14828
Medlink

Hospital
MEDlink™ @ APL

Master Policy

Underwritten by:

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

2305 Lakeland Drive Flowood, Mississippi 39232

American Public Life Insurance Company

A member of the American Fidelity Group

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

POLICYHOLDER: **Grapevine Colleyville ISD**

ADDRESS: **3051 Ira E Wood Ave Grapevine TX 76051**

POLICY NUMBER: **14828**

EFFECTIVE DATE: **January 1, 2012**

ISSUE DATE: **January 1, 2012**

POLICY ANNIVERSARY DATE: **January 1, 2012**

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

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

Signed for American Public Life Insurance Company.

Assistant Secretary

Vice President and C.A.O.

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

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 – SUBSCUBER, THE EMPLOYER LOSES THOSE BENEFITS WHICH WOULD OTHERWISE ACCRUE UNDER THE WORKER'S COMPENSATION LAW AT IT PERTAINS TO NON – SUBSCRIBERS AND THE REQUIRED NOTIFICATION 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.

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Medical Expense Supplement Insurance Plan

PLAN: Medlink Option 1

SCHEDULE OF BENEFITS

ELIGIBILITY: All active full-time employees who are:
(a) working 18 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
MAXIMUM IN-HOSPITAL BENEFIT:	$ 1,500 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 $200 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	$25 per treatment; $125 maximum per family per Calendar Year
PRE-EXISTING PERIOD: 12 Months	
PRE-EXISTING CONDITION EXCLUSION PERIOD: 0 Months	

* Any reference to the 31 – day waiting period for Late Enrollees is waived.

Policy GM-MEDlink

Medical Expense Supplement Insurance Plan

PLAN: Medlink Option 2

SCHEDULE OF BENEFITS

ELIGIBILITY: All active full-time employees who are:
(a) working 18 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
MAXIMUM IN-HOSPITAL BENEFIT:	$2,500 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 $200 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	$25 per treatment; $125 maximum per family per Calendar Year
PRE-EXISTING PERIOD: 12 Months	
PRE-EXISTING CONDITION EXCLUSION PERIOD: 0 Months	

* Any reference to the 31 – day waiting period for Late Enrollees is waived.

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 he or she normally does such duties or at some location to which his or her employment sends him or her.

An Insured will be said to be on Active Service on a day which is not a scheduled work day only if he or she would be able to perform in the usual manner all of the regular duties of his or her 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 the Insured. 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 the Insured and his or her Dependents who are insured under the Policy.

Dependent means the Insured's:
(a) married spouse who is under age 70 and who lives with the Insured; 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 the Insured; or
    (2) is less than 23 years old and going to an accredited school full time. Such child must be dependent on the Insured 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. The Company must receive proof of incapacity within 31 days after coverage would otherwise terminate. Coverage will then continue as long as the Insured's insurance stays in force and the child remain 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 the Insured, but the Insured is 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) a grandchild of the Insured (unless required by law); or
(b) a child who engages for compensation, profit or gain in any employment or business for 30 or more hours per week, unless such child is a full-time student as described in (b)(2) above.

Effective Date means the date described in the Policy. The date shown in the Insured's Certificate is his or her 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 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.

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

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.

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 his or her 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

Insured's Eligibility: Any person who:
(a) is on Active Service as an employee of the Policyholder, or as a member or employee of a member of the Policyholder, is eligible to be insured under the Policy;
(b) qualifies as an eligible Insured, as defined in the Policyholder's application, is eligible to be insured under the Policy; and
(e) meet the definition of Eligibility, as stated in the Schedule, is eligible to be insured under the Policy.

Evidence of coverage under Another Medical Plan may be required.

Insured's Effective Date: The insurance on any eligible person will take effect on:
(a) the requested Effective Date; or
(b) the Effective Date assigned by the Company upon approval of such person's written application, whichever is later, if:
  (1) the Company's underwriting rules are met;
  (2) such person is on Active Service;
  (3) such person is covered under Another Medical Plan; and
  (4) premium has been paid.

