3206
PORT NECHES-GROVES ISD
OPTION OPTION 2 -
TX

3206
TX
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PORT NECHES-GROVES ISD
ATTN EMPLOYEE BENEFITS
620 AVE. C
PORT NECHES, TX 77651-0000

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

P.O Box 925 Jackson, MS 39205-0925 • (601)936-6600 • Fax (601)932-9011

IMPORTANT NOTICE

To obtain information or make a complaint:

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

1-800-256-8606

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

2305 Lakeland Drive
Flowood, MS
39232

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

1-800-252-3439

You may write the Texas Department of Insurance at:

P. O. Box 149104
Austin, TX 78714-9104
Fax: (512) 475-1771
Web: http://www.tdi.state.tx.us
Email: ConsumerProtection@tdi.texas.gov

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

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

AVISO IMPORTANTE

Para obtener informacion o para someter una queja:

Usted puede llamar al numero de telefono gratis de American Public Life Insurance Company para informacion o para someter una queja al:

1-800-256-8606

Usted tambien puede escribir a American Public Life Insurance Company:

2305 Lakeland Drive
Flowood, MS
39232

Puede communicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al:

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas

P. O. Box 149104
Austin, TX 78714-9104
Fax: (512) 475-1771
Web: http://www.tdi.state.tx.us
Email: ConsumerProtection@tdi.texas.gov

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

UNA ESTE AVISO A SU POLIZA: Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento. adjunto.

American Public Life Insurance Company

FOR INQUIRIES OR TO OBTAIN INFORMATION, PLEASE CONTACT:

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

LIMITED BENEFIT SPECIFIED DISEASE CANCER INSURANCE POLICY

THIS POLICY PROVIDES LIMITED BENEFITS, READ IT CAREFULLY.

POLICYHOLDER:	PORT NECHES-GROVES ISD		
ADDRESS:	ATTN EMPLOYEE BENEFITS 620 AVE. C PORT NECHES TX 77651		
GROUP POLICY NUMBER:	3206	**POLICY EFFECTIVE DATE:**	09-01-2014
ISSUE DATE:	07-25-2014	**POLICY ANNIVERSARY DATE:**	09-01-2015.

In this Policy, "you" or "your" refer to the Insured shown in the Certificate Schedule. "We," "our," "us," or "Company" refer to American Public Life Insurance Company.

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

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

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

OPTIONALLY RENEWABLE: This Policy is optionally renewable. The Policyholder or we have the right to terminate the Policy on any premium due date after the first anniversary following the Policy Effective Date. We must give at least 60 days written notice to the Policyholder prior to Cancellation.

Signed for American Public Life Insurance Company.

Deanne Aycock

Chief Administrative Officer

President, Chief Operating Officer

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.

THIS POLICY PROVIDES LIMITED BENEFITS. ALL BENEFITS ARE PAYABLE DIRECTLY TO THE INSURED. THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. IF THE INSURED IS ELIGIBLE FOR MEDICARE, REVIEW THE GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE AVAILABLE FROM US. THIS COVERAGE IS NOT APPROPRIATE FOR ANY PERSON WHO IS ELIGIBLE FOR MEDICAID.

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

SECTION 1 - TABLE OF CONTENTS

SECTION 2 – POLICY SCHEDULE

Policyholder:	PORT NECHES-GROVES ISD	Pre-Existing Condition Period:	12 Months
Policy Effective Date:	09-01-2014	Pre-Existing Condition Exclusion Period:	12 Months
Policy Number:	3206	Waiting Period:	30 Days

CANCER PLAN DESCRIPTION

CANCER PLAN OPTION 2:

Limited Benefit Specified Disease Cancer Policy
Internal Cancer First Occurrence Benefit Rider
Heart Attack/Stroke First Occurrence Benefit Rider
Hospital Intensive Care Unit Benefit Rider

THIS SCHEDULE REFLECTS REVISIONS TO YOUR POLICY EFFECTIVE 09-01-2014.

SECTION 3 - DEFINITIONS

ACTIVELY AT WORK means the Insured is performing in the usual manner all of the regular duties of his or her employment:

1. as an employee, independent contractor or self-employed person; and
2. at one of the places of business where he or she normally does such duties or at some location to which his or her employer sends him or her; and
3. on a Full-Time basis.

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

ACTIVITIES OF DAILY LIVING (ADLs) mean the basic human functions required for the Covered Person to remain independent. Activities of Daily Living are as follows:

1. Bathing: Getting into or out of the tub or shower and otherwise washing the parts of the body;
2. Transferring: Moving between the bed and the chair, or the bed and a wheelchair;
3. Dressing: Putting on and taking off all necessary items of clothing, and/or medically necessary braces, and artificial limbs usually worn;
4. Toileting: Getting to and from the toilet; getting on and off the toilet; and performing associated personal hygiene; and
5. Eating: Performing all major tasks of getting food into the body.

ACTUAL CHARGE is the amount actually paid by or on behalf of the Covered Person and accepted by the provider for services provided.

AMBULATORY SURGICAL CENTER is a free-standing surgical facility which offers ambulatory medical service. The surgical facility is not part of a Hospital, but it must have been reviewed and approved by the appropriate state health commission to provide the treatment or service. An Ambulatory Surgical Center is a place that:

1. has permanent facilities that are equipped for surgical procedures performed by Physicians; and
2. provides anesthesia administered by a licensed anesthesiologist or licensed Nurse anesthetist; and
3. has registered professional nursing services available on site, whenever a patient is in the facility; and
4. has written agreements with local Hospitals to immediately accept patients who develop complications.

It must also require that the patient be admitted, treated and released within a 24-hour period.

BONE MARROW TRANSPLANT is the harvesting, storage and subsequent reinfusion of stem cells from the recipient's, or a matched donor's, bone marrow.

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

CANCER is a disease which is manifested by autonomous growth (malignancy) in which there is uncontrolled growth, function, or spread (local or distant) of cells in any part of the body. This includes Cancer in situ and malignant tumors. It does not include other conditions which may be considered precancerous or having malignant potential such as: leukoplakia; hyperplasia; polycythemia; actinic keratosis; myelodysplastic and non-malignant myeloproliferative disorders; aplastic anemia; atypia; non-malignant monoclonal gamopathy; carcinoid; or pre-malignant lesions, benign tumors or polyps.

Such Cancer must be positively diagnosed by a Physician certified by the American Board of Pathology or American Board of Osteopathic Pathology. Pathologic interpretation of the histology of skin lesions will be accepted from dermatologists certified by the American Board of Dermatopathology. Diagnosis must be made based on a microscopic examination of fixed tissue, or preparations from the hemic system (either during life or post-mortem). The pathologist establishing the diagnosis shall base his or her judgment solely on the criteria of malignancy as accepted by the American Board of Pathology or the Osteopathic Board of Pathology after a study of the histocytologic architecture or pattern of the suspect tumor, tissue and/or specimen.

Clinical diagnosis of Cancer will be accepted as evidence that Cancer exists in a Covered Person when a pathological diagnosis is medically inadvisable if: such medical evidence substantially documents the diagnosis of Cancer; and the Covered Person receives treatment for Cancer by a Physician. When the requisite diagnosis of Cancer can only be made post-mortem, benefits will be paid back to the date of terminal admission to the Hospital.

CERTIFICATE is the individual document issued to the Insured. It describes the coverage under this Policy.

CERTIFICATE EFFECTIVE DATE is the effective date of the individual Certificate issued to the Insured.

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

CERTIFICATE SCHEDULE means page 3 of the Certificate.

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

COVERED PERSON(S) is a person who is eligible for coverage under the Certificate and for whom coverage is in force (see Section 4 - Eligibility and Effective Date).

COVERED PERSON'S EFFECTIVE DATE means the date the Covered Person's coverage under the Certificate becomes effective. The Insured's effective date will be the same as the Certificate Effective Date (subject to Section 4 – Eligibility and Effective Date). The Insured's Eligible Dependents are eligible for insurance on the date the Insured becomes eligible for insurance or the date a person becomes an Eligible Dependent, whichever is later. The effective date of coverage for each Eligible Dependent will be the first of the month following our approval of the application and receipt of the first premium (see Newborn and Adopted Children provision).

DISABILITY (OR DISABLED) means the Insured is:
1. under the age of 65; and
2. unable to work at any job for which he or she is qualified by education, training, or experience; and
3. not working at any job for pay or benefits; and
4. under the care of a Physician for the treatment of Cancer;

or, the Insured is:
1. retired or age 65 or older; and
2. unable to perform two (2) or more ADLs, as defined in this policy, without the assistance of another person; and
3. under the care of a Physician for the treatment of Cancer.

DREAD DISEASE is one or more of the diseases listed below. These diseases must be first diagnosed by a Physician. Diagnosis must be made by the appropriate evaluation, analysis, and study of tissues, blood, body fluids, cultures, and/or special laboratory tests.

