Hospital
MEDlink @ APL ™

SAMPLE

Certificate of Insurance

Underwritten by:

AMERICAN PUBLIC LIFE INSURANCE COMPANY
A member of the American Fidelity Group

2305 Lakeland Drive, Flowood, Mississippi 39232

SAMPLE

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call American Public Life Insurance Company's toll-free telephone number for information or make a complaint at:

1-800-256-8606

You may also write to American Public Life Insurance Company at:

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

You may contact the Texas Department of Insurance to obtain information on companies, coverage, rights or complaints at:

1-800-252-3439

You may write the Texas Department of Insurance at:

P.O. Box 149104
Austin, TX 78714-9104
FAX# (512) 475-1771

PREMIUM OR CLAIM DISPUTES: Should you have a dispute concerning your premium or about a claim, you should contact American Fidelity first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY: This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para obtener informaci∴n o para someter una queja:

Usted puede llamar al nδmero de telϑfono gratis de American Public Life Insurance Company para informaci∴n o para someter una queja al:

1-800-256-8606

Usted tambien puede escribir a American Public Life Insurance Company:

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

Puede communicarse con el Departamento de Seguros de Texas para obtener informaci∴n acerca de compaZias, coberturas, derechos o quejas al:

1-800-252-3439

Puede escribia al Departamento de Seguros de Texas

P.O. Box 149104
Austin, TX 78714-9104
Fax# (512) 475-1771

DISPUTAS SOBRE PRIMAS O RECLAMOS: Si tiene una disputa concerniente a suprima o a un reclamo, debe comunicarse con American Fidelity Assurance Company primero. Si no se resuelve la disputa, puede entonces comunicarse con el Departamento de Seguros de Texas.

UNA ESTE AVISO ASUPOLIZA: Este aviso es s∴lo para prop∴sito de informaci∴n y no se convierte en parte o condici∴n del documento adjunto.

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

CERTIFICATE OF INSURANCE

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

This Certificate describes the benefits and provisions of the group Policy and becomes Your Certificate of insurance only if:
(1) You are eligible for the insurance (see ELIGIBILITY on Schedule of Benefits);
(2) You are on Active Service on the date it is to take effect; and
(3) You become insured and remain insured in accordance with all of the provisions of the Policy.

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

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

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

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

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Chief Administrative Officer | President, Chief Executive Officer

PLEASE READ YOUR CERTIFICATE CAREFULLY.
THE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED PROVIDES LIMITED BENEFITS AND IS DESIGNED TO SUPPLEMENT OTHER INSURANCE COVERAGE.
THIS COVERAGE SHOULD NOT BE REPRESENTED AS YOUR PRIMARY COVERAGE.
ALL BENEFITS ARE PAYABLE DIRECTLY TO YOU.

THIS IS NOT A POLICY OF WORKER'S COMPENSATION INSURANCE. THE EMPLOYER DOES NOT BECOME A SUBSCRIBER TO THE WORKER'S COMPENSATION SYSTEM BY PURCHASING THIS POLICY, AND IF THE EMPLOYER IS A NON - SUBSCRIBER, THE EMPLOYER LOSES THOSE BENEFITS WHICH WOULD OTHERWISE ACCRUE UNDER THE WORKER'S COMPENSATION LAW AS IT PERTAINS TO NON - SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.

Warning: Any person who knowingly, and with the intent to defraud or knowing that they are facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

TABLE OF CONTENTS

Schedule of Benefits

Section 1 .... Defined Terms

Section 2 .... Eligibility and Effective Date

Section 3 .... What We Will Pay

Section 4 .... What We Will Not Pay

Section 5 .... When Coverage Ends

Section 6 .... Premiums

Section 7 .... General Policy Provisions

Section 8 .... How To File A Claim / Claim Provisions

Application

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Certificate of Insurance
Policy GC-MEDlink

Medical Expense Supplement Insurance Plan

Certificate Number: Effective Date:

Policyholder:

Policy Number:

Type of Coverage: Individual Premium:

Age of Primary Insured:

Method of Payment: Frequency:

SCHEDULE OF BENEFITS

ELIGIBILITY: All active full-time employees who are:
(a) working hours or more per week;
(b) covered under Another Medical Plan; and
(c) under age 70. (This limit does not apply if you work for an employer employing 20 or more employees on a typical workday in the preceding Calendar Year.)