If an eligible person is not on Active Service due to an Accident or Sickness when his or her coverage is to take effect, it will take effect on the first day of the calendar month after the date such person returns to Active Service.

Dependent Eligibility: If Dependent coverage is available under the Policy, each Insured will be eligible for such coverage on the day he or she:
(a) becomes eligible for coverage; or
(b) acquires his or her 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) the Company's acceptance of the application; and
(b) receipt of the first premium.

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

A newborn child will become covered for Accident and Sickness automatically on the day he or she is born as long as the Insured's 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) the Company is 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 the Insured, 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 the Insured 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) the Company is 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.

Section 3
WHAT WE WILL PAY

In-Hospital Benefit: The Company 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; and
(c) with respect to Late Enrollees only, such Covered Charges are incurred more than 30 days after the Covered Person's Effective Date of coverage.

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

Outpatient Benefits: The Company 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; and,
(c) with respect to Late Enrollees only, such Covered Charges are incurred more than 30 days after the Covered Person's Effective Date of coverage.

Physician Outpatient Treatment Benefit: The Company 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.

Section 4
EXCLUSIONS (WHAT WE WILL NOT PAY)

No benefits are payable under this Policy for any expenses incurred:
(A) with respect to Late Enrollees only, during the first 30 days of coverage under the Policy, except for the Physician Outpatient Treatment Benefit; or
(B) 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 the Insured or the Insured's covered Dependent spouse:
    (1) where the Insured or the Insured's 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. The Company 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.

Section 5
TERMINATION OF COVERAGE (WHEN COVERAGE ENDS)

Your Coverage: Insurance coverage on an Insured will end on the earliest of these dates:
(a) the date the Insured 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 the Insured retires;
(e) if the Insured works for an employer employing less than 20 employees on a typical workday in the preceding Calendar Year, the date the Insured attains age 70;
(f) the date the Insured ceases to be on Active Service, as defined in Section 1;
(g) the date the Insured's coverage under Another Medical Plan ends; or
(h) the date the Insured ceases employment with the employer through whom he or she originally became insured under the Policy.

Coverage On Dependent(s): Insurance coverage on a Dependent will end on the earliest of these dates:
(a) the date the Insured's 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.

Extension of Benefits: Whenever termination of coverage under this section occurs because of termination of the Insured's 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 an Insured and his or her covered Dependent(s) may be continued during the Insured's Sabbatical Leave:

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

Sabbatical Leave means a leave of absence granted in writing by the Insured's employer for the purpose of his or her pursuit of education, research or teaching.

This provision will not apply if:

(a) the Insured's 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 the Insured was insured under the Policy; or
(c) coverage under the Insured's 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 an Insured and his or her covered Dependent(s) may be continued during a Layoff or Leave of Absence for up to a maximum period of three months.

If:

(a) the Insured's Layoff or Leave of Absence continues for more than three months; or
(b) the Insured does not return to work for the same employer, his or her 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 the Insured is no longer eligible for coverage under the Policy.

Leave of Absence must be granted in writing by the Insured's employer.

This provision will not apply if the Insured's 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.

Section 6
PREMIUMS

The first premium is due on or before the Effective Date of the Insured's 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 the Company. If the rates are changed, the Company will give the Insured at least 31 days advance written notice. If a change in benefits increases the Company's liability, premium rates may be changed on the date the Company's liability is increased.

Section 7
GENERAL POLICY PROVISIONS

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

Statements made by the Policyholder or the Insured 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 the Insured or the Insured's beneficiary.

The terms of the Policy can be changed only by endorsement or amendment signed by one of the Company's 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 the Insured may, by writing to the Company, 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, the Company 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: The Company will supply a Certificate to each Insured. 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 an Insured is issued more than one Certificate under the Policy, only the last one issued will be in effect.