Addison's Disease
Amyotrophic Lateral Sclerosis
Cystic Fibrosis
Diphtheria
Encephalitis
Grand Mal Epilepsy
Legionnaire's Disease
Meningitis
Multiple Sclerosis
Muscular Dystrophy
Myasthenia Gravis
Niemann-Pick Disease
Osteomyelitis
Poliomyelitis
Reye's Syndrome
Rheumatic Fever
Rocky Mountain Spotted Fever
Sickle Cell Anemia
Systemic Lupus Erythematosus
Tay-Sachs Disease
Tetanus
Toxic Epidermal Necrolysis
Toxic Shock Syndrome
Tuberculosis
Tularemia
Typhoid Fever
Whipple's Disease

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

1. the Insured's lawful spouse; and/or
2. the Insured's, and/or the Insured's spouse's, natural child, adopted child or stepchild who is under 26 years of age; or
3. any child, as outlined in #2 above, who becomes incapable of self-sustaining employment because of mental or physical incapacity while covered under the Certificate and prior to reaching the limiting age for dependent children. The child must be dependent on the Insured for support and maintenance. We must receive proof of incapacity within 31 days after coverage would otherwise terminate. Coverage will then continue as long as the Insured's 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 two-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 the Certificate terminates; or
4. any child under the age of 26 who is under the Insured's charge, care and control, and who has been placed in the Insured's home for adoption, or for whom the Insured is a party in a suit in which adoption of the child is sought; or
5. any child under the age of 26 for whom the Insured must provide medical support under an order issued under Chapter 154 of the Texas Family Code, or enforceable by a court in Texas; or
6. grandchildren under the age of 26 if those grandchildren are the Insured's dependents for federal income tax purposes at the time application for coverage of the grandchild is made.

EMERGENCY ROOM is a specified area within a Hospital that is designated for the emergency care of accidental injuries or sicknesses. This area must:

1. be staffed and equipped to handle trauma; and
2. be supervised and provide treatment by Physicians; and
3. provide care seven days a week, 24 hours a day.

EXPERIMENTAL TREATMENT means drugs, chemical substances or surgeries approved by the National Cancer Institute for experimental use on humans.

EXTENDED CARE FACILITY is an institution or section of a Hospital that is used for the care of convalescent patients and:

1. is licensed and operated pursuant to law; and
2. is primarily engaged in providing, in addition to room and board, skilled nursing, intermediate and custodial care under the direction of a Physician; and
3. provides 24-hour nursing services by or under the supervision of a Nurse; and
4. maintains a daily medical record of each patient; and
5. is not, other than in a minor way, a place for: rest for the aged; the care of drug addicts or alcoholics; the care and treatment of mental or nervous disorders; or educational care.

EVIDENCE OF INSURABILITY is a statement of the medical history for each person to be insured, which is used in determining if such person is eligible for coverage. Evidence of Insurability will be provided at such person's expense.

FULL-TIME is at least the minimum number of hours per week as defined in the Master Application.

HOME HEALTH CARE means professional nursing services, occupational therapy, respiratory or inhalation therapy and administration of drugs and medicines. This definition does not include: nutrition counseling; medical social services; medical supplies; prosthesis or orthopedic appliances; rental or purchase of durable medical equipment; drugs or medicines; child care; meals or housekeeping services.

HORMONE THERAPY means the use or manipulation of hormones, natural or synthetic, to prevent growth of malignancy.

HOSPICE CARE means palliative and supportive care for the Terminally Ill. Hospice Care must be provided by a licensed agency under the direction of a Physician. This definition does not include: well baby care; volunteer services; meals; housekeeping services; or family support after the death of the Covered Person.

HOSPITAL is a place that:
1. is licensed and operated pursuant to law; and
2. provides care and treatment for sick 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 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 hospice unit, including any bed designated as a hospice or a swing bed; a convalescent home; a rest or nursing facility; a rehabilitative facility; an extended-care facility; a skilled nursing facility; or a facility primarily affording custodial care, educational care, or care or treatment for persons suffering from mental diseases or disorders, or care for the aged, or care for drug or alcohol addiction.

HOSPITAL CONFINEMENT (HOSPITAL CONFINED) means the Covered Person is confined to a bed as a resident Inpatient in a Hospital, or confined in an observation unit or Emergency Room within a Hospital 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. Successive Hospital stays will be considered as one period of confinement if they are:
1. due to the same or related causes; and
2. separated by less than 30 days.

IMMEDIATE FAMILY is 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 means one of the following periods during which the Full-Time employee and/or any Eligible Dependent may first apply in writing for coverage under the Certificate:
1. if the Full-Time employee, or Eligible Dependent is eligible for coverage on the Policy Effective Date, the defined period before the Policy Effective Date as set by us and the Policyholder; or
2. if the Full-Time employee, or Eligible Dependent becomes eligible for coverage after the Policy Effective Date, the period ending 31 days after the date the Insured is first eligible to apply for coverage.

INPATIENT means a Covered Person who is admitted as a resident patient to a Hospital for at least 18 consecutive hours, and is being charged for room and board facilities. This does not include a person who is confined in an observation unit or Emergency Room in a Hospital.

INSURED (you or your) is the person named as the Insured on the Certificate Schedule. To be eligible for coverage, the Insured must be a Full-Time employee of the Policyholder.

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

NURSE is any of the following who is not a member of the Insured's immediate family:
1. a licensed practical Nurse (L.P.N.);
2. a licensed vocational Nurse (L.V.N.);
3. a graduate registered Nurse (R.N.); or

other designation as required by state law.

PHYSICIAN is a practitioner of the healing arts who is legally qualified and licensed to practice medicine, and is practicing within the scope of his or her license in the state where so licensed and renders treatment for which benefits are provided by the Certificate. The Physician must not be a member of the Covered Person's Immediate Family or anyone who normally resides with the Insured in his or her residence.

PLACEMENT (or PLACED) FOR ADOPTION, for purposes of the Certificate, means the assumption by the Insured of physical custody of the child to be adopted and the financial support and care of the child.

POLICY is the document issued to the Policyholder under which the Certificates are issued.

POLICY EFFECTIVE DATE is the date shown as the Policy Effective Date in the Policy Schedule.

POLICYHOLDER means the employer or contracting company who holds the Policy.

POLICY MONTH is 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 page and ending at 12:00 a.m. Standard Time the following month on the same date.

POLICY SCHEDULE means page 3 of the Policy.

PRE-EXISTING CONDITION means a Specified Disease for which medical advice or treatment was recommended by or received from a member of the medical profession within the Pre-Existing Condition Period immediately preceding the Covered Person's Effective Date. The Pre-Existing Condition Period is shown on the Certificate Schedule.

RADIATION, CHEMOTHERAPY, or IMMUNOTHERAPY, as approved by the American Medical Association or the Federal Drug Administration, means:

1. radiation therapy (includes mega voltage radiation, electron beam radiation and superficial x-ray therapy, using either natural or artificially propagated radiation; interstitial or intracavity application of radium or radioisotopes in sealed sources; application of radium or radioisotopic plaques or molds; or the administration internally, interstitially or intracavitarially of radium or radioisotopes in nonsealed sources);
2. chemotherapy (including surgical chemotherapy implants; cancericidal chemical substances; and photosensitizing drugs used in correlation with photodynamic therapy).
3. Immunotherapy: monoclonal antibodies and colony stimulating factors used to repair, stimulate or enhance the immune system's natural anti-cancer function.

These therapies must be used for the purpose of modification or destruction of abnormal tissue or to enhance the immune system and not for diagnosis.

These therapies do not include other procedures related to radiation and chemotherapy treatment such as treatment planning, treatment management or consultation. Design and construction of treatment devices, radiation dosimetry calculation, lab tests, x-rays, scans, medical supplies and equipment used in administration (IV solutions, needles, dressings, pumps, catheters, etc.) are not included. Anti-nausea drugs are not included.

SCHEDULE OF BENEFITS is the benefit schedule set forth in the Policy and Certificate.

SKIN CANCER means a cancer or malignant neoplasm of the skin that does not invade bone or does not metastasize to internal or visceral organs.

SPECIFIED DISEASE means Cancer, Skin Cancer or Dread Disease as defined in this Certificate.

STEM CELL TRANSPLANT is the harvesting, storage and subsequent reinfusion of stem cells from the recipient's, or a matched donor's, blood.

TERMINALLY ILL means the Covered Person's life expectancy is estimated to be six months or less.

WAITING PERIOD means a specified number of days following the Covered Person's Effective Date. No benefits will be paid for a Specified Disease that is diagnosed or occurs during the Waiting Period. The Waiting Period is shown on the Policy Schedule.

SECTION 4 - ELIGIBILITY AND EFFECTIVE DATE

ELIGIBILITY: The Insured and his or her Eligible Dependents are eligible to be insured under the Certificate if:

1. the Insured and his or her Eligible Dependents meet our underwriting rules; and
2. the Insured is Actively at Work with the Policyholder and qualifies for coverage as defined in the Master Application.

