

SERFF Tracking Number: AFDL-127354528 State: Arkansas  
Filing Company: American Public Life Insurance Company State Tracking Number: 49631  
Company Tracking Number: MEDLINKIV  
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other  
Product Name: MedlinkIV  
Project Name/Number: MedlinkIV/MedlinkIV

## Filing at a Glance

Company: American Public Life Insurance Company

Product Name: MedlinkIV

SERFF Tr Num: AFDL-127354528 State: Arkansas

TOI: H21 Health - Other

SERFF Status: Closed-Approved-  
Closed State Tr Num: 49631

Sub-TOI: H21.000 Health - Other

Co Tr Num: MEDLINKIV

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Rosalind Minor

Authors: Shari Vick, Melissa  
Mahanes, Ashlie Snyder, Ann  
Hobson

Disposition Date: 08/30/2011

Date Submitted: 08/25/2011

Disposition Status: Approved-  
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name: MedlinkIV

Status of Filing in Domicile: Authorized

Project Number: MedlinkIV

Date Approved in Domicile: 08/11/2011

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Small and Large

Group Market Type: Employer

Overall Rate Impact:

Filing Status Changed: 08/30/2011

State Status Changed: 08/30/2011

Deemer Date:

Created By: Ashlie Snyder

Submitted By: Ann Hobson

Corresponding Filing Tracking Number:

PPACA: Not PPACA-Related

PPACA Notes: null

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

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application to be used in applying for this coverage. The issue ages for these policies are age 17 and older. This policy/certificate will be marketed by American Public Life Insurance Company licensed agents and appointed brokers. The product will be marketed to employer groups. This group policy was approved in our domicile state of Oklahoma on August 11, 2011.

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, with their employer. This MEDlink IV policy supplements 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 \$500 to \$10,000 on the base policy.

There are three optional benefit riders available at the policyholder level. AMDI324APL Outpatient Hospital Benefit Rider supplements the out-of-pocket expenses incurred and the amount paid by the primary medical plan for outpatient treatment in a specified facilities.

AMDI325APL Physician's Outpatient Treatment Rider will pay \$25.00 per visit to a physician as a result of sickness or injury due to an accident. This rider includes a maximum number of visits per covered person per calendar year up to a maximum number of visits per family per calendar year.

AMDI327APL Retired Employee Amendment Rider. This rider will be chosen by the Policyholder if they wish to extend coverage to their retired employees.

The policyholder application is form GMLIV11APLMA and the employee application is GMLIV11APLA.

The Flesch scores are: GMLIV11APL master policy, 52; GMLIV11APLC certificate, 50; AMDI324APL Outpatient Hospital Benefit Rider, 50; AMDI325APL Physician Outpatient Treatment Benefit Rider, 50; AMDI327 Retired Employee Amendment Rider; 59; GMLIV11APLMA master application, 50; and GMLIV11APLA 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 verbiage on each page as submitted for approval. The pages may print on different colors of paper depending upon the market.

I hereby certify that to the best of my knowledge the forms submitted herewith are in compliance in all respects with the provisions of the insurance laws, rules and regulations of your state and such forms contain no provisions previously disapproved by the Department.

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## Company and Contact

### Filing Contact Information

Ashlie Snyder, Compliance Analyst I ashlie.snyder@af-group.com  
 2000 Classen 800-654-8489 [Phone] 5255 [Ext]  
 Oklahoma City, OK 73160 405-523-5793 [FAX]

### Filing Company Information

American Public Life Insurance Company CoCode: 60801 State of Domicile: Oklahoma  
 2305 Lakeland Drive Group Code: 330 Company Type: LAH  
 Flowood, MS 39232 Group Name: State ID Number:  
 (601) 936-2157 ext. [Phone] FEIN Number: 64-0349942

## Filing Fees

Fee Required? Yes  
 Fee Amount: \$400.00  
 Retaliatory? Yes  
 Fee Explanation: 50.00 per form.  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
American Public Life Insurance Company	\$400.00	08/25/2011	50948222

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	08/30/2011	08/30/2011

*SERFF Tracking Number:*      *AFDL-127354528*                      *State:*                      *Arkansas*  
*Filing Company:*              *American Public Life Insurance Company*      *State Tracking Number:*      *49631*  
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*TOI:*                      *H21 Health - Other*                      *Sub-TOI:*                      *H21.000 Health - Other*  
*Product Name:*              *MedlinkIV*  
*Project Name/Number:*      *MedlinkIV/MedlinkIV*

## **Disposition**

Disposition Date: 08/30/2011

Implementation Date:

Status: Approved-Closed

HHS Status: HHS Approved

State Review: Reviewed by Actuary

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Supporting Document	Thrid-Party Authorization	Approved-Closed	Yes
Supporting Document	Statement of Variability	Approved-Closed	Yes
Form	Supplemental Limited Benefit Medical Expense Policy	Approved-Closed	Yes
Form	Supplemental Limited Benefit Medical Expense Certificate	Approved-Closed	Yes
Form	Schedule of Benefits	Approved-Closed	Yes
Form	Outpatient Benefit Rider	Approved-Closed	Yes
Form	Physician Outpatient Treatment Benefit Rider	Approved-Closed	Yes
Form	Retired Employee Amendment Rider	Approved-Closed	Yes
Form	Master Application	Approved-Closed	Yes
Form	Employee Application	Approved-Closed	Yes

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## Form Schedule

### Lead Form Number: MedlinkIV

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 08/30/2011	GMLIV11A PLAR	Policy/Cont ract/Fratern al	Supplemental Limited Benefit Medical Expense Certificate Policy	Initial		50.000	GMLIV11APL AR.pdf
Approved-Closed 08/30/2011	GMLIV11A PLCAR	Certificate	Supplemental Limited Benefit Medical Expense Certificate	Initial		50.000	GMLIV11APL CAR.pdf
Approved-Closed 08/30/2011	GMLIV11S BAPLAR	Schedule Pages	Schedule of Benefits	Initial		46.000	GMLIV11SBA PLAR.pdf
Approved-Closed 08/30/2011	AMDI324A PL	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Outpatient Benefit Rider	Initial		50.000	AMDI324APL _EnhPlus.pdf
Approved-Closed 08/30/2011	AMDI325A PL	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Physician Outpatient Treatment Benefit Rider	Initial		50.000	AMDI325APL _Dr.pdf
Approved-Closed 08/30/2011	AMDI327A PL	Policy/Cont ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme	Retired Employee Amendment Rider	Initial		59.000	AMDI327APL. pdf

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 nt or Rider

Approved- GMLIV11A	Application/Master Application	Initial	50.000	GMLIV11APL
Closed PLMAAR	Enrollment			MAAR_WOS
08/30/2011	Form			etup.pdf
Approved- GMLIV11A	Application/Employee	Initial	50.000	GMLIV11APL
Closed PLA	Enrollment Application			A_Clean.pdf
08/30/2011	Form			



# American Public Life Insurance Company

A member of the American Fidelity Group®

FOR INQUIRIES OR TO OBTAIN INFORMATION, PLEASE CONTACT:

2305 Lakeland Drive, Flowood, Mississippi 39232  
Toll Free (800) 256-8606 • Local (601) 936-6600

## SUPPLEMENTAL LIMITED BENEFIT MEDICAL EXPENSE INSURANCE POLICY

**POLICYHOLDER:**

**ADDRESS:**

**GROUP POLICY NUMBER:**

**POLICY EFFECTIVE DATE:**

**ISSUE DATE:**

**POLICY ANNIVERSARY DATE:**

**CONSIDERATION:** This is a legal contract between the Policyholder and us. The provisions of this and the following pages and the application are each part of this Policy. This Policy is issued in return for the application and payment of the first premium. The Policy Effective Date is the date the first premium is due and is the date from which Policy years, premium due dates, and Policy anniversaries will be determined. Dates begin and end at 12:01 a.m. Standard Time at the address of the Policyholder.

**WHEN A PERSON BECOMES INSURED:** Each eligible person shall become insured on the later of the Certificate Effective Date or the Covered Person's Effective Date. The Certificate will describe the insurance and will also state the benefits available.

**PREMIUM PAYMENTS:** The premium must be paid on or before its due date. The due date is the first day following the end of the premium term for which the preceding premium was paid.

**OPTIONALLY RENEWABLE:** This Policy is renewable at our option. The Policyholder or we may terminate this Policy on any premium due date after the first anniversary following the Policy Effective Date, subject to 60 days written notice.

Signed for American Public Life Insurance Company.

[

Chief Administrative Officer

President, Chief Operating Officer]

**READ THIS POLICY CAREFULLY. THIS POLICY PROVIDES LIMITED BENEFITS AND IS DESIGNED TO SUPPLEMENT OTHER COMPREHENSIVE INSURANCE COVERAGE.**

**Warning:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information or knowingly presents false information in an application for insurance may be guilty of insurance fraud.

## SECTION 1 - TABLE OF CONTENTS

Consideration .....	Face Page
When A Person Becomes Insured .....	Face Page
Premium Payments .....	Face Page
Optionally Renewable .....	Face Page
Table of Contents .....	Section 1
Policy Schedule .....	Section 2
Definitions .....	Section 3
Eligibility and Effective Date .....	Section 4
Benefits .....	Section 5
Limitations and Exclusions .....	Section 6
Premiums .....	Section 7
Termination of Coverage .....	Section 8
Claims .....	Section 9
General Provisions .....	Section 10
Schedule of Benefits .....	Insert
Benefit Riders .....	Insert
Application .....	Insert
Back Page	

## SECTION 2 - POLICY SCHEDULE

Policyholder: [ABC Company]  
Policy Effective Date: [6/1/2000]

Policy Number: [M00000]

### MEDLINK® IV SUPPLEMENTAL LIMITED BENEFIT MEDICAL EXPENSE INSURANCE PLAN DESCRIPTION

**MEDLink® IV POLICY – [Basic, Enhanced Plus Plan]**

**[Outpatient Benefit Rider AMDI324APL]**

**[OPTIONAL BENEFIT RIDER]**

**[Physician Outpatient Treatment Benefit Rider AMDI325APL]**

**[Retired Employee Amendment Rider AMDI327APL]**

**PRE-EXISTING PERIOD:** [0-12] Months

**PRE-EXISTING CONDITION EXCLUSION PERIOD:** [0-12] Months

## SECTION 3 - DEFINITIONS

**ACCIDENT:** A sudden, unexpected and unintended event, which results in bodily Injury, and which is independent of disease, bodily infirmity, or any other excluded cause.

**ACTIVELY AT WORK:** The Insured is:

1. performing in the usual manner all of the regular duties of his or her employment as a Full-Time Employee on a scheduled work day; and
2. these duties are being done at one of the places of business where the Insured normally does such duties or at some location to which the Insured's employer sends him or her.

Actively At Work will include a day which is not a scheduled work day only if the Insured would be able to perform in the usual manner all of the regular duties of his or her employment as if it were a scheduled work day.

**CALENDAR YEAR:** The period beginning on January 1 and ending on December 31 of the same year.

**CERTIFICATE:** The individual Certificate issued to an Insured. It describes the coverage under this Policy; how benefits will be paid; any limitations of this Policy; and all other essential features of this Policy. If the Insured is issued more than one Certificate under this Policy, only the last one will be in effect.

**CERTIFICATE EFFECTIVE DATE:** The effective date of the individual Certificate issued to the Insured.

**CERTIFICATE MONTH:** That period of time beginning at 12:01 a.m. Standard Time on the same date of the month that the Insured's Certificate became effective, as shown on the Certificate Schedule and ending at 12:00 a.m. Standard Time the following month on the same date.

**CERTIFICATE SCHEDULE:** Page 3 of the Certificate issued to the Insured.

**COMPANY (we, us or our):** American Public Life Insurance Company.

**CONFINEMENT (CONFINED):** The Covered Person must be confined to a Hospital as an Inpatient on the advice of a Physician for at least 18 consecutive hours to be considered one day of Hospital Confinement. One period of confinement includes all consecutive calendar days a Covered Person is confined as an Inpatient in a Hospital.

