American Public Life Insurance Company

A member of the American Fidelity Group

Dear Customer:

Thank you for giving American Public Life Insurance Company the opportunity to help serve your insurance needs. We appreciate having you as a customer, and congratulate you on your wise decision to protect yourself and your family with this coverage.

It is important that you read the enclosed policy or policy certificate and any amendments attached very carefully. American Public Life wants our customers to know and understand the coverage that they have with our company. After reading your policy if you have any questions or need assistance in understanding your coverage or assistance with filing a claim please call our office toll free at 1-800-256-8606 and speak to one of our Customer Service Representatives. We also invite you to visit our website at www.ampublic.com.

Notice for insureds living in a community property state (Alaska, Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Puerto Rico, Texas, Washington, Wisconsin):

If you have designated a beneficiary other than your spouse, we may be required to pay a portion of the proceeds to your spouse at the time of your death, unless your spouse has signed a spousal waiver form. To obtain a spousal waiver form, please visit our Web site at www.ampublic.com, or call toll-free a Customer Service Representative at 1-800-256-8606. If you are calling local from the Jackson, Mississippi area, you may call 601-936-6600.

We appreciate your business and look forward to serving your insurance needs.

Sincerely,

Sharon Starnes
Vice President-Customer Service
AMERICAN PUBLIC LIFE INSURANCE COMPANY

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 cancelation. 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

SECTION 2 - CERTIFICATE SCHEDULE

Policyholder:	TULSA FOP 93 HEALTH AND WELFARE TRUST	Policy Number:	14555
Certificate Number:		Certificate Effective Date:	07-01-2013
Insured:		Insured's Issue Age:	
Plan Selected:		Premium Mode	

MEDLINK® IV
SUPPLEMENTAL LIMITED BENEFIT MEDICAL EXPENSE INSURANCE PLAN DESCRIPTION

	EFFECTIVE DATE	MONTHLY PREMIUM
MEDLink® IV POLICY – Enhanced Plan		$
Outpatient Benefit Rider AMDI323APL	07-01-2013	
OPTIONAL BENEFIT RIDER		
Physician Outpatient Treatment Benefit Rider AMDI325APL	07-01-2013	
Retired Employee Amendment Rider AMDI327APL		
	TOTAL PREMIUM:	$

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

*** This Pre-Existing Condition Limitation will be imposed only if the pre-existing condition limitation under the Other Medical Plan is imposed.**

TOTAL PREMIUM BY MODE

ANNUAL	SEMI-ANNUAL	QUARTERLY	MONTHLY

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 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 2-year period following the child's attainment of the limiting age. 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.

PLACEMENT (or PLACED) FOR ADOPTION: For purposes of this Certificate, Placement For Adoption means the assumption by you of physical custody of the child to be adopted and the financial support and care of the child.

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

Eligible persons may be added to the group originally insured under the Policy from time to time, according to the eligibility requirements described in this provision.

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 31-day period following his or her birth unless: the Company is notified in writing by the end of the 31-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 31 days of the birth of the child; and a child adopted by you from the date of Placement For Adoption. Coverage shall terminate upon the dismissal or denial of a petition for adoption. Coverage for the adopted child will not continue past 31 days after the date of Placement For Adoption unless: the Company is notified in writing by the end of the 31-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 Placement For Adoption. 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.

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 any act related to war while serving in the military forces or any auxiliary unit attached thereto; (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. routine newborn care, including routine nursery charges;
6. 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
7. where medical complications have arisen from abortion;
8. pregnancy of a Eligible Dependent child, except for complications of pregnancy;
9. 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.)
10. 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.)
11. participation in a contest of speed in power driven vehicles, parachuting, or hang gliding;

12. 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;
13. 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.)
14. alcoholism or drug addiction;
15. sex changes;
16. experimental treatment, drugs, or surgery;
17. 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.)
18. 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.
19. routine examinations, such as health exams, periodic check-ups, or routine physicals;
20. elective cosmetic surgery;
21. drugs (prescription and non-prescription for use outside of a covered facility as defined in this Certificate or any attached rider);
22. sterilization and reversal of sterilization;
23. an expense that does not meet the definition of Covered Charges;
24. an expense or service that exceeds any of the Maximum Benefits, as shown on the Schedule of Benefits; or
25. any expense for which benefits are not payable under 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.

EXTENSION OF BENEFITS: Whenever termination of coverage occurs because of termination of your employment, such termination shall be without prejudice to any Covered Person's 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, and has been continuously covered under this Policy for at least six months prior to such termination. Such Extension of Benefits shall continue for up to six months or until the Calendar Year maximum has been reached as described in this Policy.