If we require Evidence of Insurability at the point of sale, then Evidence of Insurability will always be required for any changes to the coverage.

If we do not require Evidence of Insurability at the point of sale, Evidence of Insurability will only be required if:

1. the Insured voluntarily canceled coverage and is reapplying; or
2. the Insured is applying for an amount of coverage over the Guarantee Issue limit; or
3. the Insured is applying for an increase in or addition to coverage any time after the Insured's Initial Enrollment period; or
4. an Eligible Dependent did not enroll within 31 days of eligibility.

A person must apply for insurance during the Initial Enrollment period or within 31 days of the date the person first becomes eligible for coverage. If the person does not apply during the Initial Enrollment period or within 31 days of the date the person first becomes eligible for coverage, he or she may be subject to additional underwriting by us.

PLAN OF INSURANCE: The Plan Selected shown on the Certificate Schedule determines who is covered under the Certificate, unless such person is specifically excluded by rider or endorsement. Those eligible under each plan of insurance are as follows:

1. Individual means the Insured; and
2. Individual and Spouse means the Insured and his or her lawful spouse; and
3. One-Parent Family means the Insured and his or her Eligible Dependent children; and
4. Two-Parent Family means the Insured and his or her Eligible Dependent spouse and children.

CHANGE OF PLAN: After the Initial Enrollment, the Plan Selected may be changed as follows:

1. removing a Covered Person will require:
   a) a request from the Policyholder; and
   b) submission of the correct premium for the new plan.
2. adding Eligible Dependent(s), except a newborn or adopted child as described in the Newborn and Adopted Children provision, will require:
   a) an application or notification to add the Eligible Dependent; and
   b) Evidence of Insurability (if required) for each Eligible Dependent to be added; and
   c) submission of any additional premium needed for the new plan.

The change of plan will take effect on the beginning of the next Certificate Month after the request has been received and we have notified the Insured in writing that the change has been approved.

EFFECTIVE DATE: The Insured must use forms provided by us when applying for insurance. If our underwriting rules are met and the premium has been paid, the insurance will take effect on the later of the following dates:

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

If the Insured is not Actively At Work on the Certificate Effective Date due to disability, injury, sickness, temporary layoff, leave of absence or Family and Medical Leave of Absence, coverage begins on the date the Insured returns to Actively At Work. The Insured must also be Actively at Work on the effective date of any increase in or addition to coverage that occurs after the Certificate Effective Date.

NEWBORN AND ADOPTED CHILDREN: If the plan is an Individual Plan or Individual and Spouse Plan, all of the Insured's newborn children will be covered automatically on the day he or she is born as long as the Insured's 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 we are notified 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/adopted children will also include coverage for: a newborn child adopted by the Insured from the moment of birth, if a petition for adoption was filed within 31 days of the birth of the child; and a child adopted by the Insured 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: we are notified by the end of the 31-day period of the addition of such adopted child and any applicable additional premium is paid.

If the plan is a Single Parent Family Plan or Two Parent Family Plan, 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.

SECTION 5 - BENEFITS

This section explains benefits we provide for a loss incurred while covered under the Certificate, following a diagnosis of Cancer. When coverage terminates, our obligation to pay benefits also terminates for loss incurred after coverage termination for a Specified Disease that manifested itself while the person was covered under the Certificate. A charge must be incurred for benefits to be payable.

CANCER SCREENING BENEFITS

A. **DIAGNOSTIC TESTING:** We will pay the indemnity amount shown on the Schedule of Benefits, subject to the maximum number of tests per Calendar year, for each Covered Person who receives a screening test that is generally medically recognized to detect internal Cancer including, but not limited to:

1. mammogram;
2. breast ultrasound;
3. breast thermography;
4. breast cancer blood test (CA 15-3);
5. colon cancer blood test (CEA);
6. prostate-specific antigen blood test (PSA);
7. flexible sigmoidoscopy;
8. colonoscopy;
9. virtual colonoscopy;
10. ovarian cancer blood test (CA-125);
11. pap smear (lab test required);
12. chest x-ray;
13. hemocult stool specimen;
14. serum protein electrophoresis (blood test for myeloma);
15. Thin Prep Pap test.

The Covered Person must incur a charge for the screening test. This benefit is available without a diagnosis of Cancer. Screening tests payable under this benefit will ONLY be paid under this benefit. This benefit does not include any test payable under the Medical Imaging benefit. Benefits will only be paid for tests performed after the 30-day period following the Covered Person's Effective Date.

B. **FOLLOW-UP DIAGNOSTIC TESTING:** When a Covered Person receives abnormal results from a covered screening test (See Diagnostic Testing benefit), we will pay the indemnity amount shown on the Schedule of Benefits for one follow-up invasive screening test (a test involving an incision or surgery or the insertion of an instrument into the body). For those tests involving an incision or surgery, this benefit will only be paid for a test that results in a negative diagnosis of Cancer. Diagnostic surgeries that result in a positive diagnosis of Cancer will be paid under the Surgical benefit. For those invasive tests that do not involve an incision, this benefit will be paid regardless of the diagnosis.

C. **MEDICAL IMAGING:** We will pay the indemnity amount shown on the Schedule of Benefits, subject to the maximum number of tests per Calendar Year, for a Covered Person, who has been diagnosed with Cancer, and receives either a:

1. Magnetic Resonance Imaging (MRI);
2. Computed Tomography (CT) scan;
3. Computed Axial Tomography (CAT) scan; or
4. Positron Emission Tomography (PET) scan;

when performed due to Cancer or the treatment of Cancer. The MRI, CT scan, CAT scan, or PET scan, must be done at the request of a Physician.

CANCER TREATMENT BENEFITS

D. **RADIATION THERAPY, CHEMOTHERAPY, or IMMUNOTHERAPY:** We will pay the Actual Charges up to the amount shown on the Schedule of Benefits per 12-month period when the Covered Person receives Radiation, Chemotherapy, or Immunotherapy. The 12-month period begins on the first day the Covered Person receives covered Radiation Therapy, Chemotherapy, or Immunotherapy.

This benefit is payable only when the Insured has incurred a charge for covered therapy or covered drugs as shown on the definition of Radiation, Chemotherapy, or Immunotherapy in the Certificate. For Chemotherapy and Immunotherapy, coverage will be limited to the drugs only.

This benefit does not cover other procedures related to Radiation, Chemotherapy, or Immunotherapy treatment such as treatment planning, treatment management or consultation. Design and construction of treatment devices, radiation dosimetry calculation, lab tests, x-rays, scans, medical supplies and equipment used in administration (IV solutions, needles, dressings, pumps, catheters, etc.) are not covered under this benefit. Anti-nausea drugs are not covered under this benefit. This benefit does not include any drugs or medicines covered under the Drugs and Medicine benefit or the Hormone Therapy benefit.

E. **HORMONE THERAPY:** We will pay the indemnity amount shown on the Schedule of Benefits per Calendar Year when the Covered Person receives Hormone Therapy treatment prescribed by a Physician. This benefit is payable per treatment subject to the maximum number of treatments shown on the Schedule of Benefits. This benefit covers the drugs and medicines only. It does not include associated administrative processes. This benefit does not include any drugs or medicines covered under the Drugs and Medicine benefit or the Radiation Therapy, Chemotherapy, or Immunotherapy benefit.

SURGICAL BENEFITS

F. **SURGICAL:** When a surgical operation is performed on a Covered Person for a covered diagnosed Cancer, Skin Cancer, or for reconstructive surgery due to Cancer, we will pay the lesser of:

1. the surgical unit value assigned to the procedure multiplied by the Unit Dollar Amount shown on the Schedule of Benefits; or
2. the maximum per operation amount shown on the Schedule of Benefits.

We will use the most current Physician's Relative Value Table and the Current Procedural Terminology (CPT) Code to determine the surgical unit value assigned to each procedure.

An indemnity benefit will be calculated as follows: Unit Dollar Amount shown on the Schedule of Benefits x surgical unit value = Benefit Amount (up to the maximum per operation amount shown on the Schedule of Benefits).

This benefit will be paid for surgery performed in or out of the Hospital.

Two or more surgical procedures performed through the same incision will be considered one operation and benefits will be limited to the most expensive procedure. Two or more surgical procedures performed through different incisions will be considered two operations and benefits will be paid for each procedure. In no case will the benefit payable for one operation exceed the maximum amount per operation in the Schedule of Benefits.

Diagnostic surgeries that result in a negative diagnosis of Cancer are not covered under this benefit. Bone Marrow Transplant or Stem Cell Transplant surgeries are paid under the Bone Marrow or Stem Cell Transplant benefit. Surgeries required to implant a permanent prosthetic device are covered under the Prosthesis benefit.

This benefit is payable for reconstructive breast surgery performed on a non-diseased breast to establish symmetry with a diseased breast when reconstructive surgery on the diseased breast is performed while covered under this policy. Reconstructive surgery to the non-diseased breast must occur within 24 months of the reconstructive surgery of the diseased breast.