**COVERED CHARGES:** Those charges that:

1. are incurred by a Covered Person because of an Accident or Sickness;
2. are for necessary treatment, services, and medical supplies, and recommended by a Physician;
3. are incurred in a covered facility as defined in this Policy or any attached rider;
4. are not more than any applicable Maximum Benefit set forth in the Schedule of Benefits;
5. are incurred while insured under this Policy, subject to any Extension of Benefits; and
6. are not excluded under the Limitations and Exclusions section.

**COVERED PERSON(S):** A person who is eligible for coverage under the Certificate and for whom coverage is in force (See the Eligibility and Effective Date section).

**COVERED PERSON'S EFFECTIVE DATE:** The date the Covered Person's coverage under the Certificate becomes effective. The Insured's effective date will be the same as the Certificate Effective Date (subject to the Eligibility and Effective Date section). Dependents of the Insured are eligible for insurance on the date the Insured becomes eligible for insurance or the date a person becomes an Eligible Dependent, whichever is later. The effective date of coverage for each Eligible Dependent will be the first of the month following our approval of the application and receipt of the first premium (See Newborn/Adopted Children provision).

**DEDUCTIBLE:** The out-of-pocket amount which must be satisfied by the Covered Person prior to benefits being paid under this Policy or any attached riders. The Deductible, if any, is shown on the Schedule of Benefits.

**ELIGIBLE DEPENDENTS:** Unless specifically named as excluded in any part of this contract, this means:

1. the Insured's lawful spouse who is under age 70 and is covered under the Insured's Other Medical Plan; and/or
2. the Insured's, and/or his or her spouse's, natural child, adopted child or stepchild who is under 26 years of age and who is covered under the Insured's Other Medical Plan; and/or
3. any child who becomes incapable of self-sustaining employment because of mental or physical incapacity while covered under the Certificate and prior to reaching the limiting age for dependent children as set out in #2 above. The child must be dependent on the Insured for support and maintenance. We must receive notification of the incapacity. Coverage will then continue as long as the Insured's insurance stays in force and the child remains incapacitated. The Insured must notify us if this incapacity is removed or terminated at a later date. The premium will remain at the dependent rate. The child's coverage will terminate at the earlier of the end of the Certificate Month in which the conditions cease or the date the Certificate terminates; and/or
4. any minor under the Insured's charge, care and control, who has been placed in the Insured's home for adoption and is under 26 years of age.

The term Eligible Dependent does not include the Insured's grandchild (unless required by law).

**FULL-TIME EMPLOYEE:** The Insured who works at least the minimum number of hours per week as defined in the Master Application.

**HOSPITAL:** A place that:

1. is licensed and operated pursuant to law; and
2. provides care and treatment for ill and injured persons on an Inpatient basis; and
3. provides facilities for medical, diagnostic, and surgical care (These facilities need not be at the Hospital. They may be elsewhere if there is a formal agreement for their use.); and
4. provides 24 hour a day nursing care by or under the supervision of a Nurse; and
5. is supervised by a staff of one or more Physicians; and
6. is accredited by the Joint Commission on the Accreditation of Hospitals; and
7. is not an institution, or part thereof, used as: a place for rehabilitation, a place for rest or for the aged, a nursing or convalescent home, a long term nursing unit or geriatrics ward, or an extended care facility for the care of convalescent, rehabilitative or ambulatory patients.

**IMMEDIATE FAMILY:** Anyone who is related to the Covered Person by any degree of blood, marriage or operation of law. This includes the following relatives: parents, grandparents, brothers, sisters, children, grandchildren, aunts, uncles, cousins, nephews, nieces, in-laws, adopted relatives, and step-relatives.

**INITIAL ENROLLMENT:** One of the following periods during which the Insured may first apply in writing for coverage under the Certificate:

1. if the Insured is eligible for coverage on the Policy Effective Date, the period before the Policy Effective Date as set by us and the Policyholder; or
2. if the Insured becomes eligible for coverage after the Policy Effective Date, the period ending 31 days after the date he or she is first eligible to apply for coverage.

**INJURY:** A bodily Injury which is caused directly by an Accident, independent of Sickness, disease, bodily infirmity or any other cause.

**INPATIENT:** Confinement in a Hospital for at least 18 continuous hours in duration.

**INSURED (you and your):** The person named as the Insured on the Certificate Schedule. The Insured must be a Full-Time Employee of the Policyholder and be covered under the Insured's Other Medical Plan.

**MASTER APPLICATION:** The document signed by the Policyholder that contains the answers to our questions and are the Policyholder's representations, which we accepted in good faith as being true, complete and correct. The Master Application is the basis upon which we issued this Policy.

**MAXIMUM BENEFIT(S):** The maximum dollar amounts, number of visits, or time frames, allowed for any one (1) Covered Person or combination of Covered Persons, for any benefit or combination of benefits, as shown on the Schedule of Benefits.

**MENTAL OR EMOTIONAL DISORDER:** A neurosis, psychoneurosis, psychopathy, psychosis or mental or emotional disease or disorder of any kind.

**OTHER MEDICAL PLAN:** Any basic major medical, comprehensive medical, or managed care policy provided through the Policyholder and through which a Covered Person has coverage. The term Other Medical Plan does not include TRICARE, Medicare, or Medicaid.

**PER CALENDAR DAY:** Per Calendar Day means the period of time between 12:00 a.m. and 11:59 p.m.

**PER OCCURRENCE:** Per Occurrence means treatment for the same or related condition, unless separated by a period of 90 days. Treatment for the same or related condition separated by 90 days, or an unrelated condition will be considered a new Per Occurrence.

**PHYSICIAN:** A practitioner of the healing arts who is legally qualified and licensed to practice medicine and who is practicing within the scope of his or her license in the state where so licensed. The Physician must not be a member of the Insured's Immediate Family or anyone who normally resides with the Insured in his or her residence.

**POLICY:** This Policy issued to the Policyholder which covers the Covered Persons.

**POLICY EFFECTIVE DATE:** The date shown as the Policy Effective Date in the Policy Schedule.

**POLICYHOLDER:** The employer who holds this Policy.

**POLICY MONTH:** That period of time beginning at 12:01 a.m. Standard Time on the same date of the month that this Policy became effective, as shown on the Policy Schedule and ending at 12:00 a.m. Standard Time the following month on the same date.

**POLICY SCHEDULE:** Page 3 of this Policy.

**PRE-EXISTING CONDITION:** An Injury, Sickness or physical condition for which, medical advice, consultation or treatment, including prescribed medications, was recommended by or received from a member of the medical profession within the Pre-Existing Period immediately preceding the Covered Person's Effective Date. The Pre-Existing Period is shown on the Policy Schedule. The term "Pre-Existing Condition" will also include conditions which are related to such Injury, Sickness or physical condition.

**SCHEDULE OF BENEFITS:** The benefit schedule set forth in the Policy or Certificate.

**SICKNESS:** Any illness, disease, infection or abnormal condition of the body, not caused by an Accident, which is the direct cause of the loss.

## **SECTION 4 - ELIGIBILITY AND EFFECTIVE DATE**

**Eligibility:** A person is eligible to be insured under this Policy if such person:

1. meets our underwriting rules; and
2. is Actively at Work and qualifies for coverage as defined in the Master Application; and
3. is covered under the Insured's Other Medical Plan; and,
4. is under age 70 (if the Insured works for an employer employing less than 20 employees).

Evidence of coverage under the Insured's Other Medical Plan is required. A person must apply for insurance during the Initial Enrollment period or on the date the person first becomes eligible for coverage. If the person does not apply during the Initial Enrollment period or on the date the person becomes eligible for coverage, he or she may be subject to additional underwriting by us.

**EFFECTIVE DATE:** A person must use forms provided by us when applying for insurance. If our underwriting rules are met, the premium has been paid, and all persons to be insured are covered under the Insured's Other Medical Plan, the insurance will take effect on the later of the following dates:

1. the requested Certificate Effective Date; or
2. the Certificate Effective Date assigned by us upon approval of the person's application.

If the Insured is not Actively At Work on the Certificate Effective Date due to disability, Injury, Sickness, temporary layoff, leave of absence or Family and Medical Leave of Absence, coverage begins on the date the Insured returns to Actively At Work.

**NEWBORN/ADOPTED CHILDREN:** If the Insured's plan is Employee Only or Employee and Spouse, all newborn children will be covered automatically on the day they are born as long as the Insured's coverage was in force on that date. The newborn child's coverage will not continue past the 90-day period following his or her birth unless: we are notified in writing by the end of the 90-day period of the addition of such newborn child and any applicable additional premium is paid.

Coverage for newborn children will also include coverage for: a newborn child adopted by the Insured, from the moment of birth, if a petition for adoption was filed within 60 days of the birth of the child; and a child adopted by the Insured from the date of petition. Coverage shall terminate upon the dismissal or denial of a petition for adoption. Coverage for the adopted child will not continue past 60 days after the date of petition unless: we are notified in writing by the end of the 60-day period of the addition of such adopted child; and any applicable additional premium is paid.

If the Insured's plan is Employee and Child or Employee and Family, all newborn children are covered from the moment of birth and all adopted children are covered from the moment of petition. No notification is necessary and no additional premium is due.

Coverage for Newborn/Adopted Children includes prematurity, congenital defects and birth abnormalities of a newborn/adopted child.

## SECTION 5 – BENEFITS

**In-Hospital Benefit:** In accordance with the Schedule of Benefits, we will pay for Covered Charges incurred by a Covered Person:

1. if the Covered Person is covered by the Insured's Other Medical Plan when such Covered Charges are incurred, except as provided in the Absence of the Insured's Other Medical Plan provision described in this Section; and
2. such Covered Charges are incurred while the Covered Person is an Inpatient; and
3. after satisfaction of any Deductible shown on the Schedule of Benefits; and
4. subject to the Maximum In-Hospital Benefits shown on the Schedule of Benefits; and
5. subject to the Maximum Combined In-Hospital and Outpatient Benefits, if applicable and shown on the Schedule of Benefits.

Benefits payable under this policy are limited to:

1. any out-of-pocket deductible amount incurred under the Insured's Other Medical Plan;
2. any out-of-pocket co-payment or coinsurance amounts the Covered Person actually incurs under the Insured's Other Medical Plan;
3. any out-of-pocket amount the Covered Person actually incurs under the Insured's Other Medical Plan for treatment of a Mental or Emotional Disorder limited to 30 days per Covered Person per Calendar Year.

**Ambulance Benefit:** We will pay the out-of-pocket amount up to \$350 per trip for ground transportation, or up to \$1,000 per trip for air transportation, of a Covered Person by ambulance to a Hospital or from one medical facility to another where a Covered Person is Confined as an Inpatient. This benefit is limited to one trip per day. A licensed ambulance company must provide the ambulance service. If air and ground ambulance service are both required in the same day, we will only pay the highest benefit amount. This amount is subject to the Maximum In-Hospital Benefits shown on the Schedule of Benefits, and the Maximum Combined In-Hospital and Outpatient Benefits, if applicable and shown on the Schedule of Benefits. The In-Hospital deductible does not apply to this benefit.

**Absence of the Insured's Other Medical Plan:** We will rely on the Insured to inform us when coverage under the Insured's Other Medical Plan is terminated. In the event we are unaware that the Insured's Other Medical Plan has terminated, and we have accepted premium, and out-of-pocket expenses are incurred by the Covered Person, benefits will be determined as follows:

1. benefits will be derived using the Assumed Other Medical Plan, as described following this paragraph; and
2. coverage under this 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 the Termination of Coverage section, 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 Covered Person.
\$2,001 - \$2,750	\$250 deductible, then 20% co-insurance for the first \$10,000 of Covered Charges per Calendar Year per Covered Person.
\$2,751 - \$4,250	\$500 deductible, then 20% co-insurance for the first \$10,000 of Covered Charges per Calendar Year per Covered Person.
\$4,251 or more	\$1,000 deductible, then 20% co-insurance for the first \$10,000 of Covered Charges per Calendar Year per Covered Person.

Once benefits are remitted under this provision, our obligations to the Insured will be met and the coverage will terminate due to an absence of the Insured's Other Medical Plan. We will refund any prorated unearned premium for any remaining period the Covered Person is no longer covered by this Policy.