Section 8
CLAIM PROVISIONS

The Insured should notify the Company, in writing, within 30 days (60 days in Kentucky) after he or she or one of his or her covered Dependents incurs a loss covered by the Policy. (If it is not reasonably possible to give notice within this time period, the claim will not be denied or reduced due to the delay.) Written notice should be sent to the Company at the following address:

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

A claim form should be used for filing proof of loss. They will be sent to the claimant within 15 days (10 days in Georgia) of receipt of notice of claim. If claim forms are not supplied within this stated period of time, a claimant 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 the Company within 90 days after the loss. The Company 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, the Physician's statement must be submitted..

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

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

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

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

STATEMENT OF ERISA RIGHTS

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

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

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

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

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

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

If an Insured has any questions about the Plan, he or she should contact the Plan Administrator. If an Insured has any questions about this statement or about his or her rights under ERISA, he or she should contact the nearest Area Office of the Pension Welfare Benefits Administration, U.S. Department of Labor.

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 the Insured may be required to provide and an explanation of why it is needed; and
(d) an explanation of the Plan's claim review procedure.

The Insured and the Insured's beneficiary, or a duly authorized representative may appeal any denial of a claim for benefits by filing a written request to the Company. 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. The Insured may have representation throughout this review procedure.

The Insured's 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 the Company, no later than 90 days after receipt of the Insured's 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.

☐ Plan Sponsor Set-Up
☐ Master Application

American Public Life Insurance Company
A member of the American Fidelity Group
2305 Lakeland Drive • Flowood, Mississippi • 39232
Phone: (601) 936-6600 or (800) 256-8606 • Fax: (601) 932-9011

Home Office Use Only: 14828
Group Number:
Effective Date:
No. of Insureds:
Guarantee Issue:
Take-Over:
Setup Date:

GENERAL INFORMATION

1. Plan Sponsor/Policyholder: Grapevine Colleyville ISD
2. Mailing Address: 3051 Ira E. Woods Ave City: Grapevine State: TX Zip: 76051
3. Physical Address: _____ City: _____ State: _____ Zip: _____
(if different than mailing address)
4. Plan Sponsor/Policyholder Contact Name: Judy Hill (Judy.Hill@gcisd.net) / Barbara Feldhaus
5. Contact Phone: (817) 251-5200 Fax: (817) 305-4871 6. E-mail Address: Barbara.Feldhaus@gcisd.net
7. Group Type: ☐ Association ☐ Employer ☒ Other (describe) School district
8. Tax I.D. #: 75-6001702 9. SIC Code: _____ 10. Year Established? 1869
11. Nature of Business: Public School 12. Subsidiary & Affiliated Organizations: ☒ No ☐ Yes (attach information)
13. For Associations Only: ☐ Eligibility Determined at employer level
14. Current Employees/Members Eligible: ☒ Immediately ☐ After ___ Days Employment (Full-Time Employee means ___ hours per week.)
15. New Employees/Members are Eligible After 0 Days Employment
16. Number of Current Eligible Employees/Members 1855 17. Requested Effective Date 1/1/2012
18. Do you currently have insurance like or similar to the coverage applied for? ☒ Yes ☐ No If "yes", please list type of insurance and carrier(s): Transamerica Indv. Cancer Plan
19. Will the insurance applied for replace any existing insurance? ☐ Yes ☒ No If "yes", list type of insurance, carrier, and termination date: _____
20. Will any coverage applied for be offered under a Cafeteria Plan? ☒ Yes ☐ No If "yes", which coverage? (List anniversary date, Plan Administrator, address and phone number.) National Benefit Services 800.274.0503
21. Are insureds exempt from: Social Security taxes? ☒ Yes ☐ No Medicare taxes? ☐ Yes ☒ No
22. Are insureds covered under Workers' Compensation? ☒ Yes ☐ No
23. Re-Enrollment frequency: ☐ 6 months ☒ 1 year ☐ Other _____