G. **ANESTHESIA:** We will pay the amount shown on the Schedule of Benefits for the services of an anesthesiologist received as a result of a covered surgery. Hospital Confinement is not required to receive this benefit. Services of an anesthesiologist for Bone Marrow Transplants or Stem Cell Transplants are covered under the Bone Marrow or Stem Cell Transplant benefits. Services of an anesthesiologist for Skin Cancer or surgical prosthesis implantation are not covered under this benefit.

H. **BONE MARROW TRANSPLANT:** When a Bone Marrow Transplant is performed on a Covered Person as treatment for a diagnosed Cancer, we will pay the indemnity amount, up to the maximum amount per lifetime, as shown on the Schedule of Benefits. This benefit is payable in or out of the Hospital. This benefit is payable in lieu of the Surgical benefit and the Anesthesia benefit. If a Bone Marrow Transplant and a Stem Cell Transplant are performed on the same day, only the Bone Marrow Transplant will be payable.

I. **STEM CELL TRANSPLANT:** When a Stem Cell Transplant is performed on a Covered Person as treatment for a diagnosed Cancer, we will pay the indemnity amount, up to the maximum amount per lifetime, as shown on the Schedule of Benefits. This benefit is payable in or out of the Hospital. This benefit is payable in lieu of the Surgical benefit and the Anesthesia benefit. If a Bone Marrow Transplant and a Stem Cell Transplant are performed on the same day, only the Bone Marrow Transplant will be payable.

J. **PROSTHESIS:** We will pay the indemnity amount shown on the Schedule of Benefits for a prosthetic device received due to Cancer that manifested after the 30 days following the Covered Person's Effective Date and, if surgery is required, its surgical implantation, provided the implantation of such device is prescribed by a Physician as a direct result of surgery for Cancer. This benefit does not cover prosthetic related supplies such as special bras or ostomy pouches and supplies. Artificial limbs will be paid under the surgical implantation portion of this benefit. Temporary prosthetic devices used as tissue expanders are covered under the Surgical benefit. Benefits for hair prosthesis will only be covered under the Hair Prosthesis benefit.

PATIENT CARE BENEFITS

K. **HOSPITAL CONFINEMENT:** We will pay the indemnity amount shown on the Schedule of Benefits when a Covered Person requires Hospital Confinement for the treatment of a covered Cancer or the treatment of a condition or disease directly caused by Cancer or the treatment of Cancer. We will not pay this benefit for outpatient treatment or a stay of less than 18 hours in an observation unit or Emergency Room.

L. **OUTPATIENT FACILITY:** When a surgical procedure is performed on an outpatient basis in a Hospital or at an Ambulatory Surgical Center on a Covered Person for a diagnosed Cancer, we will pay the indemnity amount shown on the Schedule of Benefits when a facility fee is charged by such Hospital or Ambulatory Surgical Center. Surgical procedures for Skin Cancer performed on an outpatient basis in a Hospital or Ambulatory Surgical Center are not covered under this benefit.

M. **ATTENDING PHYSICIAN:** When a Covered Person requires the services of a Physician, other than a surgeon, while Hospital Confined for the treatment of Cancer, we will pay the indemnity amount shown on the Schedule of Benefits for one Physician's visit per day of confinement.

N. **DREAD DISEASE:** We will pay the indemnity amount shown on the Schedule of Benefits for each day of Hospital Confinement of a Covered Person for treatment of a Dread Disease. Benefits for Dread Disease are ONLY provided under this provision.

O. **EXTENDED CARE FACILITY:** We will pay the indemnity amount shown on the Schedule of Benefits for each day a Covered Person is confined in an Extended Care Facility due to Cancer and charges are incurred for room and board. Such confinement must be at the direction of a Physician, and begin within 14 days after a Hospital Confinement. This benefit will be paid for up to the same number of days benefits were paid for the Covered Person's preceding Hospital Confinement.

P. **DONOR:** If expenses are incurred by a donor, other than the Covered Person, on behalf of a Covered Person for a covered surgery due to organ transplant, Bone Marrow Transplant, or Stem Cell Transplant, we will pay the indemnity amount shown on the Schedule of Benefits. This benefit will be paid regardless of where the surgery is performed. Blood donor expenses are not covered under this benefit.

Q. **HOME HEALTH CARE:** We will pay the indemnity amount shown on the Schedule of Benefits for Home Health Care required due to Cancer which is prescribed by a Physician in lieu of Hospital Confinement. Such care must be provided by a Nurse, or by a home health Nurse's aid under the supervision of a registered Nurse and begin within 14 days following a covered Hospital Confinement. The caregiver may not be a member of the Insured's Immediate Family. This benefit does not include physical, speech or audio therapy, or psychotherapy as these therapies are covered under the Physical, Occupational, Speech or Audio Therapy, or Psychotherapy benefit. This benefit will be paid for up to the same number of days benefits were paid for the Covered Person's preceding Hospital Confinement. If the Covered Person qualifies for coverage under the Hospice Care benefit, the Hospice Care benefit will be paid in lieu of this benefit.

R. **HOSPICE CARE:** When a Covered Person has been diagnosed by a Physician as terminally ill due to Cancer and requires Hospice Care, we will pay the indemnity amount shown on the Schedule of Benefits, subject to the maximum number of days per lifetime, for each day care is received. Care must be directed by a licensed hospice organization in the patient's home, or on an outpatient or short-term Inpatient basis in a hospice facility. The Covered Person is considered to be terminally ill if expected to live six months or less.

S. **U.S. GOVERNMENT, CHARITY HOSPITAL, OR H.M.O.:** We will pay the indemnity amount shown on the Schedule of Benefits if an itemized list of services is not available because a Covered Person is:

1. confined in a charity Hospital or a Hospital owned or operated by the United States Government; or
2. covered under a Health Maintenance Organization (H.M.O.) or a Diagnostic Related Group (D.R.G.) where no charges are made to the Covered Person.

If this option is elected, we will pay the amount shown on the Schedule of Benefits. If the Covered Person is confined as an Inpatient in a Hospital as a result of Cancer or Dread Disease, we will pay benefits for each full day of confinement. If outpatient services are provided, we will pay the benefit for each day that outpatient surgery is performed or outpatient therapy is received for Cancer covered by the Policy. This benefit will be paid in lieu of any amounts payable under provisions A through R, T through W, and Z through FF.

MISCELLANEOUS BENEFITS

T. **CANCER TREATMENT CENTER EVALUATION or CONSULTATION:** If a Covered Person obtains a treatment opinion at a National Cancer Institute designated Comprehensive Cancer Treatment Center, we will pay the indemnity amount shown on the Schedule of Benefits, subject to the maximums per lifetime. If the Comprehensive Cancer Treatment Center is located more than 50 miles from the Covered Person's place of residence, we will also pay the transportation and lodging indemnity amount shown on the Schedule of Benefits under this benefit. This benefit is payable in lieu of the Transportation and Lodging benefit (X and Y).

U. **SECOND AND THIRD SURGICAL OPINION:** We will pay the indemnity amount shown on the Schedule of Benefits for a second surgical opinion when the attending Physician recommends surgery as treatment of a diagnosed Cancer. The second surgical opinion must be obtained from the consulting Physician prior to surgery. If the second surgical opinion disagrees with the first, we will pay the amount shown on the Schedule of Benefits for a third surgical opinion. This benefit is payable once per diagnosis of Cancer. Surgical opinions for reconstructive, Skin Cancer, or prosthesis surgeries are not covered under this benefit.

V. **DRUGS AND MEDICINE:** We will pay the indemnity amount shown on the Schedule of Benefits, subject to the maximums, for anti-nausea and pain medication prescribed by a Physician and administered to a Covered Person, who is also receiving Radiation Therapy, Chemotherapy, or Immunotherapy, a covered surgery, or Bone Marrow or Stem Cell Transplant. This benefit covers drugs and medicines only. It does not include associated administrative charges. This benefit does not include drugs or medicines covered under the Radiation, Chemotherapy, or Immunotherapy benefit or the Hormone Therapy benefit.

W. **HAIR PIECE (WIG):** We will pay the indemnity amount shown on the Schedule of Benefits, subject to the lifetime maximum, for a Covered Person's hair prosthesis needed as a direct result of Cancer or the treatment of Cancer. Benefits for a hair prosthetic will only be paid under this benefit.