**SECTION 6 – LIMITATIONS AND EXCLUSIONS**

**No benefits will be payable for expenses incurred during any period the Covered Person does not have coverage under the Insured's Other Medical Plan, except as provided in the Absence of the Insured's Other Medical Plan provision, described in the Benefits section.**

**PRE-EXISTING CONDITION LIMITATION:** No benefits are payable during the Pre-Existing Condition Exclusion Period following the Covered Person's Effective Date for any loss resulting from a Pre-Existing Condition. The Pre-Existing Condition Exclusion Period is shown on the Policy Schedule.

- EXCLUSIONS:** No benefits are payable for any loss resulting from or caused, whether directly or indirectly, by:
1. war or any act of war, whether declared or undeclared, or active service in the armed forces; (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. If coverage is suspended for any Covered Person during a period of military service, we will refund the pro-rata portion of any premium paid for any such Covered Person upon receipt of the Insured's written request.)
  2. an intentionally self-inflicted Injury or Sickness;
  3. suicide or attempted suicide, while sane or insane;
  4. rest care or rehabilitative care and treatment;
  5. voluntary abortion except, with respect to the Insured or covered Eligible Dependent spouse:
    - a. where the Insured or Dependent spouse's life would be endangered if the fetus were carried to term; or
    - b. where medical complications have arisen from abortion;
  6. pregnancy of a Eligible Dependent child;
  7. participating in a riot, insurrection, rebellion, 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.)
  8. committing, or attempting to commit, an illegal act that is defined as a felony; (Felony is as defined by the law of the jurisdiction in which the act takes place.)
  9. participation in a contest of speed in power driven vehicles, parachuting, or hang gliding;

10. air travel, except:
  - a. as a fare-paying passenger on a commercial airline on a regularly scheduled route; or
  - b. as a passenger for transportation only and not as a pilot or crew member;
11. being intoxicated or under the influence of any narcotic unless administered by a Physician or taken according to the Physician's instructions; (Intoxication means that which is determined and defined by the laws and jurisdiction of the geographical area in which the event that caused the loss occurred.)
12. alcoholism or drug addiction;
13. sex changes;
14. experimental treatment, drugs (except for FDA approved cancer drugs), or surgery;
15. 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.)
16. dental or vision services, including treatment, surgery, extractions, or x-rays, unless:
  - a. 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
  - b. due to congenital disease or anomaly of a covered newborn child.
17. routine examinations, such as health exams, periodic check-ups, or routine physicals;
18. elective cosmetic surgery;
19. drugs (prescription and non-prescription for use outside of a covered facility as defined in this Policy or any attached rider);
20. sterilization and reversal of sterilization;
21. an expense that does not meet the definition of Covered Charges;
22. an expense or service that exceeds any of the Maximum Benefits, as shown on the Schedule of Benefits; or
23. any expense for which benefits are not payable under the Insured's Other Medical Plan.

## **SECTION 7 - PREMIUMS**

**PREMIUM PAYMENT:** The monthly premium and the Certificate Effective Date are shown on the Certificate Schedule. Premiums after the initial premium are due as of the first day of each new premium term. Premiums must be sent to us. If the Policyholder does not pay the premium when due or within the grace period, this Policy will lapse at the end of the period for which premium is due.

**PREMIUM TERM:** The premium term is the period of time that a premium payment will keep this Policy in force.

**PREMIUM MODE:** The premium mode the Policyholder selected upon application for this Policy is shown on the Master Application. The Policyholder may change the premium mode on any premium due date if we agree.

**PREMIUM CHANGES:** The premium rates may be changed by us at the first anniversary date of this Policy or any premium due date thereafter. No such increase in rates will be made unless 60 days prior notice is given to the Policyholder. Premiums will not increase during the initial twelve (12) months of coverage.

**REFUND OF UNUSED PREMIUM:** Upon the death of a Covered Person, any premium paid for such person for any period beyond the end of the Certificate Month in which death occurred will be refunded.

## **SECTION 8 - TERMINATION OF COVERAGE**

**TERMINATION OF POLICY:** We or the Policyholder may terminate this Policy on any premium due date after the first Policy anniversary date.

Insurance coverage under this Policy will end on the earliest of these dates:

1. the end of the grace period if the premium for all Certificates in force remains unpaid;
2. the date all Certificates under this Policy terminate;
3. the end of the Policy Month in which we receive a written request from the Policyholder to terminate this Policy;  
or
4. the end of the Policy Month in which we have terminated this Policy, subject to a 60-day written notice.

In addition, we may end the coverage of a Policyholder if:

1. fewer persons are insured than the Policyholder's application requires;
2. the Policyholder does not promptly provide us with information that is reasonably required; or
3. the Policyholder fails to perform any of its obligations that relate to this Policy.

**TERMINATION OF CERTIFICATE:** Insurance coverage under the Certificate and any attached riders will end on the earliest of these dates:

1. the date this Policy terminates;
2. the end of the grace period if the premium remains unpaid;
3. the date the Insured no longer qualifies as an Insured;
4. the date the Insured attains age 70 (if the Insured works for an employer employing less than 20 employees);
5. the date the Insured's coverage under the Insured's Other Medical Plan ends; or
6. the date of the Insured's death.

**TERMINATION OF COVERAGE:** Insurance coverage under the Certificate and any attached riders for a Covered Person will end as follows:

1. the date this Policy terminates;
2. the date the Certificate terminates;
3. the end of the Policy Month in which we receive a written request from the Policyholder to terminate the Covered Person's coverage;
4. the date a Covered Person no longer qualifies as an Insured or Eligible Dependent; or
5. the date of the Covered Person's death.

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

**TERMINATION WITHOUT PREJUDICE:** If termination of coverage occurs because of termination of the Insured's employment with the Policyholder, such termination shall be without prejudice to any loss which commenced while the Certificate was in force.

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

This provision will not apply if:

1. the Insured's Other Medical Plan does not provide a similar Extension of Coverage provision;
2. the Insured's Other Medical Plan was not in effect during the period of time the Covered Person was insured under this Policy; or
3. coverage under the Insured's Other Medical Plan was terminated more than 30 days prior to termination of coverage under this Policy.

**EXTENSION OF BENEFITS:** Whenever termination of coverage occurs because of termination of the Insured's employment, such termination shall be without prejudice to any Hospital Confinement, which commenced while the Certificate 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:

1. the Insured's Other Medical Plan does not provide a similar Extension of Benefits provision;
2. the Insured's Other Medical Plan was not in effect during the period of time the Covered Person was insured under this Policy; or
3. coverage under the Insured's Other Medical Plan was terminated more than 30 days prior to termination of coverage under this Policy.

**COBRA CONTINUATION OF COVERAGE:** This plan may be continued in accordance with the Consolidated Omnibus Reconciliation Act of 1986.

## SECTION 9 - CLAIMS

**NOTICE OF CLAIM:** We must receive the Insured's written notice, including the Policy and Certificate number, when there is a claim. Notice must be given within 60 days of the loss, or as soon as reasonably possible. Notice of claim must be received in writing at our administrative office at the address shown on page 1. Information sufficient to identify the Covered Person shall be deemed notice to us.

**CLAIM FORMS:** When we receive notice of claim, we will send the applicable claim forms to the Insured. If these forms are not sent within 15 days, proof of loss may be submitted by giving us a written statement of the nature and extent of the loss.

**PROOF OF LOSS:** Proof of Loss must be provided by the Insured at the Insured's expense, and must be given to us within 90 days after the loss. However after the 90 days, the claim will not be reduced or denied if:

1. it was not reasonably possible to give proof in that time; and
2. the proof is filed as soon as reasonably possible.

In no event, except in the absence of legal capacity, may proof be given later than 12 months after the date proof is otherwise required.

Proof of loss must include, but may not be limited to, the following documentation:

1. the finalized explanation of benefits (EOB) from the carrier of the Insured's Other Medical Plan; and
2. a Physician's statement.

Proof of loss may also include, but not be limited to, the following documentation:

1. a completed claim form; and
2. an itemized bill.

**TIME OF PAYMENT OF CLAIMS:** All benefits will be paid promptly after we receive acceptable written proof of loss.

**PAYMENT OF CLAIMS:** Benefits payable under this Policy will be paid to the Insured or to the providers of services and supplies, if the Insured so directs in writing. Any unassigned benefits that have not been paid at the time of the Insured's death will be paid to his or her designated beneficiary, if living, or to the contingent beneficiary. If no such designation is made, or in the event of death of both the beneficiary and contingent beneficiary, benefits will be paid to the Insured's estate. If benefits are payable to the Insured's estate or to any person who is not competent to give us a valid release, we have the right to pay up to \$1,000 of those benefits to any person related to the Insured by blood or marriage who we believe is justly entitled to such payment. If we make a payment under this provision in good faith, we will be released from liability to the extent of the payment.

**PHYSICAL EXAMINATION:** If the Insured makes a claim, the Insured or the Covered Person on whose behalf the claim is made must submit to a physical examination as often as we may reasonably request. We will pay for such examinations.

**LEGAL ACTION:** No legal action can be taken to receive benefits under this Policy less than 60 days after written proof of loss has been furnished as required; or more than 3 years after written proof of loss is required to be furnished.

## SECTION 10 - GENERAL POLICY PROVISIONS

**ENTIRE CONTRACT:** The contract is made up of this Policy, the Master Application of the Policyholder, the Insured's application attached to the Certificate, Schedule of Benefits, and any attached riders or endorsements.

Statements made by the Policyholder or the Insured, in the absence of fraud, are representations and not warranties. No such statements will be used to void the insurance, reduce benefits or defend a claim under this Policy unless the statement is in writing; and a copy of that statement is given to the Insured, the Insured's beneficiary, or the Insured's personal representative.

**CHANGES TO THE ENTIRE CONTRACT:** No changes to this Policy, the Certificate, or any attached riders or endorsements, will be valid unless it is approved by one of our executive officers. The change must be signed by the officer and attached to this Policy and the Certificate. No insurance producer may change this Policy or the Certificate or waive any of its provisions.

**TIME LIMIT ON CERTAIN DEFENSES:** After two years from the Covered Person's Effective Date, no misstatement made in the application, except fraudulent misstatements, will be used to void the Certificate or deny a claim for any loss commencing after the end of the two year period.

No claim for loss incurred during the Pre-Existing Condition Exclusion Period following the Covered Person's Effective Date will be reduced or denied on the ground that a Sickness or physical condition, not excluded from coverage by name or specific description, had existed prior to the Covered Person's Effective Date.

**GRACE PERIOD:** This Policy has a 31 day grace period for paying premium. This means that if a renewal premium is not paid by the date due, it may be paid during the following 31 days. During the grace period this Policy will stay in force. If the Policyholder does not pay the premium by the end of the 31 day grace period, this Policy will terminate as of the date the renewal premium became due.

The Policyholder or the Insured may cancel coverage under this Policy on any future premium due date or on any date during the Grace Period by writing to us. If coverage is canceled on a premium due date, the Grace Period will not apply. If coverage is canceled 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.

**UNPAID PREMIUM:** When a claim is paid, any premium due and unpaid may be deducted from the claim payment.

**MISSTATEMENT OF AGE:** If the Insured misstated the age of any Covered Person on his or her application, the benefits will be based on such Covered Person's correct age. Any difference in premium will be deducted from claims paid and future premiums will be adjusted accordingly. If we have accepted a premium on behalf of the person for a period after the date when coverage should have ended, we will refund any such premium, but we will not pay any claims for services the person received after coverage should have ended.

**CONFORMITY WITH STATE STATUTES:** On the Effective Date, any provision of this Policy that is in conflict with the laws of the state of issue is amended to meet the minimum requirements of those laws.