BILLING INSTRUCTIONS

Frequency: ☒ Monthly ☐ Semi-Monthly ☐ Bi-Weekly ☐ Weekly ☐ Other _____
☐ Skip Month ☐ 8/12 ☐ 9/12 ☐ 10/12 ☐ 11/12 Which months Skipped? _____
Billing Method: ☐ Paper ☒ Electronic - Email Address: alicia.b@fbsbenefits.com Date of 1st Deduction: _____
Send Billing To: Name Alicia Boothe (FBS) Phone #: 800 583 6900
(List Billing Contact and Address if different than above.)
Billing Address: 2121 N. Glenville Dr City Richardson State TX Zip 75082

GROUP PRODUCT SELECTION

Hospital Indemnity ☐ Voluntary ☐ Plan Sponsor Paid _____ % $_____ Pre-ex: ☐ apply ☐ credit ☐ waive

☐ Base Hospital Indemnity Benefit	$_____ Per Day	☐ Outpatient Sickness Rider	☐ $25	☐ $50	☐ $75
☐ Annual First Occurrence Rider	$_____ Benefit	☐ Surgical and Anesthesia Rider	_____ Units		
☐ Emergency Accident Rider	$_____ Max. Benefit	☐ Wellness / Diagnostic Test Rider			
☐ Intensive Care/Coronary Care Rider	$_____ Per Day	☐ Term Life Rider	☐ $10,000	☐ $20,000	
☐ Outpatient Surgical Facility Rider	$_____ Benefit				

Cancer ☒ Voluntary ☐ Plan Sponsor Paid ☐ Plan Sponsor Pays _____ % $_____

	OPTION 1	OPTION 2
	☐ Level 1 ☐ Level 2 ☐ Level 3	☐ Level 1 ☐ Level 2 ☐ Level 3
☐ Diagnostic Testing Benefit Rider	☐ $25 ☐ $50 ☐ $75 ☐ $100	☐ $25 ☐ $50 ☐ $75 ☐ $100
☒ Critical Illness Rider	Optional to Employee: ☐ Yes ☐ No	Optional to Employee: ☐ Yes ☐ No
☐ Cancer Only	☐ $2,500 ☐ $5,000	☐ $2,500 ☐ $5,000
☐ Heart/Stroke Only	☐ $2,500 ☐ $5,000	☐ $2,500 ☐ $5,000
☐ Cancer/Heart/Stroke	☐ $2,500 ☐ $5,000	☐ $2,500 ☐ $5,000
☐ Hospital ICU Rider	Optional to Employee: ☐ Yes ☐ No	Optional to Employee: ☐ Yes ☐ No
	Daily Benefit $_____	Daily Benefit $_____
☐ Continuation Rider		

Disability ☐ Voluntary ☐ Plan Sponsor Pays first $400/mo. (or more) benefit Pre-ex: ☐ Apply ☐ Credit

	Class A	Class B
☐ Term Life Rider ☐ $10,000 ☐ $20,000	Elimination Period _____ Days Sickness	Elimination Period _____ Days Sickness
	_____ Days Injury	_____ Days Injury
☐ Family Accident Benefit	Benefit Period _____ Months Sickness or Injury	Benefit Period _____ Months Sickness or Injury

Dental ☐ Voluntary ☐ Plan Sponsor Pays _____ % **Pre-ex: ☐ Apply ☐ Credit ☐ No Prior Coverage

Plans: ☐ American Premiere Plan ☐ American Enhanced Plan ☐ American Graded Plan
☐ American Scheduled Plus: ☐ Area 1 ☐ Area 2 ☐ Area 3 ☐ American Scheduled Basic: ☐ Area 1 ☐ Area 2 ☐ Area 3

☐ Children Orthodontic Expense Rider (Not available with the American Premiere Plan)
☐ Temporamandibular Joint Treatment Expense Rider (Not Available with the American Premiere Plan)

** If credit for prior coverage is being requested, a copy of the prior plan policy and list bill must be attached. Credit for prior coverage will not be considered without these documents. Receiving prior credit must be pre-approved by underwriting prior to completion of the applicaton.