X. **TRANSPORTATION AND LODGING:** We will pay the actual coach fare for transportation by bus, plane, or train; or, the per mile amount shown on the Schedule of Benefits for transportation by car, of a Covered Person, who has been diagnosed as having Cancer, to receive covered Radiation Therapy, Chemotherapy, or Immunotherapy treatment, Bone Marrow or Stem Cell Transplant, or surgery in a Hospital that is at least 50 miles away from the Covered Person's residence, using the most direct route. Such Hospital must be prescribed by a Physician and be the nearest Hospital which offers the specialized treatment. If the Covered Person travels by bus, plane or train, the Insured will have the option to receive the coach fare benefit or the per mile benefit. If the Insured is unable to provide proof of coach fare, the per mile benefit will be paid. If treatment is received on an outpatient basis, we will also pay the amount shown on the Schedule of Benefits, subject to the maximum number of days, for the Covered Person's lodging in a single room in a motel, hotel or other accommodation acceptable to us while the Covered Person is receiving the specialized treatment. Travel must be by scheduled bus, plane or train, or by car and be within the United States or its Territories. Travel by car will be paid at the stated rate shown on the Schedule of Benefits per mile for up to 1,000 miles round trip. Benefits will be provided for only one mode of transportation per round trip, and subject to the maximum number of trips as shown on the Schedule of Benefits. If the Covered Person receives treatment while Hospital Confined, benefits for transportation will be paid once per Hospital Confinement. Benefits for lodging will be paid only on those days the Covered Person received outpatient treatment.

Y. **FAMILY MEMBER TRANSPORTATION AND LODGING:** We will pay for one adult family member to be near a Covered Person who is receiving covered Radiation Therapy, Chemotherapy, or Immunotherapy treatment, Bone Marrow or Stem Cell Transplant, or surgery due to Cancer in a Hospital that is at least 50 miles away from the Covered Person's residence, using the most direct route. We will pay the actual coach fare for transportation by bus, plane, or train; or, the per mile amount shown on the Schedule of Benefits for transportation by car. If the family member travels by bus, plane or train, the Insured will have the option to receive the coach fare benefit or the per mile benefit. If the Insured is unable to provide proof of coach fare, the per mile benefit will be paid. If treatment for the Covered Person is received on an outpatient basis, we will pay the amount shown on the Schedule of Benefits, subject to the maximum number of days, for the family member's lodging in a single room in a motel, hotel or other accommodation acceptable to us. Travel must be by scheduled bus, plane or train, or by car and be within the United States or its Territories. Travel by car will be paid at the stated rate per mile shown on the Schedule of Benefits for up to 1,000 miles round trip. If the family member and the Covered Person who is receiving treatment travel in the same car or lodge in the same room, benefits for travel and lodging will only be paid under the Transportation and Lodging benefit. Benefits will be provided for only one mode of transportation per round trip, and subject to the maximum number of trips as shown on the Schedule of Benefits. If the Covered Person receives treatment while Hospital Confined, benefits for travel and/or lodging will be paid once per Hospital Confinement. If treatment is received on an outpatient basis, benefits for travel and/or lodging will be paid only on those days the Covered Person received outpatient treatment.

Z. **BLOOD, PLASMA, AND PLATELETS:** We will pay the indemnity amount shown on the Schedule of Benefits for blood, plasma and platelets. This does not include any laboratory processes. This benefit is payable in or out of the Hospital. Colony stimulating factors are not covered under this benefit. Benefits for Blood, Plasma, and Platelets are ONLY provided under this benefit.

AA. **EXPERIMENTAL TREATMENT:** We will provide coverage for Experimental Treatment prescribed by a Physician for the treatment of Cancer the same as we provide coverage for any non-experimental treatment covered under the Policy. This benefit is payable for treatments received in or out of the Hospital. This benefit does not provide coverage for treatments received outside of the United States or its Territories.

BB. **AMBULANCE:** We will pay the indemnity amount shown on the Schedule of Benefits, subject to the maximum number of trips per confinement, for transportation of a Covered Person by air or ground ambulance to a Hospital or from one medical facility to another where the Covered Person is admitted as an Inpatient and Hospital Confined for at least 18 consecutive hours for the treatment of Cancer. A licensed ambulance company must provide the ambulance service. If air and ground ambulance service are both required in the same day, we will pay only the highest benefit amount.

CC. **INPATIENT SPECIAL NURSING SERVICES:** We will pay the indemnity amount shown on the Schedule of Benefits for full-time special nursing care (other than that regularly furnished by a Hospital) while a Covered Person is Hospital Confined for treatment of Cancer. For the purpose of this benefit, "Full-time" means at least eight consecutive hours during a 24-hour period. Such care must be provided by a Nurse; be prescribed by a Physician; and be for the treatment of Cancer.

DD. **OUTPATIENT SPECIAL NURSING SERVICES:** We will pay the indemnity amount shown on the Schedule of Benefits for outpatient full-time private duty nursing at the Covered Person's home. Such outpatient services must begin within 14 days following a covered Hospital Confinement. For the purpose of this benefit, "Full-time" means at least eight consecutive hours during a 24-hour period. Such care must be provided by a Nurse; be prescribed by a Physician; and be for the treatment of Cancer. This benefit is payable for up to the same number of days benefits were paid for the Covered Person's preceding Hospital Confinement. If the Covered Person qualifies for coverage under the Home Health Care benefit or Hospice Care benefit, this benefit will be paid in addition to those benefits. If a Covered Person received both Inpatient Special Nursing Services and Outpatient Special Nursing Services within the same 24-hour period, only the Inpatient Special Nursing Services benefit will be payable.

EE. **MEDICAL EQUIPMENT:** We will pay the indemnity amount shown on the Schedule of Benefits, subject to the maximum per Calendar Year, for the rental or purchase of the following when prescribed by a Physician for the treatment of Cancer:

1. braces;
2. crutches;
3. wheelchairs;
4. hospital bed;
5. toilet;
6. pulleys;
7. aspirator;
8. incontinence pants;
9. oxygen;
10. surgical dressings;
11. rubber shields; or
12. colostomy and ilieostomy appliances.

This benefit will not be paid for medical equipment used while the Covered Person is Hospital Confined.

FF. **PHYSICAL, OCCUPATIONAL, SPEECH, AUDIO THERAPY, or PSYCHOTHERAPY:** If a Physician advises a Covered Person to seek physical, occupational, speech, audio therapy, or psychotherapy, we will pay the indemnity amount shown on the Schedule of Benefits, subject to the maximum amount per Calendar Year, for this treatment. These therapies must be as a result of Cancer or the treatment of Cancer and be performed by a caregiver licensed in physical, occupational, speech, audio therapy, or psychotherapy. If two or more therapies occur on the same day, only one benefit amount will be paid.

GG. **WAIVER OF PREMIUM:** If, while the Certificate is in force, the Insured becomes Disabled, we will waive all premiums due including premium for any riders attached to the Certificate. Disability must be due to Cancer and occur while receiving treatment for such Cancer for which benefits are payable under this Policy. The Insured must remain Disabled for 60 continuous days before this benefit will begin. The Waiver of Premium will begin on the next premium due date following the 60 consecutive days of Disability. This benefit will continue for as long as the Insured remains Disabled until the earliest of:

1. the date the Insured is no longer Disabled; or
2. the date coverage ends according to the Termination provisions in the Certificate.

Proof of Disability: The Insured must provide us with proof of Disability. This proof includes, but is not limited to, the following documentation:

1. a Physician's statement containing the following:
    a. the date Cancer was diagnosed;
    b. the date Disability, due to Cancer, began;
    c. the expected date, if any, such disability will end; and
2. the employer's statement with the last date of work and expected date of return, if known.

Proof of Disability must be provided for each new period of Disability before a new Waiver of Premium benefit is payable.

Proof of Continuance of Disability: The Insured must provide us with proof of continued Disability at least once every three months. From time to time, we may require proof that the Insured continues to be Disabled, but such proof will not be required more often than once a month. We may also require that the Insured be examined at reasonable intervals by one or more Physicians named by us at our expense. If proof is not furnished on request or if the Insured fails to submit to examination, no further premiums will be waived.

Notice of Recovery: The Insured must notify us in writing as soon as Disability due to Cancer ends. We will assume Disability no longer exists if:

1. the Insured does not send us proof of continued Disability at least once every three months;
2. the Insured does not agree to have a physical examination performed; or
3. the Insured notifies us the Disability has ended.

Recurrence Of Prior Disability: If, after recovery from a Disability which has lasted for at least 60 consecutive days, the Insured suffers another Disability that:

1. starts within 30 days of recovery; and
2. is due to the same or related causes as the prior Disability;

then, such Disability will be deemed to have continued during the period between recovery and recurrence.

End of Disability: If the Insured is no longer Disabled, the Insured's coverage will continue until the next premium due date. If the Insured still qualifies as an Insured under the Policy/Certificate, premium must be paid in order for the Insured's coverage under the Certificate to remain in force. If the Insured no longer qualifies as an Insured, the Insured's coverage will terminate as described in the Termination provisions in the Certificate.

This benefit does not apply if the Insured's spouse or an Eligible Child becomes Disabled.

SECTION 6 - LIMITATIONS AND EXCLUSIONS

No benefits will be paid for:

1. care or treatment received outside the territorial limits of the United States; or
2. treatment by any program engaged in research that does not meet the definition of Experimental Treatment (see Section 3); or
3. losses or medical expenses incurred prior to the Covered Person's Effective Date regardless of when Cancer was diagnosed.