Benefit Description	Benefit Amount	Premium
MAXIMUM IN-HOSPITAL BENEFIT:	$ per confinement	
MAXIMUM OUTPATIENT BENEFIT: ● Treatment in Hospital Emergency Room ● Outpatient Surgery in Hospital Outpatient Facility or Free-Standing Outpatient Surgery Center ● Diagnostic Testing in Hospital Outpatient Facility or MRI Facility	Up to $ for treatment of the same or related conditions, unless separated by a period of 90 consecutive days. Then a new Outpatient Benefit will be payable.	
PHYSICIAN OUTPATIENT TREATMENT BENEFIT: Treatment in Hospital Outpatient Clinic, Free-Standing Emergency Care Clinic or Physician Office	$ per treatment; $ maximum per family per Calendar Year	
PRE-EXISTING PERIOD:		
PRE-EXISTING CONDITION EXCLUSION PERIOD: 12 Months		

TOTAL PREMIUMS

Insured:

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Section 1
DEFINED TERMS

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

Accident means sudden, unexpected and unintended injury:
(a) which is independent of any Sickness;
(b) over which the Covered Person has no control; and
(c) that takes place while the Covered Person's coverage is in force.

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

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

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

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

Covered Charges means those charges described in Section 3 that:
(a) are incurred by a Covered Person because of an Accident or Sickness;
(b) are for necessary treatment, services and medical supplies and recommended by a Physician;
(c) are not more than any dollar limit set forth in the Schedule;
(d) are incurred while insured under the Policy, subject to any Extension of Benefits; and
(e) are not excluded under Section 4.

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

Dependent means Your:
(a) married spouse who is under age 70 and who lives with You; or
(b) unmarried child (natural, step or adopted) who is not eligible for medical coverage as an Insured under the Policy and who:
  (1) is less than 19 years old and who lives with You; or
  (2) is less than 23 years old and going to an accredited school full time. Such child must be dependent on You for principal support and maintenance; or
  (3) becomes incapable of self-support because of mental retardation or physical handicap while covered under the Policy and prior to reaching the limiting age for dependent children. The child must be dependent on You for support and maintenance. We must receive proof of incapacity within 31 days after coverage would otherwise terminate. Coverage will then continue as long as Your insurance stays in force and the child remains incapacitated. Additional proof may be required from time to time but not more often than once a year after the child attains age 23; or
  (4) is not living with You, but You are legally required to support such child, and the child would otherwise qualify under (1), (2), or (3) above.

The term Dependent does not include:
(a) Your grandchild (unless required by law); or
(b) a child who engages for compensation, profit or gain in any employment or business for 30 or more hours per week, unless such child is a full-time student as described in (b)(2) above.

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

Hospital means a licensed institution that:
(a) has on its premises:
   (1) laboratory, x-ray equipment and operating rooms where major surgical operations may be performed by licensed Physicians;
   (2) permanent and full-time facilities for the care of overnight resident bed patients under the supervision of a licensed Physician;
   (3) 24-hour-a-day nursing service by graduate registered nurses; and
   (4) the patient's written history and medical records;
   or:
(b) is accredited by the Joint Commission on Accreditation of Hospitals.

The term Hospital shall not include any institution used by the Covered Person as:
(a) a place for rehabilitation;
(b) a place for rest, or for the aged;
(c) a nursing or convalescent home;
(d) a long term nursing unit or geriatrics ward; or
(e) an extended care facility for the care of convalescent, rehabilitative or ambulatory patients.

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

Insured (You, Your) means any person who is eligible for insurance under Section 2 and is insured under the Policy by virtue of:
(a) employment by the Policyholder; or
(b) employment by a Subscribing Unit; or
(c) membership in and employment by the association or Subscribing Unit, if the Policy is issued to an association.

