welfare benefit or exercising Your rights under ERISA. If Your claim for a welfare benefit is denied in whole or in part, You must receive a written explanation of the reason for the denial. You have the right to have the Plan review and consider Your claim.

Under ERISA, there are steps You can take to enforce the above rights. For instance, if You request materials from the Plan and do not receive them within 30 days, You may file suit in a federal court. In such 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 to You because of reasons beyond the control of the Plan 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. 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 court costs and fees. If You lose, the court may order You to pay these costs and fees, for example, if it finds Your claim frivolous.

If You have any questions about the Plan, You should contact the Plan Administrator. If You have any questions about this statement or about Your rights under ERISA, You should contact the nearest Area Office of the Pension Welfare Benefits Administration, U.S. Department of Labor.]

## OUTPATIENT HOSPITAL BENEFIT RIDER

(This Rider is subject to all the Provisions, Conditions, Limitations and Exclusions of the Policy/Certificate to which it is attached which are not in conflict with those of the Rider.)

### AGREEMENT

This Rider is a part of the Policy/Certificate to which it is attached. We have issued this Rider to You because:

- (a) You paid the initial additional premium; and
- (b) We relied on the application You made.

### DEFINITIONS

**Hospital Emergency Room** means a portion of a Hospital where emergency diagnosis and treatment of Sickness or injury due to an Accident is provided.

**Hospital Outpatient Facility** means an area contained within a Hospital building that is owned and operated by the Hospital and not otherwise excluded under the terms of this policy where patients receive diagnostic testing or treatment without being admitted to the Hospital on an Inpatient basis.

**Freestanding Outpatient Surgery Center** means a freestanding facility, other than a Physician's Office, where surgical and diagnostic services are provided on an ambulatory basis.

**Magnetic Resonance Imaging (MRI) Facility** means a freestanding diagnostic imaging facility that provides diagnostic testing using magnetic resonance imaging.

**Deductible** means the amount, as shown in the Schedule of Benefits, of Covered Charges for which this rider will pay no benefits for Covered Outpatient Services.

### OUTPATIENT HOSPITAL BENEFITS

After satisfaction of the Deductible shown in the Schedule of Benefits, We will pay the Coinsurance Percentage of out-of-pocket expenses for Covered Charges for Covered Outpatient Services up to the Maximum Outpatient Benefit shown on the Schedule of Benefits if the Covered Person is covered by Another Medical Plan at the time the Covered Charges are incurred.

Covered Outpatient Services are:

- (a) Outpatient treatment in a Hospital Emergency Room without subsequently being considered an Inpatient and limited to two (2) visits per Calendar Year per Covered Person and four (4) visits per Calendar Year per family; and
- (b) Outpatient surgery performed in a Hospital Outpatient Facility or a Freestanding Outpatient Surgery Center; and
- (c) Outpatient diagnostic testing performed in a Hospital Outpatient Facility or a Magnetic Resonance Imaging (MRI) Facility; and
- (d) Outpatient treatment of a Mental or Emotional Disorder performed in a Hospital Outpatient Facility, limited to thirty (30) days of treatment per Calendar Year.

**Absence of Other Medical Plan:** In the event a Covered Person has no Other Medical Plan in force when out-of-pocket expense is incurred:

- (a) benefits will be derived using the Assumed Other Medical Plan, as described below; and,
- (b) coverage under the Policy will be terminated for such Covered Person, and any other person in the same family unit whose Other Medical Plan coverage is not in effect. Such Covered Person(s) will not be entitled to any Extensions or Continuations described in Section 5, except COBRA Continuation, where applicable.

MAXIMUM OUTPATIENT HOSPITAL BENEFIT	ASSUMED OTHER MEDICAL PLAN
\$2,000 or less	\$100 deductible, then 20% co-insurance for the first \$5,000 of Covered Charges per Calendar Year per person.
\$2,001 - \$2,750	\$250 deductible, then 20% co-insurance for the first \$10,000 of Covered Charges per Calendar Year per person.
\$2,751 - \$4,250	\$500 deductible, then 20% co-insurance for the first \$10,000 of Covered Charges per Calendar Year per person.
\$4,251 or more	\$1,000 deductible, then 20% co-insurance for the first \$10,000 of Covered Charges per Calendar Year per person.

**TERMINATION**

This Rider terminates:

- (a) when Your coverage terminates under the Policy/Certificate to which this Rider is attached; or,
- (b) when any premium for this Rider is not paid before the end of the Grace Period; or,
- (c) when You give Us a written request to do so.