# **American Public Life Insurance Company**

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

**FOR INQUIRIES OR TO OBTAIN INFORMATION, PLEASE CONTACT:**

2305 Lakeland Drive, Flowood, Mississippi 39232  
Toll Free (800) 256-8606 • Local (601) 936-6600

**SUPPLEMENTAL LIMITED BENEFIT MEDICAL EXPENSE INSURANCE POLICY**



# American Public Life Insurance Company

A member of the American Fidelity Group®

FOR INQUIRIES OR TO OBTAIN INFORMATION, PLEASE CONTACT:

2305 Lakeland Drive, Flowood, Mississippi 39232  
Toll Free (800) 256-8606 • Local (601) 936-6600

## SUPPLEMENTAL LIMITED BENEFIT MEDICAL EXPENSE CERTIFICATE OF INSURANCE

**CERTIFICATE OF INSURANCE:** The Company hereby certifies that the Company has issued and delivered to the Policyholder a group Policy, described on the Certificate Schedule attached hereto. The group Policy covers certain eligible persons, as described in this Certificate. The Policy is a legal contract between the Policyholder and the Company.

**CONSIDERATION:** The Company has issued this Certificate on the basis of the application and in exchange for payment of the first premium. The Certificate Effective Date is the date the Company assigns after the Company has approved the application for this Certificate and is the date the first premium is due. Dates begin and end at 12:01 a.m. Standard Time at the address of the Policyholder.

**OPTIONALLY RENEWABLE:** The Policy, under which this Certificate is issued, is optionally renewable. This means that the Company or the Policyholder has the right to terminate the Policy on any premium due date after the first anniversary following the Policy Effective Date. The Company must give at least 60 days written notice to the Policyholder prior to cancellation. The Company cannot cancel your coverage under this Certificate because of a change in your age or health. The Company can change your premiums for this Certificate if the Company changes premiums for all similar Certificates issued under the Policy. The Company must give you at least 60 days written notice before the Company changes your premiums.

**CONTINUATION:** This Certificate was issued under a Policy issued to the Policyholder named on the Certificate Schedule. While the Policy is in force, this Certificate will continue, subject to the Termination provision, provided the premiums are paid when due.

Signed for American Public Life Insurance Company.

[

Chief Administrative Officer

President, Chief Operating Officer]

PLEASE READ YOUR CERTIFICATE CAREFULLY.

THE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED PROVIDES LIMITED BENEFITS AND IS DESIGNED TO SUPPLEMENT OTHER COMPREHENSIVE INSURANCE COVERAGE.

**Warning.** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information or knowingly presents false information in an application for insurance may be guilty of insurance fraud.

## SECTION 1 - TABLE OF CONTENTS

Certificate of Insurance .....	Face Page
Consideration .....	Face Page
Optionally Renewable .....	Face Page
Continuation .....	Face Page
Table of Contents .....	Section 1
Certificate Schedule .....	Section 2
Definitions.....	Section 3
Eligibility and Effective Date.....	Section 4
Benefits .....	Section 5
Limitations and Exclusions.....	Section 6
Premiums .....	Section 7
Termination of Coverage.....	Section 8
Claims .....	Section 9
General Provisions.....	Section 10
Schedule of Benefits .....	Insert
Benefit Riders.....	Insert
Application.....	Insert
Back Page	

**SECTION 2 - CERTIFICATE SCHEDULE**

Policyholder:	[ABC Company]	Policy Number:	[M00000]
Certificate Number:	[C00000]	Certificate Effective Date:	[6/1/2009]
Insured:	[John Doe]	Insured's Issue Age:	[35]
Plan Selected:	[Employee, Employee & Spouse, Employee & Child, Employee & Family]	Premium Mode:	[Special Modal, Monthly, Quarterly, Semi-Annual, Annual]

**MEDLINK® IV  
SUPPLEMENTAL LIMITED BENEFIT MEDICAL EXPENSE INSURANCE PLAN DESCRIPTION**

<b>MEDLink® IV POLICY – [Basic, Enhanced Plus Plan]</b>	<b>MONTHLY PREMIUM</b>
	\$[XX.xx]

	<b>EFFECTIVE DATE</b>	
[Outpatient Benefit Rider AMDI324APL	mm/dd/yyyy]	
<b>[OPTIONAL BENEFIT RIDER</b>		
[Physician Outpatient Treatment Benefit Rider AMDI325APL	mm/dd/yyyy	\$[XX.xx] ]
[Retired Employee Amendment Rider AMDI327APL]		
	<b>TOTAL PREMIUM:</b>	\$[XX.xx]

PRE-EXISTING PERIOD: [0-12] Months  
 PRE-EXISTING CONDITION EXCLUSION PERIOD: [0-12] Months

**TOTAL PREMIUM BY MODE**

<b>ANNUAL</b>	<b>SEMI-ANNUAL</b>	<b>QUARTERLY</b>	<b>MONTHLY</b>	<b>[SPECIAL MODAL*</b>
[\$XXX.xx	\$XXX.xx	\$XXX.xx	\$XXX.xx]	\$XXX.xx]

**[\*SPECIAL MODAL PREMIUM IS THE MONTHLY PREMIUM ADJUSTED TO COINCIDE WITH CERTAIN PAYROLL DEDUCTION REQUIREMENTS.]**

**TO CALCULATE A PREMIUM OTHER THAN MONTHLY MULTIPLY THE MONTHLY PREMIUM BY: 3 FOR QUARTERLY; 6 FOR SEMI-ANNUAL; AND 12 FOR ANNUAL.**

## SECTION 3 - DEFINITIONS

**ACCIDENT:** A sudden, unexpected and unintended event, which results in bodily Injury, and which is independent of disease, bodily infirmity, or any other excluded cause.

**ACTIVELY AT WORK:** You are:

1. performing in the usual manner all of the regular duties of your employment as a Full-Time Employee on a scheduled work day; and
2. 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 employer sends you.

Actively At Work will include 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 as if it were a scheduled work day.

**CALENDAR YEAR:** The period beginning on January 1 and ending on December 31 of the same year.

**CERTIFICATE:** The individual Certificate issued to you. It describes the coverage under the Policy; how benefits will be paid; any limitations of the Policy; and all other essential features of the Policy. If you are issued more than one Certificate under the Policy, only the last one will be in effect.

**CERTIFICATE EFFECTIVE DATE:** The effective date of the individual Certificate issued to you.

**CERTIFICATE MONTH:** That period of time beginning at 12:01 a.m. Standard Time on the same date of the month that your Certificate became effective, as shown on the Certificate Schedule and ending at 12:00 a.m. Standard Time the following month on the same date.

**CERTIFICATE SCHEDULE:** Page 3 of this Certificate issued to you.

**COMPANY (we, us or our):** American Public Life Insurance Company.

**CONFINEMENT (CONFINED):** The Covered Person must be confined to a Hospital as an Inpatient on the advice of a Physician for at least 18 consecutive hours to be considered one day of Hospital Confinement. One period of confinement includes all consecutive calendar days a Covered Person is confined as an Inpatient in a Hospital.

**COVERED CHARGES:** Those charges that:

1. are incurred by a Covered Person because of an Accident or Sickness;
2. are for necessary treatment, services and medical supplies and recommended by a Physician;
3. are incurred in a covered facility as defined in this Certificate or any attached rider;
4. are not more than any applicable Maximum Benefit set forth in the Schedule of Benefits;
5. are incurred while insured under this Certificate, subject to any Extension of Benefits; and
6. are not excluded under the Limitations and Exclusions section.

**COVERED PERSON(S):** A person who is eligible for coverage under this Certificate and for whom coverage is in force (See the Eligibility and Effective Date section).

**COVERED PERSON'S EFFECTIVE DATE:** The date the Covered Person's coverage under this Certificate becomes effective. Your effective date will be the same as the Certificate Effective Date (subject to the Eligibility and Effective Date section). Your dependents are eligible for insurance on the date you become eligible for insurance or the date a person becomes an Eligible Dependent, whichever is later. The effective date of coverage for each Eligible Dependent will be the first of the month following the Company's approval of the application and receipt of the first premium (See Newborn/Adopted Children provision).

**DEDUCTIBLE:** The out-of-pocket amount which must be satisfied by the Covered Person prior to benefits being paid under the Policy or any attached riders. The Deductible, if any, is shown on the Schedule of Benefits.

**ELIGIBLE DEPENDENTS:** Unless specifically named as excluded in any part of this contract, this means:

1. your lawful spouse who is under age 70 and is covered under your Other Medical Plan; and/or
2. your, and/or your spouse's, natural child, adopted child or stepchild who is under 26 years of age and who is covered under your Other Medical Plan; and/or
3. any child who becomes incapable of self-sustaining employment because of mental or physical incapacity while covered under this Certificate and prior to reaching the limiting age for dependent children as set out in #2 above. 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 the Company if this incapacity is removed or terminated at a later date. The premium will remain at the dependent rate. The child's coverage will terminate at the earlier of the end of the Certificate Month in which the conditions cease or the date this Certificate terminates; and/or
4. any minor under your charge, care and control, who has been placed in your home for adoption and is under 26 years of age.

The term Eligible Dependent does not include your grandchild (unless required by law).

**FULL-TIME EMPLOYEE:** The Insured who works at least the minimum number of hours per week as defined in the Master Application.

**HOSPITAL:** A place that:

1. is licensed and operated pursuant to law; and
2. provides care and treatment for ill and injured persons on an Inpatient basis; and
3. provides facilities for medical, diagnostic, and surgical care (These facilities need not be at the Hospital. They may be elsewhere if there is a formal agreement for their use.); and
4. provides 24 hour a day nursing care by or under the supervision of a Nurse; and
5. is supervised by a staff of one or more Physicians; and
6. is accredited by the Joint Commission on the Accreditation of Hospitals; and
7. is not an institution, or part thereof, used as: a place for rehabilitation, a place for rest or for the aged, a nursing or convalescent home, a long term nursing unit or geriatrics ward, or an extended care facility for the care of convalescent, rehabilitative or ambulatory patients.

**IMMEDIATE FAMILY:** Anyone who is related to the Covered Person by any degree of blood, marriage or operation of law. This includes the following relatives: parents, grandparents, brothers, sisters, children, grandchildren, aunts, uncles, cousins, nephews, nieces, in-laws, adopted relatives, and step-relatives.

**INITIAL ENROLLMENT:** One of the following periods during which you may first apply in writing for coverage under this Certificate:

1. if you are eligible for coverage on the Policy Effective Date, the period before the Policy Effective Date as set by the Company and the Policyholder; or
2. if you become eligible for coverage after the Policy Effective Date, the period ending 31 days after the date you are first eligible to apply for coverage.

**INJURY:** A bodily Injury which is caused directly by an Accident, independent of Sickness, disease, bodily infirmity or any other cause.

**INPATIENT:** Confinement in a Hospital for at least 18 continuous hours in duration.

**INSURED (you and your):** The person named as the Insured on the Certificate Schedule. The Insured must be a Full-Time Employee of the Policyholder and be covered under the Other Medical Plan.

**MASTER APPLICATION:** The document signed by the Policyholder that contains the answers to the Company's questions and are the Policyholder's representations, which the Company accepted in good faith as being true, complete and correct. The Master Application is the basis upon which the Company issued the Policy.

**MAXIMUM BENEFIT:** The maximum dollar amounts, number of visits, or time frames, allowed for any one (1) Covered Person or combination of Covered Persons, for any benefit or combination of benefits, as shown on the Schedule of Benefits.

**MENTAL OR EMOTIONAL DISORDER:** A neurosis, psychoneurosis, psychopathy, psychosis or mental or emotional disease or disorder of any kind.

**OTHER MEDICAL PLAN:** Any basic major medical, comprehensive medical, or managed care policy provided through the Policyholder and through which a Covered Person has coverage. The term Other Medical Plan does not include TRICARE, Medicare, or Medicaid.

**PER CALENDAR DAY:** Per Calendar Day means the period of time between 12:00 a.m. and 11:59 p.m.

**PER OCCURRENCE:** Per Occurrence means treatment for the same or related condition, unless separated by a period of 90 days. Treatment for the same or related condition separated by 90 days, or an unrelated condition will be considered a new Per Occurrence.

**PHYSICIAN:** A practitioner of the healing arts who is legally qualified and licensed to practice medicine and who is practicing within the scope of his or her license in the state where so licensed. The Physician must not be a member of your Immediate Family or anyone who normally resides with you in your residence.