ONLY LOSS FOR CANCER OR DREAD DISEASE: This Policy pays only for loss resulting from definitive Cancer treatment including direct extension, metastatic spread, or recurrence. Proof must be submitted to support each claim. This Policy also covers other conditions or diseases directly caused by Cancer or the treatment of Cancer. This Policy does not cover any other disease, sickness or incapacity, which existed prior to the diagnosis of Cancer, even though after contracting Cancer it may have been complicated, aggravated or affected by Cancer or the treatment of Cancer except for conditions specifically provided in the Dread Disease benefit.

PRE-EXISTING CONDITION EXCLUSION: No benefits are payable for any loss incurred during the Pre-Existing Condition Exclusion Period following the Covered Person's Effective Date as the result of a Pre-Existing Condition. The Pre-Existing Condition Exclusion Period is shown on the Certificate Schedule. Pre-Existing Conditions specifically named or described as excluded in any part of this contract are never covered. If any change to coverage after the Certificate Effective Date results in an increase or addition to coverage, the Time Limit on Certain Defenses and Pre-Existing Condition Limitation for such increase will be based on the effective date of such increase (see Changes to Coverage in Section 10).

WAITING PERIOD: This Policy contains a Waiting Period during which no benefits will be paid. If any Covered Person has a Specified Disease diagnosed before the end of the Waiting Period immediately following the Covered Person's Effective Date, coverage for that person will apply only to loss that is incurred after one year from the Covered Person's Effective Date. The Waiting Period is shown on the Certificate Schedule. If any Covered Person is diagnosed as having a Specified Disease during the Waiting Period immediately following the Covered Person's Effective Date, the Insured may elect to void the Certificate from the beginning and receive a full refund of premium.

If this Policy replaced Specified Disease Cancer coverage from another company that terminated within 30 days of the Certificate Effective Date, the Waiting Period will be waived for those Covered Persons that were covered under the prior coverage. However, the Pre-Existing Condition Limitation provision will still apply.

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, the Certificate will terminate at the end of the period for which premium is due (see Grace Period in Section 10).

PREMIUM CHANGES: The premium rates may be changed by us 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. If a change in benefits increases our liability, premium rates may be changed on the date the liability is increased.

REFUND OF UNEARNED 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 the death occurred will be refunded.

SECTION 8 - TERMINATION OF COVERAGE

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

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

In addition, we may end the coverage of a Policyholder if:
1. fewer persons are insured than the Policyholder's application requires;
2. the Policyholder does not promptly provide us with information that is reasonably required; or
3. the Policyholder fails to perform any of its obligations that relate to this Policy.

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

1. the date the Policy terminates;
2. the end of the grace period if the premium remains unpaid;
3. the date insurance has ceased on all persons covered under the Certificate;
4. the end of the Certificate Month in which the Policyholder requests to terminate this coverage;
5. the date the Insured no longer qualifies as an Insured;
6. the date of the Insured's death.

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

1. the date the Policy terminates;
2. the date the Certificate terminates;
3. the end of the grace period if the premium remains unpaid;
4. the end of the Certificate Month in which the Policyholder requests to terminate the coverage for an Eligible Dependent;
5. the date a Covered Person no longer qualifies as an Insured or Eligible Dependent;
6. the date of the Covered Person's death.

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

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

CANCELLATION BY THE INSURED: The Insured may cancel the Certificate at any time by notifying the Policyholder. Notice must then be communicated to us by the Policyholder (see Termination of Certificate above, bullet 4). Cancellation will take effect pursuant to Termination of Certificate, bullet 4, or on such later date as may be specified in such notice. In the event of such Cancellation, we will promptly return the pro rata portion of any unearned premium paid to the premium payor. This will not prejudice any claim that originated prior to the date Cancellation took effect.

SECTION 9 - CLAIMS

NOTICE OF CLAIM: Notice of claim must be given to us within twenty (20) days after the loss occurs or begins when there is a claim for covered charges, or as soon as reasonably possible. We must receive notice at our home office at 2305 Lakeland Drive, Flowood, Mississippi 39232 or to any authorized insurance producer. Information sufficient to identify the Covered Person shall be deemed notice to us.

CLAIM FORMS: When we receive notice of claim, we will send the claim forms. If these forms are not sent within 15 days, proof of loss may be submitted by giving us a written statement of the nature and extent of the loss within the time limit for filing written proof of loss (see Proof of Loss provision).

PROOF OF LOSS: Written proof of loss must be given to us within 90 days after the date of such loss. However, the claim will not be reduced or denied if it was not reasonably possible to give proof in that time; and the proof is filed as soon as reasonably possible. In no event, except the absence of legal capacity, may proof be given later than one year after the loss.

TIME OF PAYMENT OF CLAIMS: All benefits will be paid immediately, once we receive due written proof of loss. For continuing losses, we will pay the benefits due monthly on receipt of due proofs of loss. All benefits will be paid directly to the Insured.

Subject to our benefit maximums, we will pay the Texas Department of Human Resources for the actual cost of medical expenses the Department pays through medical assistance for a Covered Person if the Insured is entitled to payment for medical expenses under this policy.

All benefits payable under this policy for an Eligible Child for whom benefits for financial and medical assistance are being provided by the Texas Department of Human Services will be paid to such Department if:

1. the Department is paying benefits for financial and medical assistance service programs under Chapter 31 or Chapter 32 of the Human Resources Code; and
2. the Insured has possession or access to the child pursuant to a court order or are required by the court to pay child support.

We must receive written notice at our home office. Such notice must be attached to the insurance claim when first submitted, and state that all benefits must be paid directly to the Texas Department of Human Services.

PAYMENT OF CLAIMS: We will pay all benefits to the Insured. Should we fail to pay the benefits payable upon receipt of due written proof of loss, we shall have fifteen (15) working days thereafter within which to mail the Insured a letter or notice which states the reasons we have for not paying the claim, either in whole or in part, and which also gives the Insured a written itemization of any documents or other information needed to process the claim or any portions thereof which are not being paid. When all listed documents or other information needed to process the claim have been received, we shall then have fifteen (15) working days within which to process and either pay the claim or deny it, in whole or in part, giving the Insured the reasons we may have for denying such claim or any portion thereof.

Any benefits that have not been paid at the time of the Insured's death will be paid to the beneficiary, if living, or to the Insured's estate. If benefits are payable to the Insured's estate or to any person who is not competent to give us a valid release, we have the right to pay up to $1,000 of those benefits to any person related to the Insured by blood or marriage who we believe is justly entitled to such payment. If we make a payment under this provision in good faith, we will be released from liability to the extent of the payment.

PHYSICAL EXAMINATION: If the Covered Person makes a claim, the Covered Person must submit to a physical examination as often as we may reasonably request. We will pay for these examinations.

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

SECTION 10 - GENERAL PROVISIONS

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

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

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

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

No claim for any 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 on the date of loss, had existed prior to the Covered Person's Effective Date.

CHANGES TO COVERAGE: The Insured may have the right to change the plan or amount of insurance, or both, after the Certificate Effective Date if the Policyholder and we agree. A new application and Evidence of Insurability may be required. Any change in coverage will only apply to a Cancer that occurs after the effective date of such change in coverage. No changes to coverage will be allowed during the first 12 months except for a qualifying event including, but not limited to, a birth, death, divorce, adoption or marriage. No increases to coverage will be allowed if a diagnosis of Cancer has occurred prior to the request for change.

If any change to coverage after the Certificate Effective Date results in an increase in or addition to coverage, the premiums will be based on his or her attained age on the effective date of the increase or addition, and the Time Limit on Certain Defenses and Pre-Existing Condition Limitation for such increase will be based on the effective date of such increase or addition. Such changes include, but are not limited to, the following:

1. an increase in the benefit amounts;
2. adding a Covered Person; or
3. adding a rider.

If any change to coverage after the Certificate Effective Date results in a decrease in or deletion to coverage, the premiums will be based on his or her original age on the effective date of the decrease or deletion, and the Time Limit on Certain Defenses and Pre-Existing Condition Limitation will not be affected. Such changes include, but are not limited to, the following:

1. a decrease in the benefit amounts;
2. deleting a Covered Person; or
3. deleting a rider.

GRACE PERIOD: The 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, the Certificate will stay in force. If the premium is not paid by the end of the 31-day grace period, the Insured's Certificate will terminate as of the date the renewal premium became due.

UNPAID PREMIUM: Upon determining the Insured's continued eligibility, any premium due and unpaid may be deducted from the claim payment when a claim is paid.