Coverage on a Dependent terminates under this Rider when such person ceases to be an Eligible Dependent.

**PREMIUMS**

While this Rider is in effect, premiums are due according to the terms of the Policy/Certificate. We reserve the right to change the premiums for this Rider. If We do change such premiums, We will do so only if We give You 45 days notice before such change becomes effective.

**EFFECTIVE DATE**

The Effective Date of this Rider is the Policy Date and the Benefit Amount, Premiums, Insured Persons and Issue Age are as shown in the Schedule of Benefits. Unless amended by this Rider, Policy/Certificate Definitions and Terms apply to this Rider.

Signed for American Public Life Insurance Company at Flowood, Mississippi.



Assistant Secretary



Vice President and C.A.O.

## PHYSICIAN OUTPATIENT TREATMENT BENEFIT RIDER

(This Rider is subject to all the Provisions, Conditions, Limitations and Exclusions of the Policy/Certificate to which it is attached which are not in conflict with those of the Rider.)

### AGREEMENT

This Rider is a part of the Policy/Certificate to which it is attached. We have issued this Rider to You because:

- (a) You paid the initial additional premium; and
- (b) We relied on the application You made.

### DEFINITIONS

**Hospital Emergency Room** means a portion of a Hospital where emergency diagnosis and treatment of Sickness or injury due to an Accident is provided.

**Hospital Outpatient Facility** means an area contained within a Hospital building that is owned and operated by the Hospital and not otherwise excluded under the terms of this policy where patients receive diagnostic testing or treatment without being admitted to the Hospital on an Inpatient basis.

**Freestanding Emergency Care Clinic** means a location, distinct from a Hospital Emergency Room or a Physician's Office, whose purpose is to diagnose and treat Sickness or injury due to an Accident for unscheduled, ambulatory patients seeking immediate medical attention.

**Physician's Office** means the location, other than a Hospital or skilled nursing facility, where a Physician routinely provides health examinations, diagnosis and treatment of Sickness or injury due to an Accident on an ambulatory basis.

### PHYSICIAN OUTPATIENT TREATMENT BENEFIT

We will pay up to the benefit amount shown in the Schedule of Benefits for Covered Charges incurred by a Covered Person in a Hospital Outpatient Facility, Freestanding Emergency Care Clinic, or Physician's Office, as the result of:

- (a) treatment due to Sickness; or
- (b) emergency care for an injury due to an Accident.

The Covered Person must be covered by Another Medical Plan and not be confined as an Inpatient when such Covered Charges are incurred.

### LIMITATIONS

Benefits are limited to a maximum of four (4) visits per Covered Person per Calendar Year and eight (8) visits per family per Calendar Year. Benefits for treatment in a Hospital Emergency Room are excluded under the terms of this Rider.

### TERMINATION

This Rider terminates when:

- (a) Your coverage terminates under the Policy/Certificate to which this Rider is attached; or
- (b) any premium for this Rider is not paid before the end of the Grace Period; or
- (c) You give Us a written request to do so.

Coverage on a Dependent terminates under this Rider when such person ceases to be an Eligible Dependent.

### PREMIUMS

While this Rider is in effect, premiums are due according to the terms of the Policy/Certificate. We reserve the right to change the premiums for this Rider. If We do change such premiums, We will do so only if We give You 45 days notice before such change becomes effective.

**EFFECTIVE DATE**

The Effective Date of this Rider is the Policy Date and the Benefit Amount, Premiums, Insured Persons and Issue Age are as shown in the Schedule of Benefits. Unless amended by this Rider, Policy/Certificate Definitions and Terms apply to this Rider.

Signed for American Public Life Insurance Company at Flowood, Mississippi.



Assistant Secretary



Vice President and C.A.O.