MEDlink®

Benefit Amount (Check the options that apply, at least one and no more than two):

☐ $500 ☐ $1,000 ☐ $1,250 ☐ $1,500 ☐ $1,750 ☐ $2,000 ☐ $2,500 ☐ $3,500 ☐ $5,000

MEDlink® II

Option A	Option B
Maximum In-Hospital Benefit:	Maximum In-Hospital Benefit:
☐ $1,000 ☐ $1,500 ☐ $2,000 ☐ $2,500	☐ $1,000 ☐ $1,500 ☐ $2,000 ☐ $2,500
☐ $3,000 ☐ $3,500 ☐ $4,500 ☐ $5,000	☐ $3,000 ☐ $3,500 ☐ $4,500 ☐ $5,000
☐ $7,500 ☐ $10,000	☐ $7,500 ☐ $10,000
☐ Outpatient Hospital Benefit Rider:	☐ Outpatient Hospital Benefit Rider:
☐ $500 ☐ $750 ☐ $1,000 ☐ $1,250	☐ $500 ☐ $750 ☐ $1,000 ☐ $1,250
☐ $1,500 ☐ $1,750 ☐ $2,000 ☐ $2,250	☐ $1,500 ☐ $1,750 ☐ $2,000 ☐ $2,250
☐ $2,500	☐ $2,500
Outpatient Deductible: ☐ $100 ☐ $250 ☐ $500	Outpatient Deductible: ☐ $100 ☐ $250 ☐ $500
☐ *Physician's Outpatient Treatment Rider*	☐ *Physician's Outpatient Treatment Rider*

MEDlink® III

Option A	Option B
Coinsurance Percentage:	Coinsurance Percentage:
☐ 100% ☐ 90% ☐ 80% ☐ 70%	☐ 100% ☐ 90% ☐ 80% ☐ 70%
☐ 60% ☐ 50%	☐ 60% ☐ 50%
Maximum In-Hospital Benefit:	Maximum In-Hospital Benefit:
☐ $1,000 ☒ $1,500 ☐ $2,000 ☐ $2,500	☐ $1,000 ☐ $1,500 ☐ $2,000 ☒ $2,500
☐ $3,000 ☐ $3,500 ☐ $4,000 ☐ $4,500	☐ $3,000 ☐ $3,500 ☐ $4,000 ☐ $4,500
☐ $5,000 ☐ $6,000 ☐ $7,000 ☐ $8,000	☐ $5,000 ☐ $6,000 ☐ $7,000 ☐ $8,000
☐ $9,000 ☐ $10,000	☐ $9,000 ☐ $10,000
☐ Outpatient Hospital Benefit Rider:	☐ Outpatient Hospital Benefit Rider:
☐ 50% of Maximum In-Hospital Benefit Amount up to $4,000	☐ 50% of Maximum In-Hospital Benefit Amount up to $4,000
☐ 80% of Maximum In-Hospital Benefit Amount up to $4,000	☐ 80% of Maximum In-Hospital Benefit Amount up to $4,000
Outpatient Deductible: ☐ Annual OR ☐ Per Occurrence	Outpatient Deductible: ☐ Annual OR ☐ Per Occurrence
☐ $100 ☐ $250 ☐ $500 ☐ $750 ☐ $1,000	☐ $100 ☐ $250 ☐ $500 ☐ $750 ☐ $1,000
☐ Waive Deductible for Accident Treatment	☐ Waive Deductible for Accident Treatment
☐ Physician's Outpatient Treatment Rider	☐ Physician's Outpatient Treatment Rider

Minimum Standards for all MEDlink® products

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

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

b) Where Holder is an employer and eligible persons are employees:

_____ employees

_____ percent of employees

c) Where Holder is a trade association:

_____ percent of member firms must participate and maintain proper *participation*

_____ percent of employees in firm with _____ or more employees

_____ percent of employees in firm with _____ or less employees

If these standards are not met, the Company may: (1) ask for satisfactory evidence of insurability before an eligible person's coverage takes effect: or (2) terminate the Policy.