The Company may charge premiums for the period of the Extension of Benefits. The premium charged shall be the premium which would have been charged for the coverage provided under the Policy had the termination not occurred.

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 for all clean claims within 45 calendar days after the Company receives acceptable written proof of loss. "Clean claim" means a claim that has no defect or impropriety, including a lack of any required substantiating documentation, or particular circumstance requiring special treatment that impedes prompt payment.

If a claim or any portion of a claim is determined to have defects or improprieties, including a lack of any required substantiating documentation, or particular circumstance requiring special treatment, the Company will notify you in writing within 30 calendar days after receiving your claim. The written notice shall specify the portion of the claim that is causing a delay in processing and explain any additional information or corrections needed.

Upon receipt of additional information or corrections which led to the claim's being delayed and a determination that the information is accurate, the Company shall either pay or deny the claim or a portion of the claim within 45 calendar days. Payment shall be considered made on the date a draft or other valid instrument which is equivalent to the amount of the payment is placed in the United States mail in a properly addressed, postpaid envelope, or if not so posted, the date of delivery. An overdue payment will include simple interest at the rate of 10% per year.

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.

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
MEDLINK® IV BASE POLICY – ENHANCED	
Maximum In-Hospital Benefits	$1,000 per Covered Person **per Confinement**
In-Hospital Deductible	$0 per Covered Person **per Confinement** Waived for Accident
OUTPATIENT BENEFIT RIDER AMDI323APL	
Maximum Outpatient Benefits	$750 per Covered Person **Per Occurrence** for Covered Outpatient Services
Outpatient Deductible	$0 per Covered Person **Per Occurrence** Waived for Accident
Covered Outpatient Services Hospital Emergency Room	
Urgent Care Facility	Maximum of 3 Urgent Care visits per Covered Person per Calendar Year. Maximum of 6 Urgent Care visits per Calendar Year for all Covered Persons combined
Outpatient Surgery in Hospital Outpatient Facility or Freestanding Outpatient Surgery Center	
Diagnostic Testing in Hospital Outpatient Facility or MRI Facility	
Outpatient Treatment for a Mental or Emotional Disorder in a Hospital Outpatient Facility	Maximum of 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

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OUTPATIENT BENEFIT RIDER
ENHANCED 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

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.

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) outpatient surgery performed in a Hospital Outpatient Facility or a Freestanding Outpatient Surgery Center; and
d) outpatient diagnostic testing performed in a Hospital Outpatient Facility or a Magnetic Resonance Imaging (MRI) Facility; and
e) 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
A member of the American Fidelity Group

2305 Lakeland Drive, Flowood, Mississippi 39232
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

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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.

President, Chief Operating Officer

American Public Life Insurance Company
A member of the American Fidelity Group
2305 Lakeland Drive, Flowood, Mississippi 39232
Toll Free (800) 256-5606 ● Local (601) 936-6600

Amendment Rider

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. This rider will terminate on the same date as the Policy/Certificate to which it is attached.

The Definitions section of your Policy/Certificate is amended as follows:

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. The 90 day period of separation begins on the date treatment was received for which an outpatient benefit was paid that resulted in the Per Occurrence Benefit Maximum being met.

President, Chief Operating Officer

NOTICE OF
PROTECTION PROVIDED BY
OKLAHOMA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a brief summary of the Oklahoma Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Oklahoma law, which determines who and what is covered and the amounts of coverage. The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Oklahoma law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are:

- Life Insurance
    - $300,000 in death benefits
    - $100,000 in cash surrender or withdrawal values
- Health Insurance
    - $500,000 in hospital, medical and surgical insurance benefits
    - $300,000 in disability income insurance benefits
    - $300,000 in long-term care insurance benefits
    - $100,000 in other types of health insurance benefits
- Annuities
    - $300,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000, except that with regard to hospital, medical and surgical insurance benefits, the maximum amount that will be paid is $500,000.

NOTE: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Oklahoma law.

To learn more about the above protections, please visit the Association's website at www.mdlifega.org, or contact:

Oklahoma Life & Health Insurance Guaranty Association
201 Robert S. Kerr, Suite 600
Oklahoma City, OK 73102
Phone: (405) 272-9221

Oklahoma Department of Insurance
3625 NW 56th Street, Suite 100
Oklahoma City, OK 73112
1-800-522-0071 or (405) 521-2828

Insurance companies and agents are not allowed by Oklahoma law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Oklahoma law, then Oklahoma law will control.