# American Public Life Insurance Company

A member of the American Fidelity Group  
2305 Lakeland Drive • Flowood, Mississippi 39232

1. Name of Holder: _____	2. Main address: _____
3. Nature of Business: _____	
4. Classes and locations of persons eligible: _____	5. Subsidiary and affiliated organizations: _____
6. Total number of persons eligible: _____	For Individual Benefits: _____
For Dependent Benefits: _____	
7. Have any of the classes of persons eligible been covered under any group policy or plan within the past five years? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, please specify the: (a) benefits provided; (b) underwriting company or organization; and (c) date these benefits were terminated. _____	
8. GROUP INSURANCE APPLIED FOR (please check):	
<input type="checkbox"/> MEDlink® III	
<i>Coinsurance Percentage:</i>	<input type="checkbox"/> 100% <input type="checkbox"/> 90% <input type="checkbox"/> 80% <input type="checkbox"/> 70% <input type="checkbox"/> 60% <input type="checkbox"/> 50%
<i>Maximum In-Hospital Benefit Amount:</i>	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$3,000 <input type="checkbox"/> \$3,500 <input type="checkbox"/> \$4,000
<input type="checkbox"/> Outpatient Hospital Benefit Rider	<input type="checkbox"/> \$4,500 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$6,000 <input type="checkbox"/> \$7,000 <input type="checkbox"/> \$8,000 <input type="checkbox"/> \$9,000 <input type="checkbox"/> \$10,000
<i>Maximum Outpatient Hospital Benefit Amount:</i>	<input type="checkbox"/> 50% of Maximum In-Hospital Benefit Amount up to a maximum of \$4,000
<i>Outpatient Annual Deductible:</i>	<input type="checkbox"/> 80% of Maximum In-Hospital Benefit Amount up to a maximum of \$4,000
<input type="checkbox"/> Physician's Outpatient Treatment Rider	<input type="checkbox"/> \$100 <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$750 <input type="checkbox"/> \$1,000
Special Request: _____	<input type="checkbox"/> Waive Outpatient Deductible for Accident Treatment
9. MINIMUM STANDARDS	
Before any policy takes effect the following minimum standards must be met:	
a) Where Holder is an employer and eligible persons are employees: _____ employees _____ percent of employees	b) Where Holder is a trade association: _____ percent of member firms must participate and maintain proper participation _____ percent of employees in firm with _____ or more employees _____ percent of employees in firm with _____ or less employees
If these standards are not met, the Company may: (1) ask for satisfactory evidence of insurability before an eligible person's coverage takes effect; or (2) terminate the Policy.	
10. EFFECTIVE DATE REQUESTED: _____	
If this application is approved by the Company, group insurance will take effect: (a) on the Effective Date; or, (b) on the date the required number of eligible persons have enrolled, if such persons are to pay for part of the cost of their coverage; whichever is the later date. Group insurance will be issued: (a) at the Company's rates; and, (b) under the terms and conditions of the policy or policies applied for.	
If this application is not approved, no insurance will take effect. Any premium payment advanced by the Holder will be returned.	
11. THE HOLDER DECLARES that to the best of his knowledge and belief the statements and answers shown above are true and complete. The Holder understands and agrees that: (a) the application will form a part of any policy issued; (b) no information given to, or acquired by, any representative of the Company will bind the Company unless it appears in writing on this application; (c) no waiver or modification will bind the Company unless it is in writing and is signed by an Executive Officer of the Company; and (d) only those persons eligible under the terms of the policy or policies issued will be covered.	
Dated At: _____ on the _____ day of _____, _____.	
Holder/Applicant: _____	
Signed By: _____	Official Position: _____
Witness: _____	Soliciting Agent if other than Witness: _____



# American Public Life Insurance Company

A member of the American Fidelity Group  
 2305 Lakeland Drive • Flowood, Mississippi 39232  
 (800) 256-8606

## GROUP ENROLLMENT FORM for MEDlink® III

Last Name		First Name		Middle Name	Suffix	Sex <input type="checkbox"/> M <input type="checkbox"/> F	
Age	Date of Birth	Social Security Number		Home Phone #: (    )		Select Plan Desired: <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee & Spouse* <input type="checkbox"/> Employee & Children* <input type="checkbox"/> Employee & Family* <small>* Complete Back of Application</small>	
Number and Street			Work Phone #: (    )				
City		State	Zip Code		U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No* <small>*Complete Back of Application</small>		
Employer		Occupation		Date of Employment		Requested Effective Date	
Insurance Applied For: <input type="checkbox"/> MEDlink® III <input type="checkbox"/> Outpatient Hospital Rider <input type="checkbox"/> Physician's Outpatient Treatment Rider							
Group #:				Total Premium: \$			
Is any proposed insured currently covered by Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," this policy will not be issued.							
<p>I acknowledge I have received the following brochure: _____</p> <p>I hereby enroll or change, as indicated above, this group insurance coverage for which I am eligible. I authorize my employer to deduct my contributions, if any, from my pay. <b>ANY CHANGE REQUIRES WRITTEN NOTICE.</b> I understand and agree that no coverage will take effect, until a Policy or Certificate is issued. I further understand and agree that this coverage will not become effective or remain in effect for any person to be covered who is not also covered by a major medical or comprehensive medical policy which includes managed care and this coverage may contain Pre-Existing Limitations.</p> <p><b>NOTICE:</b> Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.</p>							
Agent (where required by law):				Date:			
Agent No:				Signature (applicant):			