Other (or **Another) Medical Plan** means any basic Major Medical or Comprehensive Medical policy which includes managed care and through which a Covered Person has coverage. The term Other Medical Plan does not include CHAMPUS.

Physician means a practitioner of the healing arts who:
(a) is practicing within the scope of his or her license in the state where so licensed; and
(b) is not related to the Covered Person.

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

Policyholder means the association, employer, or trustee who holds the Policy.

Pre-Existing Condition means a disease, Accident, Sickness, or physical condition for which the Covered Person:
(a) had treatment;
(b) incurred expense;
(c) took medication; or
(d) received a diagnosis or advice from a Physician;

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

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

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

Subscribing Unit means an employer, or an employer who is a member of an association, who has elected in writing to participate in the coverage under the Policy.

Total Disability (or **Totally Disabled)** means You are prevented from performing the material and substantial duties of Your occupation. For Dependents, "Totally Disabled" means the inability to perform a majority of the normal activities of a person of like age in good health.

Section 2
ELIGIBILITY AND EFFECTIVE DATE

Your Eligibility: If You:
(a) are on Active Service as an employee of the Policyholder, or as a member or employee of a member of the Policyholder, You are eligible to be insured under the Policy;
(b) qualify as an eligible Insured, as defined in the Policyholder's application, You are eligible to be insured under the Policy; and,
(c) meet the definition of Eligibility, as stated in the Schedule, You are eligible to be insured under the Policy.

Evidence of coverage under Another Medical Plan may be required.

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

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

Dependent Eligibility: If Dependent coverage is available under the Policy, You will be eligible for such coverage on:
(a) the day You become eligible for coverage; or
(b) the day You acquire Your first Dependent;

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

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

Dependent Effective Date: The Effective Date of coverage for each eligible Dependent will be the first of the month following:
(a) Our acceptance of the application; and
(b) receipt of the first premium.

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

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A newborn child will become covered for Accident and Sickness automatically on the day he or she is born as long as Your coverage was in force on that date. Accident or Sickness includes prematurity, congenital defects and birth abnormalities of a newborn child. The newborn child's coverage will not continue past the 31-day period following his or her birth unless:
(a) We are notified by the end of the 31-day period of the addition of such newborn child; and
(b) any applicable additional premium is paid.

Coverage for newborn children will also include coverage for:
(a) a newly-born child adopted by You, from the moment of birth, if a petition for adoption was filed within 31 days of the birth of the child; and
(b) a child adopted by You from the date of petition for adoption.

Coverage for the adopted child will not continue past 31 days after the date of filing of the petition unless:
(a) We are notified by the end of the 31-day period of the addition of such adopted child; and
(b) any applicable additional premium is paid.

In all other instances, if a Dependent is Totally Disabled on the date coverage (with respect to that particular Dependent) would otherwise take effect, the coverage of that Dependent will be deferred until the first of the month following the Dependent's cessation of Total Disability.

SAMPLE

Section 3
WHAT WE WILL PAY

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

Benefits payable are limited to:
(a) any out-of-pocket deductible amount;
(b) any out-of-pocket co-payment or coinsurance amounts the Covered Person actually incurs after the Other Medical Plan has paid;
(c) any out-of-pocket amount the Covered Person actually incurs for surgery performed by a Physician after the Other Medical Plan has paid; and
(d) the Maximum In-Hospital Benefit shown in the Schedule.

Outpatient Benefits: We will pay benefits, as shown on the Schedule, for Covered Charges incurred by a Covered Person if:
(a) the Covered Person is covered by Another Medical Plan when such Covered Charges are incurred, except as provided in the Absence of Other Medical Plan provision, described in this Section;
(b) such Covered Charges are for:
    (1) treatment in a Hospital emergency room without the Covered Person subsequently being considered an Inpatient;
    (2) surgery performed in a Hospital outpatient facility or a free-standing outpatient surgery center; or
    (3) diagnostic testing performed in a Hospital outpatient facility or a magnetic resonance imaging (MRI) facility.