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 Your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of You and other Plan participants and beneficiaries. No one, including Your employer, 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 reconsider 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 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.

The Plan Administrator has full discretion and authority to determine the benefits and amounts payable and to construe and interpret all terms and provisions of this booklet.

If You have any questions about the Plan, You should contact the Plan Administrator. If You have any questions about this statement, Your rights under ERISA, health care coverage portability, or continuation of health care coverage under COBRA, You may also contact:

U.S. Department of Labor
Employee Benefits Security Administration
200 Constitution Avenue, N W
Room N5625
Washington, D.C. 20210
(202) 219-8776

NOTICE OF THE RIGHT TO APPEAL

Any adverse benefit determination will be explained in writing and the explanation will include:

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

You, Your beneficiary, or a duly authorized representative may appeal any adverse benefit determination by filing a request for review to the Plan Administrator. 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 180 days after receipt of the written notice of adverse benefit determination. Non-urgent benefit determinations on appeal shall be rendered by the Plan Administrator within 15 days of receipt of Your request for review for Pre-Service Claims, and within 30 days of receipt of Your request for review for Post-Service Claims. Urgent Care benefit determinations on appeal shall be rendered within 72 hours of receipt of Your request for review. The decision, after the review, shall be in writing and shall include specific references to the pertinent plan provisions on which the decision was based.

Copies of the Plan's Claims Procedures are obtainable, without charge, upon written request to the Plan Administrator.

Effective date of this notice: April 14, 2003

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

American Public Life Insurance Company

A member of the American Fidelity Group

P.O. Box 925 Jackson, MS 39205-0925

1-800-256-8606

If you have questions about this notice, please contact the person listed under "Whom to Contact" at the end of this notice.

SUMMARY

In order to provide you with benefits, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides that if American Public Life Insurance Company receives personal information about your health, from you, your physicians, hospitals, and others who provide you with health care services we are required to keep this information confidential. This notice of our privacy practices is intended to inform you of the ways we may use your information and the occasions on which we may disclose this information to others.

KINDS OF INFORMATION TO WHICH THIS NOTICE APPLIES

This notice applies to individually identifiable protected health information that is created or received by us and that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual, or for which there is a reasonable basis to believe the information can be used to identify the individual (hereinafter referred to as "protected health information").

POLICIES AND/OR RIDERS AFFECTED BY THIS NOTICE

The following policies and/or riders and any combination thereof, provided by American Public Life Insurance Company and subject to the privacy policies and procedures set forth in this notice: cancer insurance; medical expense insurance; health indemnity insurance; hospital indemnity insurance; dental insurance; medical expense reimbursement plans; and any other coverages offered by us that meet the definition of a health plan contained in the HIPAA Privacy Rule.

The following policies and/or riders and any combination thereof, provided by American Public Life Insurance Company, and other coverages that do not meet the definition of a health plan contained in the HIPAA Privacy Rule are not covered under this notice: disability income insurance; accident only insurance; accidental death and dismemberment insurance; life insurance; annuity plans; Roth individual retirement accounts; simplified employee pension plans; and excess loss coverage on Self-Funded Health Plans.

WHO MUST ABIDE BY THIS NOTICE

All employees, staff, students, volunteers and other personnel whose work involves one of the products covered under this notice and who are under the direct control of American Public Life Insurance "Company must abide by this notice. The people and organizations to which this notice applies (referred to as "we," "our," and "us") have agreed to abide by its terms. We may share your information with each other for purposes of payment and operations activities as described below.

OUR LEGAL DUTIES

- We are required by law to maintain the privacy of your protected health information**.**
- We are required to provide this notice of our privacy practices and legal duties regarding protected health information to anyone who asks for it.
- We are required to abide by the terms of the notice that is currently in effect.

OUR RIGHT TO CHANGE THIS NOTICE

We reserve the right to change our privacy practices, as described in this notice, at any time. We reserve the right to apply these changes to any protected health information, which we already have as well as to protected health information we receive in the future. Before we make any material change in the privacy practices described in this notice, we will write a new notice that includes the change. The new notice will include an effective date. We will mail the new notice to all named insureds then covered by a product subject to the notice within 60 days of the effective date.

HOW WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION.

We may use your protected health information, or disclose it to others, for a number of different reasons. This notice describes these reasons. For each reason, we have written a brief explanation. We also provide some examples. These examples do not include all of the specific ways we may use or disclose your information. But any time we use your information, or disclose it to someone else, it will fit one of the reasons listed here.