**POLICY:** The Policy issued to the Policyholder which covers the Covered Persons.

**POLICY EFFECTIVE DATE:** The date shown as the Policy Effective Date in the Certificate Schedule.

**POLICYHOLDER:** The employer who holds the Policy.

**POLICY MONTH:** That period of time beginning at 12:01 a.m. Standard Time on the same date of the month that the Policy became effective, as shown on the Policy Schedule and ending at 12:00 a.m. Standard Time the following month on the same date.

**POLICY SCHEDULE:** Page 3 of the Policy.

**PRE-EXISTING CONDITION:** An Injury, Sickness or physical condition for which, medical advice, consultation or treatment, including prescribed medications, was recommended by or received from a member of the medical profession within the Pre-Existing Period immediately preceding the Covered Person's Effective Date. The Pre-Existing Period is shown on the Certificate Schedule. The term "Pre-Existing Condition" will also include conditions which are related to such Injury, Sickness or physical condition.

**SCHEDULE OF BENEFITS:** The benefit schedule set forth in the Policy or Certificate.

**SICKNESS:** Any illness, disease, infection or abnormal condition of the body, not caused by an Accident, which is the direct cause of the loss.

## **SECTION 4 - ELIGIBILITY AND EFFECTIVE DATE**

**Eligibility:** A person is eligible to be insured under this Certificate if such person:

1. meets the Company's underwriting rules; and
2. is Actively at Work and qualifies for coverage as defined in the Master Application; and
3. is covered under your Other Medical Plan; and,
4. is under age 70 (if you work for an employer employing less than 20 employees).

Evidence of coverage under your Other Medical Plan is required. A person must apply for insurance during the Initial Enrollment period or on the date the person first becomes eligible for coverage. If the person does not apply during the Initial Enrollment period or on the date the person becomes eligible for coverage, he or she may be subject to additional underwriting by the Company.

**EFFECTIVE DATE:** A person must use forms provided by the Company when applying for insurance. If the Company's underwriting rules are met, the premium has been paid, and all persons to be insured are covered under your Other Medical Plan, the insurance will take effect on the later of the following dates:

1. the requested Certificate Effective Date; or
2. the Certificate Effective Date assigned by the Company upon approval of the person's application.

If you are not Actively At Work on the Certificate Effective Date due to disability, Injury, Sickness, temporary layoff, leave of absence or Family and Medical Leave of Absence, coverage begins on the date you return to Actively At Work.

**NEWBORN/ADOPTED CHILDREN:** If your plan is Employee Only or Employee and Spouse, all newborn children will be covered automatically on the day they are born as long as your coverage was in force on that date. The newborn child's coverage will not continue past the 90-day period following his or her birth unless: the Company is notified in writing by the end of the 90-day period of the addition of such newborn child and any applicable additional premium is paid.

Coverage for newborn children will also include coverage for: a newborn 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 a child adopted by you from the date of petition. Coverage shall terminate upon the dismissal or denial of a petition for adoption. Coverage for the adopted child will not continue past 60 days after the date of petition unless: the Company is notified in writing by the end of the 60-day period of the addition of such adopted child; and any applicable additional premium is paid.

If your plan is Employee and Child or Employee and Family, all newborn children are covered from the moment of birth and all adopted children are covered from the moment of petition. No notification is necessary and no additional premium is due.

Coverage for Newborn/Adopted Children includes prematurity, congenital defects and birth abnormalities of a newborn/adopted child.

## SECTION 5 – BENEFITS

**In-Hospital Benefit:** In accordance with the Schedule of Benefits, the Company will pay for Covered Charges incurred by a Covered Person:

1. if the Covered Person is covered by your Other Medical Plan when such Covered Charges are incurred, except as provided in the Absence of the Insured's Other Medical Plan provision, described in this Section; and
2. such Covered Charges are incurred while the Covered Person is an Inpatient; and
3. after satisfaction of any Deductible shown on the Schedule of Benefits; and
4. subject to the Maximum In-Hospital Benefits shown on the Schedule of Benefits; and
5. subject to the Maximum Combined In-Hospital and Outpatient Benefits, if applicable and shown on the Schedule of Benefits.

Benefits payable under this Certificate are limited to:

1. any out-of-pocket deductible amount incurred under your Other Medical Plan;
2. any out-of-pocket co-payment or coinsurance amounts the Covered Person actually incurs under your Other Medical Plan;
3. any out-of-pocket amount the Covered Person actually incurs under your Other Medical Plan for treatment of a Mental or Emotional Disorder limited to 30 days per Covered Person per Calendar Year.

**Ambulance Benefit:** The Company will pay the out-of-pocket amount up to \$350 per trip for ground transportation, or up to \$1,000 per trip for air transportation, of a Covered Person by ambulance to a Hospital or from one medical facility to another where a Covered Person is Confined as an Inpatient. This benefit is limited to one trip per day. A licensed ambulance company must provide the ambulance service. If air and ground ambulance service are both required in the same day, the Company will only pay the highest benefit amount. This amount is subject to the Maximum In-Hospital Benefits shown on the Schedule of Benefits, and the Maximum Combined In-Hospital and Outpatient Benefits, if applicable and shown on the Schedule of Benefits. The In-Hospital deductible does not apply to this benefit.

**Absence of the Insured's Other Medical Plan:** The Company will rely on you to inform the Company when coverage under your Other Medical Plan is terminated. In the event the Company is unaware that your Other Medical Plan has terminated, and the Company has accepted premium, and out-of-pocket expenses are incurred by the Covered Person, benefits will be determined as follows:

1. benefits will be derived using the Assumed Other Medical Plan, as described following this paragraph; and
2. coverage under this Certificate 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 the Termination of Coverage section, 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 Covered Person.
\$2,001 - \$2,750	\$250 deductible, then 20% co-insurance for the first \$10,000 of Covered Charges per Calendar Year per Covered Person.
\$2,751 - \$4,250	\$500 deductible, then 20% co-insurance for the first \$10,000 of Covered Charges per Calendar Year per Covered Person.
\$4,251 or more	\$1,000 deductible, then 20% co-insurance for the first \$10,000 of Covered Charges per Calendar Year per Covered Person.

Once benefits are remitted under this provision, the Company's obligations to you will be met and the coverage will terminate due to an absence of your Other Medical Plan. The Company will refund any prorated unearned premium for any remaining period the Covered Person is no longer covered by this Certificate.

**SECTION 6 – LIMITATIONS AND EXCLUSIONS**

**No benefits will be payable for expenses incurred during any period the Covered Person does not have coverage under your Other Medical Plan, except as provided in the Absence of the Insured's Other Medical Plan provision, described in the Benefits section.**

**PRE-EXISTING CONDITION LIMITATION:** No benefits are payable during the Pre-Existing Condition Exclusion Period following the Covered Person's Effective Date for any loss resulting from a Pre-Existing Condition. The Pre-Existing Condition Exclusion Period is shown on the Certificate Schedule.

- EXCLUSIONS:** No benefits are payable for any loss resulting from or caused, whether directly or indirectly, by:
1. war or any act of war, whether declared or undeclared, or active service in the armed forces; (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. If coverage is suspended for any Covered Person during a period of military service, the Company will refund the pro-rata portion of any premium paid for any such Covered Person upon receipt of your written request.)
  2. an intentionally self-inflicted Injury or Sickness;
  3. suicide or attempted suicide, while sane or insane;
  4. rest care or rehabilitative care and treatment;
  5. voluntary abortion except, with respect to you or your covered Eligible Dependent spouse:
    - a. where you or your Dependent spouse's life would be endangered if the fetus were carried to term; or
    - b. where medical complications have arisen from abortion;
  6. pregnancy of a Eligible Dependent child;
  7. participating in a riot, insurrection, rebellion, 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.)
  8. committing, or attempting to commit, an illegal act that is defined as a felony; (Felony is as defined by the law of the jurisdiction in which the act takes place.)
  9. participation in a contest of speed in power driven vehicles, parachuting, or hang gliding;

10. air travel, except:
  - a. as a fare-paying passenger on a commercial airline on a regularly scheduled route; or
  - b. as a passenger for transportation only and not as a pilot or crew member;
11. being intoxicated or under the influence of any narcotic unless administered by a Physician or taken according to the Physician's instructions; (Intoxication means that which is determined and defined by the laws and jurisdiction of the geographical area in which the event that caused the loss occurred.)
12. alcoholism or drug addiction;
13. sex changes;
14. experimental treatment, drugs (except for FDA approved cancer drugs), or surgery;
15. 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.)
16. dental or vision services, including treatment, surgery, extractions, or x-rays, unless:
  - a. 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
  - b. due to congenital disease or anomaly of a covered newborn child.
17. routine examinations, such as health exams, periodic check-ups, or routine physicals;
18. elective cosmetic surgery;
19. drugs (prescription and non-prescription for use outside of a covered facility as defined in this Certificate or any attached rider);
20. sterilization and reversal of sterilization;
21. an expense that does not meet the definition of Covered Charges;
22. an expense or service that exceeds any of the Maximum Benefits, as shown on the Schedule of Benefits; or
23. any expense for which benefits are not payable under the your Other Medical Plan.

## **SECTION 7 - PREMIUMS**

**PREMIUM PAYMENT:** The monthly premium and the Certificate Effective Date are shown on the Certificate Schedule. If the premium is not paid when due or within the grace period, this Certificate will terminate at the end of the period for which premium is due.

**PREMIUM TERM:** The premium term is the period of time that a premium payment will keep this Certificate in force.

**PREMIUM MODE:** The premium mode the Policyholder selected upon application for the Policy is shown on the Master Application. The Policyholder may change the premium mode on any premium due date if the Company agrees.

**PREMIUM CHANGES:** The premium rates may be changed by the Company at the first anniversary date of the Policy or any premium due date thereafter. No such increase in rates will be made unless 60 days prior notice is given to the Policyholder. Premiums will not increase during the initial twelve (12) months of coverage.

**REFUND OF UNUSED PREMIUM:** Upon the death of a Covered Person, any premium paid for such person for any period beyond the end of the Certificate Month in which death occurred will be refunded.

## **SECTION 8 - TERMINATION OF COVERAGE**

**TERMINATION OF POLICY:** The Company or the Policyholder may terminate the Policy on any premium due date after the first Policy anniversary date.

Insurance coverage under the Policy will end on the earliest of these dates:

1. the end of the grace period if the premium for all Certificates in force remains unpaid;
2. the date all Certificates under the Policy terminate;
3. the end of the Policy Month in which the Company receives a written request from the Policyholder to terminate the Policy; or
4. the end of the Policy Month in which the Company has terminated the Policy, subject to a 60-day written notice.

In addition, the Company may end the coverage of a Policyholder if:

1. fewer persons are insured than the Policyholder's application requires;
2. the Policyholder does not promptly provide the Company with information that is reasonably required; or
3. the Policyholder fails to perform any of its obligations that relate to the Policy.

**TERMINATION OF CERTIFICATE:** Insurance coverage under this Certificate and any attached riders will end on the earliest of these dates:

1. the date the Policy terminates;
2. the end of the grace period if the premium remains unpaid;
3. the date you no longer qualify as an Insured;
4. the date you attain age 70 (if you work for an employer employing less than 20 employees);
5. the date your coverage under your Other Medical Plan ends; or
6. the date of your death.

**TERMINATION OF COVERAGE:** Insurance coverage under this Certificate and any attached riders for a Covered Person will end as follows:

1. the date the Policy terminates;
2. the date this Certificate terminates;
3. the end of the Certificate Month in which the Company receives a written request from you to terminate the Covered Person's coverage;
4. the date a Covered Person no longer qualifies as an Insured or Eligible Dependent; or
5. the date of the Covered Person's death.

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

**TERMINATION WITHOUT PREJUDICE:** If termination of coverage occurs because of termination of your employment with the Policyholder, such termination shall be without prejudice to any loss which commenced while this Certificate was in force.

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

This provision will not apply if:

1. your Other Medical Plan does not provide a similar Extension of Coverage provision;
2. your Other Medical Plan was not in effect during the period of time the Covered Person was insured under the Policy; or
3. coverage under your Other Medical Plan was terminated more than 30 days prior to termination of coverage under the Policy.