Physician Outpatient Treatment Benefit: We will pay the benefit shown on the Schedule if a Covered Person incurs Covered Charges as the result of:
(a) treatment due to Sickness; or
(b) emergency care for an injury due to an Accident

by a Physician if:
(1) the Covered Person is covered by Another Medical Plan when such Covered Charges are incurred; and
(2) such Covered Expense is incurred while the Covered Person is not an Inpatient.

Absence of Other Medical Plan: In the event a Covered Person has no Other Medical Plan in force when out-of-pocket expense is incurred:
(a) benefits will be derived using the Assumed Other Medical Plan, as described below; and
(b) coverage under the Policy will be terminated for such Covered Person, and any other person in the same family unit whose Other Medical Plan coverage is not in effect. Such Covered Person(s) will not be entitled to any Extensions or Continuations described in Section 5, except COBRA Continuation, where applicable.

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

SAMPLE

Section 4
WHAT WE WILL NOT PAY

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

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

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Section 5
WHEN COVERAGE ENDS

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

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

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

We may end the coverage of a Subscribing Unit if fewer persons are insured than the Policyholder's application requires.

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

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

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

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

Continuation of Coverage During a Sabbatical Leave: Coverage for You and Your covered Dependent(s) may be continued during Your Sabbatical Leave:
(a) until the date Your Sabbatical Leave ends; or
(b) for up to 12 months, whichever is earlier.

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

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

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

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

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

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

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

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

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

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Section 6
PREMIUMS

The first premium is due on or before the Effective Date of Your Coverage. Thereafter, premiums are due on or before the premium due date. Premiums may be remitted to :
(a) Our Home Office; or
(b) an authorized agent of Ours.

The premium rates may be changed by Us. If the rates are changed, We will give You at least 31 days advance written notice. If a change in benefits increases Our liability, premium rates may be changed on the date Our liability is increased.

Section 7
GENERAL POLICY PROVISIONS

Entire Contract-Changes: The entire contract shall include:
(a) the Policy;
(b) the application of the Policyholder;
(c) Your application, attached to the Certificate: and
(d) all endorsements and amendments.

Statements made by the Policyholder or You are representations and not warranties, if fraud was not intended. (The words "if fraud was not intended" do not apply in Georgia or North Carolina.) No such statements will be used to avoid the insurance, reduce benefits, or defend a claim under the Policy unless:
(a) the statement is in writing; and
(b) a copy of that statement is given to You or Your beneficiary.

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

Time Limit on Certain Defenses: After two years from the Effective Date of coverage for a Covered Person, no statements in the application, except fraudulent misstatements, can be used to:
(a) avoid the coverage; or
(b) deny a claim for loss incurred that starts after such two-year period.

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

The Policyholder, Subscribing Unit, or You may, by writing to Us, cancel the coverage under the Policy:
(a) on any future premium due date; or
(b) on any date during the Grace Period.

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

Legal Actions: No legal action may be brought to recover under the Policy:
(a) within 60 days after written proof of loss has been furnished as required; or
(b) more than three (3) years from the time written proof of loss is required to be furnished (five (5) years in Kansas, six (6) years in South Carolina).

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

Certificates: We will supply You a Certificate. This Certificate will describe:
(a) the insurance benefits;
(b) to whom benefits will be paid;
(c) any limitations of the Policy; and
(d) all other essential features of the Policy.

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

SAMPLE

Section 8
HOW TO FILE A CLAIM / CLAIM PROVISIONS

You should notify Us, in writing, within 30 days (60 days in Kentucky) You or one of Your covered Dependents incurs a loss covered by the Policy. (If it is not reasonably possible to give notice within this time period, Your claim will not be denied or reduced due to the delay.) Send Your written notice to Us at the following address:

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

Use a claim form for filing proof of loss. We will send You claim forms within 15 days (10 days in Georgia) after We receive Your notice of a claim. If We do not supply You claim forms within this stated period of time, You can give proof by sending, in writing, a description of the loss regarding the nature and extent of the loss. Proof of loss must be given to Us within 90 days after the loss. We will accept late proof if:
(a) it was not reasonably possible to give proof in that time; and
(b) the proof is given within one (1) year from the date of loss. This one (1) year limit will not apply in the absence of legal capacity.

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

Time of Payment of Claims: Benefits for a covered loss will be paid as soon as We receive written proof of loss.