MEDlink III CERTAPP(1/08)AR

**COMPLETE IF DEPENDENT COVERAGE APPLIED FOR**

1. Dependents Proposed For Insurance: Last Name    First Name    Initial	S E X	A G E	U.S. Citizen?  <input type="checkbox"/> Yes <input type="checkbox"/> No	BIRTHDATE			APPLICANT'S SOCIAL SECURITY #:
				Mo.	Date	Yr.	
a. Spouse			<input type="checkbox"/> Yes <input type="checkbox"/> No				- -
b. Children			<input type="checkbox"/> Yes <input type="checkbox"/> No				- -
2.			<input type="checkbox"/> Yes <input type="checkbox"/> No				- -
3.			<input type="checkbox"/> Yes <input type="checkbox"/> No				- -
4.			<input type="checkbox"/> Yes <input type="checkbox"/> No				- -
5.			<input type="checkbox"/> Yes <input type="checkbox"/> No				- -
6.			<input type="checkbox"/> Yes <input type="checkbox"/> No				- -

If any U.S. Citizen question was answered "No," list name and country of citizenship? \_\_\_\_\_

**Special Requests:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

*SERFF Tracking Number:*      *AFDL-125593019*                      *State:*                      *Arkansas*  
*Filing Company:*              *American Public Life Insurance Company*      *State Tracking Number:*      *38604*  
*Company Tracking Number:*      *MEDLINK III*  
*TOI:*                      *H21 Health - Other*                      *Sub-TOI:*                      *H21.000 Health - Other*  
*Product Name:*              *MEDlink III*  
*Project Name/Number:*      *MEDlink III/MEDlink III*

## **Rate Information**

Rate data does NOT apply to filing.

SERFF Tracking Number: AFDL-125593019 State: Arkansas  
 Filing Company: American Public Life Insurance Company State Tracking Number: 38604  
 Company Tracking Number: MEDLINK III  
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other  
 Product Name: MEDlink III  
 Project Name/Number: MEDlink III/MEDlink III

## Supporting Document Schedules

<b>Satisfied -Name:</b>	Certification/Notice	<b>Review Status:</b>	Approved-Closed	04/17/2008
<b>Comments:</b>				
<b>Attachments:</b>				
	AR FLESCH HEALTH.pdf			
	AR Certification.pdf			
<b>Bypassed -Name:</b>	Application	<b>Review Status:</b>	Approved-Closed	04/17/2008
<b>Bypass Reason:</b>	New application and enrollment form are attached under the Form Schedule tab.			
<b>Comments:</b>				
<b>Bypassed -Name:</b>	Health - Actuarial Justification	<b>Review Status:</b>	Approved-Closed	04/17/2008
<b>Bypass Reason:</b>	N/A - not required for group health			
<b>Comments:</b>				
<b>Bypassed -Name:</b>	Outline of Coverage	<b>Review Status:</b>	Approved-Closed	04/17/2008
<b>Bypass Reason:</b>	N/A - not required for group health			
<b>Comments:</b>				
<b>Satisfied -Name:</b>	Authorization	<b>Review Status:</b>	Approved-Closed	04/17/2008
<b>Comments:</b>				
<b>Attachment:</b>				
	Authorization08.pdf			



# American Public Life Insurance Company

A member of the American Fidelity Group

## ARKANSAS FLESCH CERTIFICATION

This is to certify that the Flesch scores for the enclosed forms are as follows:

Form Number	Flesch Score	Words Contained in Text
GM MEDlink III (1/08) Master Policy	50	23896
GC MEDlink III (1/08) Certificate	50	24609
GM/GC MEDlink III OP (1/08) Outpatient Hospital Benefit Rider	53 (w/o defined terms)	2069
GM/GC MEDlink III PhysT (1/08) Physician's Outpatient Treatment Benefit Rider	55 (w/o defined terms)	1695
MEDlink III Master App (1/08) Group Master Application	52	2545
MEDlink III CERTAPP(1/08) Employee's Application	50	1471

The forms are printed in not less than 10 point type, one point leaded.