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

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

American Public Life Insurance Company

FOR INQUIRIES OR TO OBTAIN INFORMATION, PLEASE CONTACT:
2305 Lakeland Drive, Flowood, Mississippi 39232
Toll Free (800) 256-8606

LIMITED BENEFIT SPECIFIED DISEASE CANCER INSURANCE POLICY

SCHEDULE OF BENEFITS

CANCER SCREENING BENEFITS	BENEFIT AMOUNT
A. Diagnostic Testing Maximum 1 test per Covered Person per Calendar Year	$ 50
B. Follow-Up Diagnostic Testing Maximum 1 test per Covered Person per Calendar Year	$ 100
C. Medical Imaging Per test up to maximum of 1 tests per Covered Person per Calendar Year, following diagnosis of Cancer	$ 500

CANCER TREATMENT BENEFITS	BENEFIT AMOUNT
D. Radiation Therapy, Chemotherapy, Immunotherapy Maximum per Covered Person per 12-month period	$ 20,000
E. Hormone Therapy Per treatment up to maximum of 12 treatments per Covered Person per Calendar Year	$50

SURGICAL BENEFITS	BENEFIT AMOUNT
F. Surgical Unit Dollar Amount Maximum per operation	$ 30 $ 3,000
G. Anesthesia Percent of amount paid for covered surgery	25%
H. Bone Marrow Transplant Maximum per Covered Person per lifetime	$ 6,000
I. Stem Cell Transplant Maximum per Covered Person per lifetime	$ 600
J. Prosthesis Surgical Implantation Maximum 1 device per site per Covered Person per lifetime Non-Surgical (does not include Hair Piece) Maximum 1 device per site per Covered Person per lifetime	$ 1,000 $ 100

PATIENT CARE BENEFITS	BENEFIT AMOUNT
K. Hospital Confinement Per day of Hospital Confinement Per day for Eligible Dependent children	$ 100 $ 200
L. Outpatient Hospital or Ambulatory Surgical Center Per day surgery is performed	$ 200
M. Attending Physician Per day of Hospital Confinement	$ 30
N. Dread Disease Per day of Hospital Confinement	$ 100
O. Extended Care Facility Per day up to same number of Hospital Confinement Days	$ 100
P. Donor Per day	$ 100
Q. Home Health Care Per day up to same number of Hospital Confinement Days	$ 100
R. Hospice Care Per day up to maximum of 365 days per Covered Person per lifetime	$ 100
S. U.S. Government, Charity Hospital or HMO Maximum per day of Hospital Confinement	$ 100

SCHEDULE OF BENEFITS

MISCELLANEOUS BENEFITS		BENEFIT AMOUNT
T.	**Cancer Treatment Center Evaluation or Consultation** Maximum 1 evaluation or consultation per Covered Person per lifetime	Not Included
	Evaluation or Consultation Travel and Lodging Maximum 1 per Covered Person per lifetime	Not Included
U.	**Second and Third Surgical Opinion**	
	Per Diagnosis of Cancer	$ 300
	Per Diagnosis if 3rd Opinion Required	$ 300
V.	**Drugs and Medicine**	
	Inpatient, per Confinement	$ 150
	Outpatient, per Prescription	$ 50
	Maximum outpatient per Covered Person per month	$ 150
W.	**Hair Piece (Wig)**	
	Maximum of 1 benefit per Covered Person per lifetime	$ 150
X.	**Transportation**	
	Travel by bus, plane or train	Actual Coach Fare or $ 0.40 per mile
	Travel by car	$ 0.40 per mile
	Maximum of 12 trips per Covered Person per Calendar Year for all modes of transportation combined	
	Lodging	
	Per day up to maximum of 100 days per Covered Person per Calendar Year	$ 50
Y.	**Family Transportation**	
	Travel by bus, plane or train	Actual Coach Fare or $ 0.40 per mile
	Travel by car	$ 0.40 per mile
	Maximum of 12 trips per Covered Person per Calendar Year for all modes of transportation combined	
	Family Lodging	
	Per day up to maximum of 100 days per Covered Person per Calendar Year	$ 50
Z.	**Blood, Plasma, and Platelets**	
	Per day	$ 300
AA.	**Experimental Treatment** Paid in the same manner and under the same maximums as any other benefit in this Schedule	
BB.	**Ambulance**	
	Ground, per trip	$ 200
	Air, per trip	$ 2,000
	Maximum 2 trips per Covered Person per Hospital Confinement for all modes of transportation combined	
CC.	**Inpatient Special Nursing Services**	
	Per day of Hospital Confinement	$ 150
DD.	**Outpatient Special Nursing Services**	
	Per day up to same number of Hospital Confinement Days	$ 150
EE.	**Medical Equipment**	
	Maximum 1 benefit per Covered Person per Calendar Year	Not Included
FF.	**Physical, Occupational, Speech, Audio Therapy or Psychotherapy**	
	Per visit.	$ 25
	Maximum per Covered Person per Calendar Year	$ 1,000

SCHEDULE OF BENEFITS

BENEFIT RIDERS	BENEFIT AMOUNT
Internal Cancer First Occurrence Rider	
Lump Sum Benefit	$ 5,000
Lump Sum for Eligible Dependent children	$ 7,500
Maximum 1 per Covered Person per lifetime	
Heart Attack/Stroke First Occurrence Rider	
Lump Sum Benefit	$ 2,500
Lump Sum for Eligible Dependent children	$ 3,750
Maximum 1 per Covered Person per lifetime	
Hospital Intensive Care Unit Rider	
Intensive Care Unit per day	$ 600
Step Down Unit per day	$ 300
Maximum of 45 days per Confinement for any combination of Intensive Care Unit or Step Down Unit	

American Public Life Insurance Company
2305 Lakeland Drive, Flowood, Mississippi 39232
Toll Free (800) 256-8606

Internal Cancer First Occurrence Benefit Rider

OPTIONALLY RENEWABLE – BENEFITS DECREASE BY 50% AT AGE 70
SUBJECT TO THE COMPANY'S RIGHT TO CHANGE PREMIUM RATES

Effective Date: 09-01-2014

This rider is issued in return for the application and receipt of the first premium for this rider. This rider is 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.

DEFINITIONS

CARCINOMA IN SITU, for the purpose of benefits under this rider, means an early stage of Internal Cancer in which the tumor, or tumor cells, are confined to the organ or tissue where it first developed. The disease has not invaded other parts of the organ, tissue, or spread to distant parts of the body. For all cancers, the staging, as supported by medical documents including pathology, surgical and clinical information, will be used to determine if the cancer in question meets the definition of Carcinoma In Situ.
Examples of Carcinoma In Situ include, but are not limited to:

1. for prostate cancer: a diagnosis of Stage A1 or A2, using the Jewett-Whitmore system, or a diagnosis of T1a or T1b using the Tumors, Nodes, Metastases (TNM) system, or equivalent staging; or
2. for breast cancer: a diagnosis of "in situ," or Tis, using the TNM system, or equivalent staging; or
3. for colon cancer: a diagnosis of Stage 0, using the American Joint Cancer Committee (AJCC) staging, or Tis, using the TNM system, or equivalent staging; or
4. for melanoma: a diagnosis of Stage 0, using the AJCC staging, or Tis, using the TNM system, or Level I, using the Clark Level staging, or equivalent staging; or
5. any other cancer which meets the definition of Carcinoma In Situ.

Carcinoma In Situ does not include Internal Cancer, Skin Cancer, or conditions that may be considered pre-cancerous or having malignant potential such as:

1. Actinic keratosis; or
2. Myelodysplastic and non-malignant myeloproliferative disorders; or
3. Aplastic anemia; or
4. Atypia; or
5. Non-malignant monoclonal gamopathy; or
6. Pre-malignant lesions, benign tumors or polyps; or
7. Leukoplakia; or
8. Hyperplasia; or
9. Carcinoid; or
10. Polycythemia.

DATE OF DIAGNOSIS means the date shown on the pathological report submitted; or, the date a Physician establishes the Internal Cancer diagnosis through the use of clinical evidence submitted or laboratory findings.

INTERNAL CANCER means a disease that is manifested by autonomous growth (malignancy) in which there is uncontrolled growth, function, or spread (local or distant) of cells in any part of the body. For the purposes of this

definition, it does not include other conditions that may be considered pre-cancerous or having malignant potential such as:

1. Actinic keratosis;
2. Myelodysplastic and non-malignant myeloproliferative disorders;
3. Aplastic anemia;
4. Atypia;
5. Non-malignant monoclonal gamopathy;
6. Leukoplakia;
7. Hyperplasia;
8. Carcinoid;
9. Polycythemia; or
10. Carcinoma in Situ or any Skin Cancer other than invasive malignant melanoma into the dermis or deeper.

A legally licensed doctor of medicine certified by the American Board of Pathology or American Board of Osteopathic Pathology must positively diagnose the Cancer. Diagnosis must be made based on microscopic examination of fixed tissue, or preparations from the hemic system (either during life or post mortem). The pathologist establishing the diagnosis shall base his or her judgment solely on the criteria of malignancy as accepted by the American Board of Pathology or the Osteopathic Board of Pathology after a study of the histocytologic architecture of pattern of the suspect tumor, tissue and/or specimen.