**EXTENSION OF BENEFITS:** Whenever termination of coverage occurs because of termination of your employment, such termination shall be without prejudice to any Hospital Confinement which commenced while this Certificate 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:

1. your Other Medical Plan does not provide a similar Extension of Benefits provision;
2. your Other Medical Plan was not in effect during the period of time the Covered Person was insured under the Policy; or
3. coverage under your Other Medical Plan was terminated more than 30 days prior to termination of coverage under the Policy.

**COBRA CONTINUATION OF COVERAGE:** This plan may be continued in accordance with the Consolidated Omnibus Reconciliation Act of 1986.

## SECTION 9 - CLAIMS

**NOTICE OF CLAIM:** The Company must receive written notice, including the Policy and Certificate number, when there is a claim. Notice must be given within 60 days of the loss, or as soon as reasonably possible. Notice of claim must be received in writing at the Company's administrative office at the address shown on page 1. Information sufficient to identify the Covered Person shall be deemed notice to the Company.

**CLAIM FORMS:** When the Company receives notice of claim, the Company will send the applicable claim forms. If these forms are not sent within 15 days, proof of loss may be submitted by giving the Company a written statement of the nature and extent of the loss.

**PROOF OF LOSS:** Proof of Loss must be provided by you at your expense and must be given to the Company within 90 days after the loss. However after the 90 days, the claim will not be reduced or denied if:

1. it was not reasonably possible to give proof in that time; and
2. the proof is filed as soon as reasonably possible.

In no event, except in the absence of legal capacity, may proof be given later than 12 months after the date proof is otherwise required.

Proof of loss must include, but may not be limited to, the following documentation:

1. the finalized explanation of benefits (EOB) from the carrier of the Insured's Other Medical Plan; and
2. a Physician's statement.

Proof of loss may also include, but not be limited to, the following documentation:

1. a completed claim form; and
2. an itemized bill.

**TIME OF PAYMENT OF CLAIMS:** All benefits will be paid promptly after the Company receives acceptable written proof of loss.

**PAYMENT OF CLAIMS:** Benefits payable under this Certificate will be paid to you or to the providers of services and supplies, if you so direct in writing. Any unassigned benefits that have not been paid at the time of your death will be paid to your designated beneficiary, if living, or to the contingent beneficiary. If no such designation is made, or in the event of death of both the beneficiary and contingent beneficiary, benefits will be paid to your estate. If benefits are payable to your estate or to any person who is not competent to give the Company a valid release, the Company has the right to pay up to \$1,000 of those benefits to any person related to you by blood or marriage who the Company believes is justly entitled to such payment. If the Company makes a payment under this provision in good faith, the Company will be released from liability to the extent of the payment.

**PHYSICAL EXAMINATION:** If you make a claim, you or the Covered Person on whose behalf the claim is made must submit to a physical examination as often as the Company may reasonably request. The Company will pay for such examinations.

**LEGAL ACTION:** No legal action can be taken to receive benefits under this Certificate less than 60 days after written proof of loss has been furnished as required or more than 3 years after written proof of loss is required to be furnished.

## SECTION 10 - GENERAL PROVISIONS

**ENTIRE CONTRACT:** The contract is made up of the Policy, the Master Application of the Policyholder, your application attached to this Certificate, Schedule of Benefits, and any attached riders or endorsements.

Statements made by the Policyholder or you, in the absence of fraud, are representations and not warranties. No such statements will be used to void the insurance, reduce benefits or defend a claim under this Certificate unless the statement is in writing; and a copy of that statement is given to you, your beneficiary, or your personal representative.

**CHANGES TO THE ENTIRE CONTRACT:** No changes to the Policy, this Certificate, or any attached riders or endorsements, will be valid unless it is approved by one of the Company's executive officers. The change must be signed by the officer and attached to the Policy and this Certificate. No insurance producer may change the Policy or this Certificate or waive any of its provisions.

**TIME LIMIT ON CERTAIN DEFENSES:** After two years from the Covered Person's Effective Date, no misstatement made in the application, except fraudulent misstatements, will be used to void this Certificate or deny a claim for any loss commencing after the end of the two year period.

No claim for loss incurred during the Pre-Existing Condition Exclusion Period following the Covered Person's Effective Date will be reduced or denied on the ground that a Sickness or physical condition, not excluded from coverage by name or specific description, had existed prior to the Covered Person's Effective Date.

**GRACE PERIOD:** This Certificate has a 31-day grace period for paying premium. This means that if a renewal premium is not paid by the date due, it may be paid during the following 31 days. During the grace period this Certificate will stay in force. If the premium is not paid by the end of the 31 day grace period, your Certificate will terminate as of the date the renewal premium became due.

The Policyholder or you may cancel coverage under this Certificate on any future premium due date or on any date during the Grace Period by writing to the Company. If coverage is canceled on a premium due date, the Grace Period will not apply. If coverage is canceled during the Grace Period and a claim is filed for expenses incurred during the Grace Period for which benefits are payable, the Company will deduct the premium for the Grace Period from the claim payment. This will not further extend the Grace Period.

**UNPAID PREMIUM:** When a claim is paid, any premium due and unpaid may be deducted from the claim payment.

**MISSTATEMENT OF AGE:** If you misstated the age of any Covered Person on your application, the benefits will be based on such Covered Person's correct age. Any difference in premium will be deducted from claims paid and future premiums will be adjusted accordingly. If the Company has accepted a premium on behalf of the person for a period after the date when coverage should have ended, the Company will refund any such premium, but the Company will not pay any claims for services the person received after coverage should have ended.

**CONFORMITY WITH STATE STATUTES:** On the Effective Date, any provision of this Certificate that is in conflict with the laws of the state of issue is amended to meet the minimum requirements of those laws.



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**FOR INQUIRIES OR TO OBTAIN INFORMATION, PLEASE CONTACT:**

2305 Lakeland Drive, Flowood, Mississippi 39232  
Toll Free (800) 256-8606 • Local (601) 936-6600

**SUPPLEMENTAL LIMITED BENEFIT MEDICAL EXPENSE CERTIFICATE OF INSURANCE**

## SCHEDULE OF BENEFITS

### MEDlink® IV - Supplemental Limited Benefit Medical Expense Insurance Plan

#### BENEFIT DESCRIPTION

#### BENEFIT AMOUNT AND LIMITATIONS

##### **Maximum Combined In-Hospital and Outpatient Benefits**

[\$500 to \$10,000] per Covered Person **per Calendar Year** for in-Hospital and outpatient benefits combined. Maximum of [\$1,500-\$30,000] per Calendar Year for all Covered Persons combined.]

##### **MEDLINK® IV BASE POLICY - [BASIC, ENHANCED PLUS]**

##### **Maximum In-Hospital Benefits**

[[ \$500 to \$10,000] per Covered Person **per Calendar Year**. Maximum of [\$1,500-\$30,000] per Calendar Year for all Covered Persons combined /

##### **In-Hospital Deductible**

[\$500 to \$10,000] per Covered Person **per Confinement ]**  
[[ \$0-2500] per Covered Person **per Calendar Year /**  
[\$0-2500] per Covered Person **per Confinement ]**  
[ [Waived for Accident]]

##### **OUTPATIENT BENEFIT RIDER AMDI324APL**

##### **Maximum Outpatient Benefits**

[ [\$0-\$7,500] per Covered Person **per Calendar Year** for Covered Outpatient Services. Maximum of [\$0-\$22,500] per Calendar Year for all Covered Persons combined /

##### **Outpatient Deductible**

[\$0-\$7,500] per Covered Person **Per Calendar Day** for Covered Outpatient Services /

[\$0-\$7,500] per Covered Person **Per Occurrence** for Covered Outpatient Services ]

[ [\$0-\$1,000] per Covered Person **per Calendar Year /**  
[\$0-\$1,000] per Covered Person **Per Calendar Day /**  
[\$0-\$1,000] per Covered Person **Per Occurrence ]**  
[ [Waived for Accident] ]

##### **Covered Outpatient Services** Hospital Emergency Room

##### **Urgent Care Facility**

Maximum of [2-6] Urgent Care visits per Covered Person per Calendar Year. Maximum of [4-12] Urgent Care visits per Calendar Year for all Covered Persons combined

##### **Outpatient Surgery in Hospital Outpatient Facility or Freestanding Outpatient Surgery Center**

##### **Cancer Treatment Facility**

##### **Physical Therapy Facility**

##### **Diagnostic Testing in Hospital Outpatient Facility or MRI Facility**

##### **Outpatient Treatment for a Mental or Emotional Disorder in a Hospital Outpatient Facility**

Maximum of 30 days of treatment per Covered Person per Calendar Year ]

##### **OPTIONAL BENEFIT RIDERS**

##### **PHYSICIAN OUTPATIENT TREATMENT BENEFIT RIDER AMDI325APL**

##### **Treatment in Hospital Outpatient Facility, Freestanding Emergency Care Clinic, Urgent Care Facility/Clinic, or Physician Office**

\$25 per visit; Maximum of 4 visits per Covered Person per Calendar Year, and 8 visits per Calendar Year for all Covered Persons combined] ]



# American Public Life Insurance Company

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## OUTPATIENT BENEFIT RIDER [ENHANCED PLUS PLAN]

We have issued this rider in exchange for and on the basis of your application and payment of the first premium. This rider is a part of the Policy/Certificate to which it is attached. It is subject to all the provisions of the Policy/Certificate that are not in conflict with the provisions of this rider. The rider effective date is shown on the Certificate Schedule. The benefit amounts and Maximum Benefits are shown on the Schedule of Benefits.

### DEFINITIONS

**CANCER** means the autonomous growth (malignancy) in which there is uncontrolled growth, function, or spread (local or distant) of cells in any part of the body.

**CANCER TREATMENT** means the treatment of Cancer at a Cancer Treatment Facility. For the purpose of this rider this does not include supplies or drugs recommended or purchased for use outside of the Cancer Treatment Facility, or routine visits designed to diagnose or prevent the reoccurrence of Cancer (not otherwise covered under this rider).

**CANCER TREATMENT FACILITY** means a facility where the treatment of Cancer is provided on an outpatient basis. This also includes an oncologist's office and a Physician's Office.

**FREESTANDING OUTPATIENT SURGERY CENTER** means a freestanding facility where surgical and diagnostic services are provided on an ambulatory basis. For the purpose of this rider, this does not include a Physician's Office.

**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.

**MAGNETIC RESONANCE IMAGING (MRI) FACILITY** means a freestanding diagnostic imaging facility that provides diagnostic testing using magnetic resonance imaging.

**PHYSICAL THERAPY** means the treatment of physical dysfunction or Injury, at a Physical Therapy Facility, by the use of therapeutic exercise and the application of modalities, intended to restore or facilitate normal function or development. For the purpose of this rider this does not include kinesiology, speech or occupational therapy, or equipment recommended, used or purchased for use outside of the Physical Therapy Facility.

**PHYSICAL THERAPY FACILITY** means an office, center, or clinic in which a licensed physical therapist provides Physical Therapy.

**PHYSICIAN'S OFFICE** means the location in which a Physician routinely, on an appointment basis, provides health examinations, diagnosis and treatment of Sickness or Injury due to an Accident on an ambulatory basis. For the purpose of this rider, this does not include a Hospital, Freestanding Outpatient Surgery Center or Urgent Care Facility.

**URGENT CARE** means necessary medical intervention that is required for a Sickness or Injury that would not result in further disability or death if not treated immediately, but requires professional attention and has the potential to develop such a threat if treatment is delayed longer than 24 hours.

**URGENT CARE FACILITY** means a medical facility or clinic where ambulatory patients can be treated on a walk-in basis, without an appointment, and receive immediate Urgent Care. For the purpose of this rider, this does not include a Physician's Office.

## BENEFITS

**Outpatient Benefits:** In accordance with the Schedule of Benefits, we will pay for Covered Charges incurred by a Covered Person:

- a) if the Covered Person is covered by the Other Medical Plan at the time the Covered Charges are incurred; and
- b) after satisfaction of any Deductible shown on the Schedule of Benefits; and
- c) subject to the Maximum Outpatient Benefits shown on the Schedule of Benefits; and
- d) subject to the Maximum Combined In-Hospital and Outpatient Benefits, if applicable and shown on the Schedule of Benefits.