The application has been scored by the Flesch method.

---

Alex M Bagby, A.S.A., M.A.A.A.  
Vice President and Chief Risk Officer

April 3, 2008  
Date

 **American Fidelity  
Assurance Company**  
A member of the American Fidelity Group

April 3, 2008

Arkansas Department of Insurance  
1200 W Third St  
Little Rock Arkansas 72201 1904

**RE: American Public Life Insurance Company**  
FEIN Number: 64-0349942  
NAIC#: 60801

Filing: GM MEDlink III (1/08)AR, et al.

Please accept this letter certifying that American Public Life Insurance Company will comply with regulations in the State of Arkansas regarding association group business. We will file with the state for prior approval and will not write association business until approval is granted by the state.

If you require additional information, please do not hesitate to contact me.

Sincerely,



Alex M. Bagby, ASA, MAAA  
Vice President & Chief Risk Officer  
American Public Life Insurance Company  
(800) 654-8489



# American Public Life Insurance Company

**A member of the American Fidelity Group.**

January 2, 2008

NAIC Number: 60801  
FEIN Number: 64-0349942

To Whom It May Concern:

American Fidelity Assurance Company, located at 2000 N. Classen Boulevard, Oklahoma City, Oklahoma, 73125, is hereby authorized to submit forms for approval to the Department of Insurance on behalf of American Public Life Insurance Company. Changes to the forms, as may be necessary to gain approval, are included in this authorization.

Sincerely,

Alex M. Bagby, ASA, MAAA  
Vice President & Chief Risk Officer





# American Public Life Insurance Company

A member of the American Fidelity Group  
 2305 Lakeland Drive • Flowood, Mississippi 39232  
 (800) 256-8606

## GROUP ENROLLMENT FORM for MEDlink® III

Last Name		First Name		Middle Name	Suffix	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Age	Date of Birth	Social Security Number		Home Phone #: ( )	Select Plan Desired: <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee & Spouse* <input type="checkbox"/> Employee & Children* <input type="checkbox"/> Employee & Family* <small>* Complete Back of Application</small>	
Number and Street			Work Phone #: ( )			
City	State	Zip Code		U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No* <small>*Complete Back of Application</small>		
Employer		Occupation		Date of Employment	Requested Effective Date	
Insurance Applied For: <input type="checkbox"/> MEDlink® III <input type="checkbox"/> Outpatient Hospital Rider <input type="checkbox"/> Physician's Outpatient Treatment Rider						
Group #:				Total Premium: \$		
Is any proposed insured currently covered by Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," this policy will not be issued.						
<p>I hereby enroll or change, as indicated above, this group insurance coverage for which I am eligible. I authorize my employer to deduct my contributions, if any, from my pay. <b>ANY CHANGE REQUIRES WRITTEN NOTICE.</b> I understand and agree that no coverage will take effect, until a Policy or Certificate is issued. I further understand and agree that this coverage will not become effective or remain in effect for any person to be covered who is not also covered by a major medical or comprehensive medical policy which includes managed care and this coverage may contain Pre-Existing Limitations.</p> <p><b>NOTICE:</b> Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.</p>						
Agent (where required by law):				Date:		
Agent No:				Signature (applicant):		

MEDlink III CERTAPP(1/08)AR

**COMPLETE IF DEPENDENT COVERAGE APPLIED FOR**

1. Dependents Proposed For Insurance: Last Name    First Name    Initial	S E X	A G E	U.S. Citizen?  <input type="checkbox"/> Yes <input type="checkbox"/> No	BIRTHDATE			APPLICANT'S SOCIAL SECURITY #:
				Mo.	Date	Yr.	
a. Spouse			<input type="checkbox"/> Yes <input type="checkbox"/> No				- -
b. Children			<input type="checkbox"/> Yes <input type="checkbox"/> No				- -
2.			<input type="checkbox"/> Yes <input type="checkbox"/> No				- -
3.			<input type="checkbox"/> Yes <input type="checkbox"/> No				- -
4.			<input type="checkbox"/> Yes <input type="checkbox"/> No				- -
5.			<input type="checkbox"/> Yes <input type="checkbox"/> No				- -
6.			<input type="checkbox"/> Yes <input type="checkbox"/> No				- -

If any U.S. Citizen question was answered "No," list name and country of citizenship? \_\_\_\_\_

**Special Requests:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_