Payment of Benefits: All benefits will be paid to You. Benefits payable under the Policy are not assignable to providers of services and supplies.

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

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

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STATEMENT OF ERISA RIGHTS

As a participant in the Plan, You are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

(a) examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all Plan documents, including insurance contracts and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.

(b) obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

(c) receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

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

Under ERISA, there are steps You can take to enforce the above rights. For instance, if You request materials from the Plan and do not receive them within 30 days, You may file suit in a federal court. In such case, the court may require the Plan Administrator to provide the materials and pay You up to $110 a day until You receive the materials, unless the materials were not sent to You because of reasons beyond the control of the Plan Administrator. If You have a claim for benefits which is denied or ignored, in whole or in part, You may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if You are discriminated against for asserting Your rights, You may seek assistance from the U.S. Department of Labor, or You may file suit in a federal court. The court will decide who should pay court costs and legal fees. If You are successful, the court may order the person You have sued to pay these court costs and fees. If You lose, the court may order You to pay these costs and fees, for example, if it finds Your claim frivolous.

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

SAMPLE

NOTICE OF THE RIGHT TO APPEAL

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

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

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

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

SAMPLE

IMPORTANT INFORMATION ABOUT COVERAGE UNDER THE TEXAS LIFE, ACCIDENT, HEALTH AND HOSPITAL SERVICE INSURANCE GUARANTY ASSOCIATION

Texas law establishes a system, administered by the Texas Life, Accident, Health and Hospital Service Insurance Guaranty Association (the "Association"), to protect policyholders if their life or health insurance company fails to or cannot meet its contractual obligations. Only the policyholders of insurance companies which are members of the Association are eligible for this protection. However, even if a company is a member of the Association, protection is limited and policyholders must meet certain guidelines to qualify. (The law is found in the *Texas Insurance Code*, Article 21.28-D.)

BECAUSE OF STATUTORY LIMITATIONS ON POLICYHOLDER PROTECTION, IT IS POSSIBLE THAT THE ASSOCIATION MAY NOT COVER YOUR POLICY OR MAY NOT COVER YOUR POLICY IN FULL.

Eligibility for Protection by the Association

When an insurance company which is a member of the Association is designated as impaired by the Texas Commissioner of Insurance, the Association provides coverage to policyholders who are:

- **residents of Texas** at the time that their insurance company is impaired
- **residents of other states,** ONLY if the following conditions are met:
  1) The policyholder has a policy with a company based in Texas;
  2) The company has never held a license in the policyholder's state of residence;
  3) The policyholder's state of residence has a similar guaranty association; and
  4) The policyholder is *not eligible* for coverage by the guaranty association of the policyholder's state of residence.

Limits of Protection by the Association

Accident, Accident and Health, or Health Insurance:

- up to a total of $200,000 for one or more policies for each individual covered.

Life Insurance:

- net cash surrender value up to a total of $100,000 under one or more policies on any one life; or
- death benefits up to a total of $300,000 under one or more policies on any one life.

Individual Annuities:

- net cash surrender amount up to a total of $100,000 under one or more policies owned by one contractholder.

Group Annuities:

- net cash surrender amount up to $100,000 in allocated benefits under one or more policies owned by one contractholder; or
- net cash surrender amount up to $5,000,000 in unallocated benefits under one contractholder regardless of the number of contracts.

THE INSURANCE COMPANY AND ITS AGENTS ARE PROHIBITED BY LAW FROM USING THE EXISTENCE OF THE ASSOCIATION FOR THE PURPOSE OF SALES, SOLICITATION, OR INDUCEMENT TO PURCHASE ANY FORM OF INSURANCE.

When you are selecting an insurance company, you should not rely on coverage by the Association.

Texas Life, Accident, Health and Hospital
Service Insurance Guaranty Association
301 Congress, Suite 500
Austin, Texas 78701
800-982-6362

Texas Department of Insurance
P.O. Box 149104
Austin, Texas 78714-9104
800-252-3439

(THIS FORM IS NOT A PART OF YOUR CONTRACT)

SAMPLE