Accident	☐ Voluntary	☐ Plan Sponsor Pays	_____ %	$_____
	☐ 24 Hour	☐ Off the Job Only		
	☐ 1 Unit	☐ 2 Units	☐ 3 Units	☐ 4 Units

Special Request(s) for Any Group Product(s):

MASTER APPLICATION AGREEMENT

If this application is approved American Public Life Insurance Company, group insurance will take effect: (a) on the Effective Date; or, (b) on the date the required number of eligible persons have enrolled, if such persons are to pay for part of the cost of their coverage; whichever is the later date. Group insurance will be issued: (a) at the Company's rates; and, (b) under the terms and conditions of the policy or policies applied for. If this application is not approved, no insurance will take effect. Any premium payment advanced by the Policyholder will be returned.

THE POLICYHOLDER DECLARES that to the best of his knowledge and belief the statements and answers shown above are true and complete. The Policyholder understands and agrees that: (a) the application will form a part of any policy issued; (b) no information given to, or acquired by, any representative of the Company will bind the Company unless it appears in writing on this application; (c) no waiver or modification will bind the Company unless it is in writing and is signed by an Executive Officer of the Company; and (d) only those persons eligible under the terms of the policy or policies issued will be covered. I hereby request American Public Life Insurance Company to issue the Group Insurance Policy(ies) and Certificates of Insurance for the coverage applied for. I agree to collect and remit premiums for insurance products for the insured (and dependents, if applicable).

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

Elaine Cox — Signature of Plan Sponsor Official

C.F.O. — Title

11/09/11 — Date

[signature] — Agent Signature

6544508 — Agent Number

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

FRAUD WARNING

In **FL, KY, OH** and **OK**: Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim (in **FL** and **KY** – or application) containing any false, incomplete, or misleading information (in **FL** – is guilty of a felony of the third degree.) concerning a material fact is guilty of insurance fraud (in **KY** – insurance fraud is a felony). In **LA, ME, NJ, NM** and **VA**: Any person who knowingly presents false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to (in **NJ** and **NM** – civil fines and criminal penalties,) fines and confinement in prison (in **ME, TN** and **VA** – and denial of insurance benefits).

A08MASAPP

INDIVIDUAL PRODUCT SELECTION

						Section 125	
☐ Life:	Plan Sponsor will pay _____	%	Insured will pay _____	%		☐ Yes	☐ No
☑ Cancer:	Plan Sponsor will pay 0	%	Insured will pay 100	%		☑ Yes	☐ No
☐ Select Dental:	Plan Sponsor will pay _____	%	Insured will pay _____	%		☐ Yes	☐ No
☐ Heart Disease:	Plan Sponsor will pay _____	%	Insured will pay _____	%		☐ Yes	☐ No
☐ Hospital Indemnity:	Plan Sponsor will pay _____	%	Insured will pay _____	%		☐ Yes	☐ No
☐ Intensive Care:	Plan Sponsor will pay _____	%	Insured will pay _____	%		☐ Yes	☐ No
☐ Accident:	Plan Sponsor will pay _____	%	Insured will pay _____	%		☐ Yes	☐ No
☑ Other: Medlink	Plan Sponsor will pay 0	%	Insured will pay 100	%		☐ Yes	☐ No

PLAN SPONSOR SET-UP AGREEMENT

I agree to collect and remit premiums for insurance products for the insured (and dependents, if applicable).

Elaine Cox — Signature of Plan Sponsor Official

CFO — Title

11/09/11 — Date

A08ERSETUP