1. Payment.

We will use your protected health information, and disclose it to others, as necessary to make payment for the health care services you receive. For instance, an employee in our claim-processing department may use your protected health information to pay your claims. We will also send you information about claims we pay and claims we do not pay (called an "explanation of benefits"). The explanation of benefits will include information about claims we receive for the Insured and each dependent who are enrolled together under a single contract or identification number. Under certain circumstances, you may receive this information confidentially: see the *"Confidential Communication"* section in this notice. We may also disclose some of your protected health information to companies with whom we contract for payment-related services. For instance, if you owe us money, we may give information about you to a collection company with whom we contract to collect bills for us. We will not use or disclose more information for payment purposes than is necessary.

2. Health Care Operations.

We may use and disclose your protected health information for activities that are necessary to operate this organization. This includes reading your protected health information to review the performance of our staff. We may also use your information and the information of other members to plan what services we need to provide, expand, or reduce. We may disclose your protected health information as necessary to others with whom we contract to provide administrative services. This includes our lawyers, auditors, accreditation services, and consultants, for instance.

3. Legal Requirement to Disclose Information.

We may use or disclose your information when we are required by law to do so. This includes reporting information to government agencies that have the legal responsibility to monitor the health care system. For instance, we may be required to disclose your protected health information, and the information of others, if we are audited by the state insurance department. We will also disclose your protected health information when we are required to do so by a court order or other judicial or administrative process.

4. Public Health Activities.

We will disclose your protected health information when required to do so for public health purposes. This includes reporting certain diseases, births, deaths, and reactions to certain medications. It also includes reporting certain information regarding products and activities regulated by the federal Food and Drug Administration. It may also include notifying people who have been exposed to a disease.

5. To Report Abuse.

We may disclose your protected health information when the information relates to a victim of abuse, neglect or domestic violence. We will make this report only in accordance with laws that require or allow such reporting, or with your permission.

6. Government Oversight.

We may disclose your protected health information if authorized by law to a government oversight agency (e.g., a state insurance department) conducting audits, investigations, or civil or criminal proceedings.

7. Judicial or Administrative Proceedings.

We may disclose your protected health information in the course of a judicial or administrative proceeding (e.g., to respond to a subpoena or discovery request).

8. Law Enforcement.

We may disclose your protected health information for law enforcement purposes. This includes providing information to help locate a suspect, fugitive, material witness or missing person, or in connection with suspected criminal activity. We must also disclose your protected health information to a federal agency investigating our compliance with federal privacy regulations.

9. Coroners.

We may disclose your protected health information to coroners, medical examiners, and/or funeral directors consistent with the law.

10. Organ Donation.

We may use or disclose your protected health information for cadaveric organ, eye or tissue donation.

11. Workers' Compensation.

We may disclose your protected health information to workers' compensation agencies if necessary for your workers' compensation benefit determination.

12. Limited Data Sets.

We may use or disclose, under certain circumstances, limited amounts of your protected health information that is contained in limited data sets.

13. Research.

We may use or disclose your protected health information for research purposes, but only as permitted by law.

14. Specialized Purposes.

We may use or disclose the protected health information of members of the armed forces as authorized by military command authorities. We may disclose your protected health information for a number of other specialized purposes. We will only disclose as much information as is necessary for the purpose. For instance, we may disclose your protected health information for national security, intelligence, and protection of the president.

15. To Avert a Serious Threat.

We may use or disclose your protected health information if we decide that the disclosure is necessary to prevent serious harm to the public or to an individual. The disclosure will only be made to someone who is able to prevent or reduce the threat.

16. Family and Friends.

We may disclose your protected health information to a member of your family or to someone else that is involved in your medical care or payment for care. This may include telling a family member about the status of a claim, or what benefits you are eligible to receive. In the event of a disaster, we may provide information about you to a disaster relief organization so they can notify your family of your condition and location. We will not disclose your information to family or friends if you object.

17. Health Benefits Information.

If your employer sponsors your enrollment in American Public Life's health plan, your protected health information may be disclosed to your employer, as necessary for the administration of your employer's health benefit program for employees. Employers may receive this information only for purposes of administering their employee group health plans, and must have special rules to prevent the misuse of your information for other purposes.

18. Products and Services.

We may contact you to provide information about other health-related products and services that may be of interest to you. For example, we may use and disclose your protected health information for the purpose of communicating to you about our health insurance products that could enhance or substitute for existing health plan coverage, and about health-related products and services that may add value to your existing health plan.