If the Deductible is on a Per Occurrence basis, and the Covered Person receives more than one Covered Outpatient Service on the same calendar day, only one Deductible will be required to be met.

Benefits payable under this rider are limited to any out-of-pocket deductible, copayment, and coinsurance amounts the Covered Person incurs under the Other Medical Plan for:

- a) outpatient treatment in a Hospital Emergency Room without subsequently being considered an Inpatient; and
- b) outpatient treatment in an Urgent Care Facility; and
- c) Cancer Treatment performed in a Cancer Treatment Facility; and
- d) Physical Therapy performed in a Physical Therapy Facility; and
- e) outpatient surgery performed in a Hospital Outpatient Facility or a Freestanding Outpatient Surgery Center; and
- f) outpatient diagnostic testing performed in a Hospital Outpatient Facility or a Magnetic Resonance Imaging (MRI) Facility; and
- g) outpatient treatment of a Mental or Emotional Disorder performed in a Hospital Outpatient Facility.

**Ambulance Benefit:** We will pay the out-of-pocket amount up to \$350 per trip for ground transportation, or up to \$1,000 per trip for air transportation, of a Covered Person by ambulance to a Hospital or from one medical facility to another where a Covered Person resides less than 18 hours. If the Covered Person is Confined to a Hospital for 18 hours or more, this benefit will be payable under the In-Hospital Benefit in the base Policy. This benefit is limited to one trip per day. A licensed ambulance company must provide the ambulance service. If air and ground ambulance service are both required in the same day, we will only pay the highest benefit amount. This amount is subject to the Maximum Outpatient Benefits shown on the Schedule of Benefits, and the Maximum Combined In-Hospital and Outpatient Benefits, if applicable and shown on the Schedule of Benefits. The Outpatient Deductible does not apply to this benefit.

[



President, Chief Operating Officer ]



# American Public Life Insurance Company

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Toll Free (800) 256-8606 • Local (601) 936-6600

## PHYSICIAN OUTPATIENT TREATMENT BENEFIT RIDER

We have issued this rider in exchange for and on the basis of your application and payment of the first premium. This rider is a part of the Policy/Certificate to which it is attached. It is subject to all the provisions of the Policy/Certificate that are not in conflict with the provisions of this rider. The rider effective date is shown on the Certificate Schedule. The benefit amounts and Maximum Benefits are shown on the Schedule of Benefits.

### 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.

**PHYSICIAN'S OFFICE** means the location in which a Physician routinely, on an appointment basis, provides health examinations, diagnosis and treatment of Sickness or Injury due to an Accident on an ambulatory basis. For the purpose of this rider this does not include a Hospital.

**URGENT CARE** means necessary medical intervention that is required for a Sickness or Injury that would not result in further disability or death if not treated immediately, but requires professional attention and has the potential to develop such a threat if treatment is delayed longer than 24 hours.

**URGENT CARE FACILITY** means a medical facility or clinic where ambulatory patients can be treated on a walk-in basis, without an appointment, and receive immediate Urgent Care.

### BENEFITS

#### PHYSICIAN OUTPATIENT TREATMENT BENEFIT

We will pay the benefit amount shown in the Schedule of Benefits for the professional fee of a Physician incurred by a Covered Person in a Hospital Outpatient Facility, Urgent Care Facility, or Physician's Office, as the result of:

- a) treatment due to Sickness; or
- b) care for an Injury due to an Accident.

The Covered Person must be covered by the Other Medical Plan and not be confined as an Inpatient when such Covered Charges are incurred. Benefits for treatment in a Hospital Emergency Room are excluded under the terms of this Rider.

President, Chief Operating Officer ]



# American Public Life Insurance Company

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## RETIRED EMPLOYEE AMENDMENT RIDER

The Policy or Certificate to which this Rider is attached is hereby amended as follows:

With respect to eligible retirees, all references to Actively at Work and Full-Time Employee in the following Sections do not apply:

- **SECTION 3, DEFINITIONS;** and
- **SECTION 4, ELIGIBILITY AND EFFECTIVE DATE.**

This Rider is subject to all of the provisions of the Policy or Certificate as long as this Rider does not amend them. This Rider will terminate on the same date as the Policy or Certificate to which it is attached.

[

A handwritten signature in black ink, appearing to read 'J. H. Tate'.

President, Chief Operating Officer ]

- SUPPLEMENTAL LIMITED  
BENEFIT MEDICAL EXPENSE  
POLICY APPLICATION  
 PLAN SPONSOR SET-UP



**A member of the American Fidelity Group**  
2305 Lakeland Drive • Flowood, Mississippi • 39232  
Phone: (601) 936-6600 or (800) 256-8606 • Fax: (877) 807-0911

**Home Office Use Only:**

Group Number: \_\_\_\_\_  
Effective Date: \_\_\_\_\_  
No. of Insureds: \_\_\_\_\_  
Guarantee Issue: \_\_\_\_\_  
Take-Over: \_\_\_\_\_  
Setup Date: \_\_\_\_\_

**GENERAL INFORMATION**

1. Plan Sponsor/Policyholder: \_\_\_\_\_  
Mailing \_\_\_\_\_
2. Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
3. Physical Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
(if different than mailing address)
4. Plan Sponsor/Policyholder Contact Name: \_\_\_\_\_  
Contact \_\_\_\_\_
5. Phone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_ E-mail Address: \_\_\_\_\_
6. Tax I.D.#: \_\_\_\_\_ SIC Code: \_\_\_\_\_ Year Established? \_\_\_\_\_
7. Nature of Business: \_\_\_\_\_ Subsidiary & Affiliated Organizations:  No  Yes (attach information)
8. Current Employees are Eligible:  Immediately  After \_\_\_\_\_ Days Employment (Full-Time Employee means \_\_\_\_\_ hours per week.)
9. New Employees are Eligible After \_\_\_\_\_ Days Employment
10. Number of Currently Eligible Employees \_\_\_\_\_ Requested Effective Date \_\_\_\_\_
11. Do you currently have insurance like or similar to the coverage applied for?  Yes  No If "yes", please list type of insurance and carrier(s): \_\_\_\_\_
12. Will the insurance applied for replace any existing insurance?  Yes  No If "yes" list type of insurance, carrier, and termination date: \_\_\_\_\_
13. Will any coverage applied for be offered under a Cafeteria Plan?  Yes  No If "yes" which coverage? (List anniversary date, Plan Administrator, address and phone number.) \_\_\_\_\_
14. Are insureds exempt from: Social Security taxes?  Yes  No Medicare taxes?  Yes  No
15. Are insureds covered under Workers' Compensation?  Yes  No
16. Re-Enrollment frequency:  6 months  1 year  Other \_\_\_\_\_

**BILLING INSTRUCTIONS**

Premium Mode:  Monthly  Semi-Monthly  Bi-Weekly  Weekly  Other \_\_\_\_\_  
 Skip Month:  8/12  9/12  10/12  11/12 Which months Skipped? \_\_\_\_\_

Billing Method:  Paper  Electronic – Email Address: \_\_\_\_\_ Date of 1<sup>st</sup> Deduction: \_\_\_\_\_

Send Billing To: Name \_\_\_\_\_ Phone #: ( ) \_\_\_\_\_  
(List Billing Contact and Address if different than above.)

Billing Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**MEDlink® IV PRODUCT SELECTION**

Voluntary  Plan Sponsor Paid \_\_\_\_\_ % Pre-ex:  apply  credit  waive

**PLAN AND PLAN MAXIMUMS:**

**[ BASIC]**

- Calendar Year In-Hospital Maximum ]  
 Per Confinement In-Hospital Maximum ] ]

**[ ENHANCED PLUS]**

- Combined In-Hospital and Outpatient Benefit Maximums  
Calendar Year In-Hospital, Calendar Year Outpatient ]
- Separate In-Hospital and Outpatient Benefit Maximums  
[ Calendar Year In-Hospital, Calendar Year Outpatient ]  
[ Calendar Year In-Hospital, Per Calendar Day Outpatient ]  
[ Calendar Year In-Hospital, Per Occurrence Outpatient ]  
[ Per Confinement In-Hospital, Per Calendar Day Outpatient ]  
[ Per Confinement In-Hospital, Per Occurrence Outpatient ] ]

**[OPTIONAL RIDERS**

- Physician's Outpatient Treatment Rider ]  
 Retired Employee Amendment Rider ] ]

**BENEFIT AMOUNTS:****In-Hospital Benefit Amount**

\$500    \$1,000    \$1,500    \$2,000    \$2,500    \$3,000    \$3,500    \$4,000    \$4,500    \$5,000  
 \$5,500    \$6,000    \$6,500    \$7,000    \$7,500    \$8,000    \$8,500    \$9,000    \$9,500    \$10,000

**[Outpatient Benefit Amount**

\$0    \$200    \$250    \$500    \$750    \$1,000    \$1,250    \$1,500    \$1,750    \$2,000  
 \$2,250    \$2,500    \$2,750    \$3,000    \$3,250    \$3,500    \$3,750    \$4,000    \$4,250    \$4,500  
 \$4,750    \$5,000    \$5,250    \$5,500    \$5,750    \$6,000    \$6,250    \$6,500    \$6,750    \$7,000  
 \$7,250    \$7,500

**DEDUCTIBLE AMOUNTS:****In-Hospital Deductible**

Per Calendar Year    Per Confinement]   [ Waive for Accident]

\$0    \$500    \$1,000    \$1,500    \$2,000    \$2,500]

**Outpatient Deductible**

Per Calendar Year    Per Calendar Day    Per Occurrence]   [ Waive for Accident]

\$0    \$100    \$250    \$500    \$750    \$1,000 ]

**Minimum standards for MEDlink® IV**

Before any policy takes effect the following minimum standards must be met:

a) Submit a copy of the MEDlink® IV proposal and a summary of the employer's major medical plan to include carrier name and renewal date.

b) Where Holder is an employer and eligible persons

c) Where Holder is a trade association:

are employees:

\_\_\_\_\_ percent of member firms must participate and maintain proper participation

\_\_\_\_\_ employees

\_\_\_\_\_ percent of employees in firm with \_\_\_\_\_ or more employees

\_\_\_\_\_ percent of 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.

**Special Request(s):****EMPLOYER ACKNOWLEDGEMENT IF PLAN IS 100% EMPLOYER PAID**

Thank you for considering American Public Life in planning for the financial security of your employees. We appreciate the opportunity you have given us to present our products to you and them.

In order for your employees to make an informed decision regarding the application for coverage, we have developed a detailed brochure that outlines the provisions of the insurance plan. Please ensure that your employees read the brochure(s) carefully and ask a Company representative any questions they may have regarding information contained in the brochure(s).

Our Company will rely on answers given by your employees on the application for coverage in order to determine if coverage can be issued. Moreover, we have the right to rescind coverage or deny claims based on the failure to provide accurate information at the time of application. If your employees are applying for any coverage that is subject to insurability it may result in additional investigations while the application is being underwritten and at the time of any claim. Any underwriting decision will rely upon the cooperation of medical providers and pro-active assistance from your employees, as the applicant, in obtaining medical information needed to determine eligibility for coverage.

Please remember this group coverage may require your employees to be Actively at Work on that date in order for their coverage to begin. Any health coverage for which your employees apply may have wording that may limit benefits for a preexisting medical condition for which they had treatment, took medication, received a diagnosis, or incurred expense. Any health coverage for which they are applying may also have wording that could limit or reduce their benefits.

**MASTER APPLICATION AGREEMENT**

If this application is approved American Public Life Insurance 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 Policyholder will be returned.

**THE POLICYHOLDER DECLARES** that the statements and answers shown above are true and complete. The Policyholder 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. I hereby request American Public Life Insurance Company to issue the Group Insurance Policy(ies) and Certificates of Insurance for the coverage applied for. I agree to collect and remit premiums for insurance products for the insured (and dependents, if applicable).

**No Insurance is Effective until the Policy and Certificates are actually issued and then only from the Effective Date.**

**Plan is 100% Employer Paid**      Please acknowledge that Brochure(s) APSB \_\_\_\_\_  
has been explained to you and that you will distribute copies of the brochure(s) to your employees by signing below.