MORE STRINGENT LAW

In the event applicable law, other than the HIPAA Privacy Rule, prohibits or materially limits our uses and disclosures of protected health information, as set forth above, we will restrict our uses or disclosure of your protected health information in accordance with the more stringent standard.

YOUR RIGHTS

1. Authorization.

We may use or disclose your protected health information for any purpose that is listed in this notice without your written authorization. We will not use or disclose your protected health information for any other reason without your written authorization. If you authorize us to use or disclose your protected health information, you have the right to revoke the authorization at any time. For information about how to authorize us to use or disclose your protected health information, or about how to revoke an authorization, contact the person listed under "Whom to Contact" at the end of this notice. You may not revoke an authorization for us to use and disclose your information to the extent that we have taken action in reliance on the authorization or if the authorization was obtained as a condition of obtaining insurance, and we have the right, under other law, to contest a claim under the policy or the policy itself.

2. Request Restrictions.

You have the right to request restrictions on certain of our uses and disclosures of your protected health information for insurance payment or health care operations, disclosures made to persons involved in your care, and disclosures for disaster relief purposes. For example, you may request that we not disclose your protected health information to your spouse. Your request must describe in detail the restriction you are requesting. We will consider your request. But we are not required to agree. We cannot agree to restrict disclosures that are required by law.

3. Confidential Communication.

If you believe that the disclosure of certain information could endanger you, you have the right to ask us to communicate with you at a special address or by a special means. For example, you may ask us to send explanations of benefits that contain your protected health information to a different address rather than to your home. Or you may ask us to speak to you personally on the telephone rather than sending your protected health information by mail. We will agree to any reasonable request. Requests for confidential communications must be in writing, it must state that the disclosure of the protected health information could endanger you, it must be signed by you or your representative, and sent to us at the address under "Whom to Contact" at the end of the notice.

4. Inspect and Receive a Copy of Protected Health Information.

You have a right to inspect certain protected health information about you that we have in our records, and to receive a copy of it. This right is limited to information about you that is kept in records that are used to make decisions about you. For instance, this includes claim and enrollment records. If you want to review or receive a copy of these records, you must make the request in writing, you must state that you are requesting access to your protected health information and either you or your representative must sign the request. We may charge a fee for the cost of copying and mailing the records. To ask to inspect your records, or to receive a copy, contact us at the address under "Whom to Contact" at the end of this notice. We may deny you access to certain information. If we do, we will give you the reason, in writing. We will also explain how you may appeal the decision.

5. Amend Protected Health Information.

You have the right to ask us to amend protected health information about you, which you believe is not correct, or not complete. If you want to request that we amend your protected health information you must make this request in writing, it must be signed by either your or your representative, and give us the reason you believe the information is not correct or complete. Your request to amend your information must be sent to the address under "Whom To contact" at the end of this notice. We may deny your request if we did not create the information, if it is not part of the records we use to make decisions about you, if the information is something you would not be permitted to inspect or copy, or if it is complete and accurate.

6. Accounting of Disclosures.

You have a right to receive an accounting of certain disclosures of your information to others. This accounting will list the times we have given your protected health information to others. The list will include dates of the disclosures, the names of the people or organizations to whom the information was disclosed, a description of the information, and the reason. We will provide the first list of disclosures you request at no charge. We may charge you for any additional lists you request during the following 12 months. You must tell us the time period you want the list to cover. To be considered, your accounting requests must be in writing, signed by you or your representative and sent to the address under "Whom to Contact" at the end of this notice.

7. Paper Copy of this Privacy Notice.

You have a right to receive a paper copy of this notice. If you have received this notice electronically, you may receive a paper copy by contacting the person listed under "Whom to Contact" at the end of this notice.

8. Complaints.

You have a right to complain about our privacy practices, if you think your privacy has been violated. You may file your complaint with the person listed under "Whom to Contact" at the end of this notice. You may also file a complaint directly with the Secretary of the U. S. Department of Health and Human Services. All complaints must be in writing, must describe the situation giving rise to the complaint and must be filed within 180 days of the date you know, or should have known, of the event giving rise to the complaint. You will not be subject to any retaliation for filing a complaint.

WHOM TO CONTACT:

Contact the person listed below:

- For more information about this notice; or
- For more information about our privacy policies; or
- If you want to exercise any of your rights, as listed on this notice; or
- If you want to request a copy of our current notice of privacy practices.

Privacy Official
American Public Life Insurance Company
P.O. Box 925
Jackson, MS 39205-0925
1-800-256-8606

This notice is also available on our Web site: www.ampublic.com