\_\_\_\_\_  
Signature of Plan Sponsor Official

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

\_\_\_\_\_  
Agent Signature

\_\_\_\_\_  
Agent Number

Employer groups may be subject to certain State and/or Federal Employment related laws (including ERISA, IRS Sections 89 and 125, and COBRA) and is solely responsible for compliance of these laws including any required benefit payments not covered by an insurance plan.

**FRAUD WARNING**

**Warning:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes a claim for the proceeds of an insurance policy containing any false, incomplete or misleading information or knowingly presents false information in an application for insurance may be guilty of insurance fraud.

GMLIV11APLMAAR

FOR AGENT USE ONLY:

Requested Effective Date: \_\_\_\_\_

- New Enrollment
- Family Status Change
- Benefit Change



# American Public Life Insurance Company

A member of the American Fidelity Group®

2305 Lakeland Drive • Flowood, Mississippi 39232  
Phone: (601) 936-6600 or (800) 256-8606  
Fax: (601) 936-2157

FOR HOME OFFICE USE ONLY:

Effective Date: \_\_\_\_\_

Group #: \_\_\_\_\_

## Group MEDlink® Enrollment Form

### PROPOSED INSURED'S INFORMATION

	Last Name	First Name	MI	Sex	Birthdate Mo/Day/Yr	Age	Height Feet/Inches	Weight Lbs.	Social Security #
Applicant				<input type="checkbox"/> M <input type="checkbox"/> F					
Spouse				<input type="checkbox"/> M <input type="checkbox"/> F					
Child 1				<input type="checkbox"/> M <input type="checkbox"/> F					
Child 2				<input type="checkbox"/> M <input type="checkbox"/> F					
Child 3				<input type="checkbox"/> M <input type="checkbox"/> F					
Child 4				<input type="checkbox"/> M <input type="checkbox"/> F					

Resident Address: Number & Street City State Zip Home Phone Email Address

Mailing Address: (if different) Number & Street City State Zip

Are all proposed insureds covered under the Employer's major medical plan?  Yes  No

### MASTER POLICYHOLDER

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Work Phone: \_\_\_\_\_  
Employment Date: \_\_\_\_\_

### BENEFICIARY INFORMATION

Primary \_\_\_\_\_ Relationship \_\_\_\_\_  
Contingent \_\_\_\_\_ Relationship \_\_\_\_\_

### CITIZENSHIP INFORMATION

Is/Are the person(s) to be insured and the beneficiary(ies) a citizen of the United States?  Yes  No (If No, give details.)

Full Name Country of Citizenship Permanent VISA (resident) card # or application receipt #

### PRODUCT SELECTION

MEDlink® IV Group Supplemental Limited Benefit Medical Expense Insurance Total Premium \$

### FRAUD WARNINGS

**Warning:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes a claim for the proceeds of an insurance policy containing any false, incomplete or misleading information or knowingly presents false information in an application for insurance may be guilty of insurance fraud. In KY and OH: Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or application containing any false, incomplete, or misleading information concerning a material fact is guilty of insurance fraud (in KY: which is a crime). In LA, ME, MA, NJ, and TN: Any person who knowingly presents 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 (in NJ: civil fines and criminal penalties.) fines and confinement in prison (in ME and TN: and denial of insurance benefits).

### SIGNATURE AND ACKNOWLEDGMENT

I have received and reviewed the outline of coverage, if applicable, and a copy of consumer brochure(s) # APSB  
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. ANY CHANGE REQUIRES WRITTEN NOTICE. All statements and answers in this application are complete, true and correct and are made as a consideration of the insurance herein applied for. I understand and agree that no coverage will take effect, until a Certificate is issued. I understand that this coverage will not become effective or remain in effect for any person to be covered who is not also covered under your Employer's major medical or comprehensive medical policy, which includes managed care.

Signed At (City and State) \_\_\_\_\_ Date \_\_\_\_\_

Signature of Applicant \_\_\_\_\_

### AGENT STATEMENT

Signature of Licensed Agent \_\_\_\_\_ Agent's Printed Name and Agent Number \_\_\_\_\_

**MATERIAL OMISSIONS OR MISSTATEMENTS IN THIS APPLICATION MAY VOID INSURANCE.**

SERFF Tracking Number: AFDL-127354528 State: Arkansas  
 Filing Company: American Public Life Insurance Company State Tracking Number: 49631  
 Company Tracking Number: MEDLINKIV  
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other  
 Product Name: MedlinkIV  
 Project Name/Number: MedlinkIV/MedlinkIV

## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Flesch Certification	Approved-Closed	08/30/2011
<b>Comments:</b>		
<b>Attachment:</b> FleschCert_AR.pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Application	Approved-Closed	08/30/2011
<b>Comments:</b> See Forms Schedule for new master application and employee application.		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Health - Actuarial Justification	Approved-Closed	08/30/2011
<b>Comments:</b>		
<b>Attachment:</b> MEDlink IV Actuarial - AR.pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b> Outline of Coverage	Approved-Closed	08/30/2011
<b>Bypass Reason:</b> N/A		
<b>Comments:</b>		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b> PPACA Uniform Compliance Summary	Approved-Closed	08/30/2011
<b>Bypass Reason:</b> Not a PPACA filing.		
<b>Comments:</b>		

SERFF Tracking Number: AFDL-127354528 State: Arkansas  
Filing Company: American Public Life Insurance Company State Tracking Number: 49631  
Company Tracking Number: MEDLINKIV  
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other  
Product Name: MedlinkIV  
Project Name/Number: MedlinkIV/MedlinkIV

**Item Status:** Approved-Closed  
**Status Date:** 08/30/2011  
**Satisfied - Item:** Thrid-Party Authorization  
**Comments:**  
**Attachment:**  
2011\_Authorization.pdf

**Item Status:** Approved-Closed  
**Status Date:** 08/30/2011  
**Satisfied - Item:** Statement of Variability  
**Comments:**  
**Attachment:**  
MLIV\_SOVAR.pdf



# American Fidelity Assurance Company

A member of the American Fidelity Group®

## READABILITY CERTIFICATION

I, Michelle Lynch, hereby certify that policy forms enclosed on the Forms filing tab meet the minimum reading ease score required by the Insurance Code in your state. The Flesch Score for each form, excluding medical terminology, defined terms, and state mandated language, is shown on the Forms Schedule Tab.

For AR and VA: the word count is:

GMLIV11APL Supplemental Limited Benefit Medical Expense Insurance Policy is 5019.

GMLIV11APLC Supplemental Limited Benefit Medical Expense Insurance Certificate is 4950.

AMD1324APL Outpatient Benefit Rider is 745.

AMD1325APL Physician Outpatient Treatment Benefit Rider is 320.

AMD1327APL Retired Employee Amendment Rider is 91.

GMLIV11APLA Enrollment Application is 296.

GMLIV11APLMA Master Application is 1048.

A handwritten signature in black ink that reads 'Michelle Lynch'.

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Michelle Lynch  
Assistant Vice President and Compliance Manager

August 5, 2011

Date



# American Public Life Insurance Company

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

January 10, 2011

NAIC Number: 60801  
FEIN Number: 64-0349942

To Whom It May Concern:

American Fidelity Assurance Company, located at 2000 N. Clasen 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®

## STATEMENT OF VARIABILITY

The **MEDlink IV Policy et. seq.** contains variable information. All forms are completed in John Doe format and variable items are enclosed in brackets [ ]. The ranges for all variable items are shown within the brackets. All variable items will become fixed at time of policy approval. Any changes made to these items will be limited to new issues.

1. The signatures on the documents for the Company have been marked variable.

### **Policy Schedule and Certificate Schedule (Page 3)**

2. The Policy/Certificate Number is the unique identifier our company assigns to the policy/certificate at time of issue.
3. The Insured's name is the name of the Insured as it appears on the application for insurance. The format will be first name followed by last name.
4. The Effective Date is the date the policy/certificate goes into effect. This is the date the first premium is due; and is the date from which policy/certificate years, premium due dates, and policy/certificate anniversaries will be determined. Possible formats include: 1/1/08; 01/01/2008; January 1, 2008; or Jan 1, 2008.
5. The Issue Age is the Insured's age at time of issue.
6. The Plan Selected variables are Employee, Employee and Spouse, Employee & Child or Employee and Family.
7. The Premium Mode variables are Annual, Semi-Annual, Quarterly, Monthly or Skip Month.
8. The Plan Description Section on the Policy will list the options available to the Policyholder. The Plan Description Section on the Certificate will list the options the Certificateholder has chosen.
9. The Pre-Existing Period and Pre-Existing Condition Exclusion Period will range from 0-12 months.
10. The total premiums will be shown in 4 columns if the premium mode elected is monthly, quarterly, semi-annual or annual. The appropriate premiums will be displayed beginning with Annual and follow in chronological order, ending with Monthly.

If a Special Modal premium is elected to coincide with payroll deduction requirements. The total premiums will be displayed in 5 columns if the premium method elected is a skip month premium. The columns will be displayed as listed above with the exception of ending with Monthly. The skip month mode will be shown as column 5. The column heading will be: Special Modal. In addition to the 5<sup>th</sup> column, a paragraph will print directly under the Total Premium By Mode describing the Special Modal Premium. The paragraph will state, "\*\*SPECIAL MODAL PREMIUM IS THE MONTHLY PREMIUM ADJUSTED TO COINCIDE WITH CERTAIN PAYROLL DEDUCTION REQUIREMENTS."

**Master Application, Schedule of Benefits, Outline of Coverage (if applicable)**

11. The Company has not decided what marketing name they wish to use for the three available selections. For the purpose of this SOV and the documents we will refer to them as [Basic, and Enhanced Plus Plans]. While these marketing names may change, the combination of benefit/riders will remain unchanged:  
Basic Plan = the base policy only  
Enhanced Plus Plan = the base policy and Rider AMDI324APL.  
The benefit plan will be chosen at the policyholder level on the master application.
12. We are offering two optional benefit riders, which may also be attached to these plans: the AMDI325APL Physician Outpatient Treatment Rider and the AMDI327APL Retired Employees Amendment Rider.
13. The selections available on the GMLIV11APLMA Master Application, will be driven by the needs of our market. The range for all variable items are included on the GMLIV11APLMA. Although we are requesting approval of all the ranges listed on the application, the company may decide to market only a few of those options at this time. Any changes made to these options will be limited to new issues. We have designed this plan to meet the flexibility needs of our customers. Therefore, in addition to the benefit/deductible amounts the policyholder will elect on the Master Application, the policyholder will also be able to elect the benefit structure. Available options are as follows:
- (a) the In-Hospital Deductible ranges from \$0-\$2,500 in \$500 increments. If an In-Hospital Deductible is elected, the policyholder must elect how they want to structure the In-Hospital Deductible. We are currently offering 2 options: a per calendar year deductible or per confinement deductible. They may also elect to have this deductible waived for accidents;
  - (b) the range for the Outpatient Deductible is \$0, \$100, \$250, \$500, \$750 or \$1,000. If an Outpatient Deductible is elected, the policyholder must elect how they want to structure the Outpatient Deductible. We are currently offering 2 options: a per calendar year deductible or per occurrence deductible. They may also elect to have this deductible waived for accidents.
  - (c) If the policyholder elects the Enhanced Plus plan, they will also need to decide the structure of the inpatient and outpatient benefits. We are offering two choices: 1) a combined maximum and 2) a separate maximum:
    - 1. if a combined maximum is elected, the In-Hospital and Outpatient and Combined Maximums will all be on a calendar year basis;
    - 2. if a separate maximum is elected, the policyholder must choose whether they want: 1) a calendar year In-Hospital and Outpatient maximum, 2) a calendar year In-Hospital and Per Calendar Day Outpatient maximum, 3) a calendar year In-Hospital and Per Occurrence Outpatient maximum, 3) a Per Confinement In-Hospital and Per Calendar Day Outpatient benefit, or 4) a Per Confinement In-Hospital and Per Occurrence Outpatient benefit.
14. The Schedule of Benefits, Certificate Schedule and Policy Schedule will reflect the choices selected by the policyholder.



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Shari Vick  
Compliance Analyst Team Leader

8/1/11  
Date