Clinical diagnosis of Cancer will be accepted as evidence that Cancer exists when a pathological diagnosis is medically inadvisable if: such medical evidence substantially documents the diagnosis of Cancer; and the Covered Person receives treatment for Cancer by a Physician legally licensed for the practice of medicine.

PRE-EXISTING CONDITION, for the purpose of benefits under this rider, means an Internal Cancer for which medical advice or treatment was recommended by or received from a member of the medical profession within the Pre-Existing Condition Period immediately preceding the Covered Person's Effective Date of this rider. The Pre-Existing Condition Period is shown on the Certificate Schedule.

WAITING PERIOD means the number of days shown in the Certificate Schedule following the Effective Date of this rider. No benefits will be paid for an Internal Cancer when the Date of Diagnosis occurs during the Waiting Period.

BENEFITS

If, while this rider is in force and subject to the Exclusions and Limitations, a Covered Person receives a first diagnosis of Internal Cancer, we will pay the lump sum benefit. This benefit amount is shown on the Schedule of Benefits. The Date of Diagnosis of Internal Cancer must occur after the Waiting Period. Only one benefit amount per Covered Person per lifetime is payable under this rider.

The Internal Cancer lump sum benefit amount will reduce by 50% at age 70.

PREMIUM

The premium shown in the Policy/Certificate Schedule is payable under the same conditions as the premium for the Policy/Certificate.

TIME LIMIT ON CERTAIN DEFENSES

After two years from the Effective Date of this rider, no misstatements (except fraudulent misstatements) made by you in the application for this rider will be used to void the rider or to deny a claim for loss that begins after the end of such two year period.

EXCLUSIONS AND LIMITATIONS

No benefits will be paid for:

1. a diagnosis of Internal Cancer received outside the territorial limits of the United States; or
2. a metastasis to a new site of any Cancer diagnosed prior to the Covered Person's Effective Date, as this is not considered a first diagnosis of an Internal Cancer.

PRE-EXISTING CONDITION EXCLUSION: No benefits are payable for any loss incurred during the Pre-Existing Condition Exclusion Period following the Covered Person's Effective Date of this rider as the result of a Pre-Existing Condition, as defined in this rider. The Pre-Existing Condition Exclusion Period is shown on the Certificate Schedule.

WAITING PERIOD: This rider contains a Waiting Period during which no benefits will be paid. If any Covered Person has an Internal Cancer diagnosed before the end of the Waiting Period immediately following the Covered Person's Effective Date of this rider, coverage for that person will apply only to loss that is incurred after one year from the Covered Person's Effective Date of this rider. The Waiting Period is shown on the Certificate Schedule.

TERMINATION OF RIDER COVERAGE

This rider will terminate and coverage will end for all Covered Persons on the earliest of:

1. the end of the grace period if the premium for this rider remains unpaid;
2. the date the Policy or Certificate to which this rider is attached terminates;
3. the end of the Certificate Month in which we receive a request from the Policyholder to terminate this rider;
4. the date of your death;
5. the date the lump sum benefit amount for Internal Cancer has been paid for all Covered Persons under this rider.

Coverage on an Eligible Dependent terminates under this rider when such person ceases to meet the definition of Eligible Dependent, as defined in the Policy/Certificate.

Signed for American Public Life Insurance Company.

President, Chief Operating Officer

American Public Life Insurance Company
2305 Lakeland Drive, Flowood, Mississippi 39232
Toll Free (800) 256-8606

Heart Attack/Stroke First Occurrence Benefit Rider

OPTIONALLY RENEWABLE – BENEFITS DECREASE BY 50% AT AGE 70
SUBJECT TO THE COMPANY'S RIGHT TO CHANGE PREMIUM RATES

Effective Date: 09-01-2014

This rider is issued in return for the application and receipt of the first premium for this rider. This rider is 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.

DEFINITIONS

DATE OF DIAGNOSIS means the date a Physician establishes the diagnosis through the use of clinical evidence submitted or laboratory findings.

HEART ATTACK means an acute myocardial infarction resulting in the sudden death of the heart muscle resulting from a blockage of one or more coronary arteries. A Physician must make the diagnosis and treatment must occur within 72 hours of the onset of symptoms. The diagnosis must be based on an event, which consists of all of the following:

1. the sudden onset of symptoms consistent with a heart attack; and
2. elevation of cardiac (heart) biomarkers; and
3. electrocardiagraphic changes consistent with a heart attack.

The definition of Heart Attack does not include congestive heart failure, atherosclerotic heart disease, angina, including unstable angina, coronary disease or any other dysfunction of the cardiovascular system.

PRE-EXISTING CONDITION, for the purpose of this rider, means a condition for which medical advice or treatment was recommended by or received from a member of the medical profession within the Pre-Existing Condition Period immediately preceding the Covered Person's Effective Date of this rider. The Pre-Existing Condition Period is shown on the Certificate Schedule.

STROKE means a sudden neurological impairment of sensory and/or motor functions due to aneurysm rupture, acute cerebral occlusion, or acute cerebral hemorrhage from a cerebral artery, which results in permanent damage to the nervous system deficit that is diagnosed by a Physician. Stroke does not mean head injury, transient ischemic attack, multi-infarct dementia, or chronic cerebrovascular insufficiency.

WAITING PERIOD means the number of days shown in the Certificate Schedule following the Effective Date of this rider. No benefits will be paid for a Heart Attack or Stroke when the Date of Diagnosis occurs during the Waiting Period.

BENEFITS

If, while this rider is in force, a Covered Person receives a first diagnosis of Heart Attack or Stroke, we will pay you a lump sum benefit. This benefit amount is shown on your Schedule of Benefits. The Date of Diagnosis of the Heart Attack or Stroke must occur after the Waiting Period. Only one benefit amount per Covered Person per lifetime is payable under this rider.

The Heart Attack/Stroke lump sum benefit amount will reduce by 50% at age 70.

PREMIUM

The premium shown in the Policy/Certificate Schedule is payable under the same conditions as the premium for the Policy/Certificate.

TIME LIMIT ON CERTAIN DEFENSES

After two years from the Effective Date of this rider, no misstatements (except fraudulent misstatements) made by you in the application for this rider will be used to void the rider or to deny a claim for loss that begins after the end of such two year period.

EXCLUSIONS AND LIMITATIONS

PRE-EXISTING CONDITION EXCLUSION: No benefits are payable for any loss incurred during the Pre-Existing Condition Exclusion Period following the Covered Person's Effective Date of this rider as the result of a Pre-Existing Condition, as defined in this rider. The Pre-Existing Condition Exclusion Period is shown on the Certificate Schedule.

WAITING PERIOD: This rider contains a Waiting Period during which no benefits will be paid. If any Covered Person has a Heart Attack or Stroke diagnosed before the end of the Waiting Period immediately following the Covered Person's Effective Date of this rider, coverage for that person will apply only to loss that is incurred after one year from the Covered Person's Effective Date of this rider. The Waiting Period is shown on the Certificate Schedule.

EXCLUSIONS: We will not pay benefits for any loss caused by or resulting from:

1. intentionally self-inflicted bodily injury, suicide or attempted suicide, whether sane or insane;
2. alcoholism or drug addiction;
3. any act of war, declared or undeclared, or any act related to war, or active service in the armed forces, or military service for any country at war; (If coverage is suspended for any Covered Person during a period of military service, we will refund the pro-rata portion of any premium paid for any such Covered Person upon receipt of the Policyholder's written request.)
4. participation in any activity or event while intoxicated or under the influence of any narcotic unless administered by a Physician or taken according to the Physician's instructions; or
5. participation in, or attempting to participate in, a felony, riot or insurrection (a felony is defined by the law of the jurisdiction in which the activity takes place).

TERMINATION OF RIDER COVERAGE

This rider will terminate and coverage will end for all Covered Persons on the earliest of:

1. the end of the grace period if the premium for this rider remains unpaid;
2. the date the Policy or Certificate to which this rider is attached terminates;
3. the end of the Certificate Month in which we receive a request from the Policyholder to terminate this rider;
4. the date of your death;
5. the date the lump sum benefit amount for Heart Attack or Stroke has been paid for all Covered Persons under this rider.

Coverage on an Eligible Dependent terminates under this rider when such person ceases to meet the definition of Eligible Dependent, as defined in the Policy/Certificate.

Signed for American Public Life Insurance Company.

President, Chief Operating Officer

American Public Life Insurance Company
2305 Lakeland Drive, Flowood, Mississippi 39232
Toll Free (800) 256-8606

Hospital Intensive Care Unit Rider

OPTIONALLY RENEWABLE – BENEFITS DECREASE BY 50% AT AGE 70
SUBJECT TO THE COMPANY'S RIGHT TO CHANGE PREMIUM RATES

NO BENEFITS, UNDER THIS HOSPITAL INTENSIVE CARE UNIT RIDER, WILL BE PROVIDED DURING THE FIRST TWO YEARS FOLLOWING THE EFFECTIVE DATE OF THIS RIDER FOR CONFINEMENTS CAUSED BY ANY HEART CONDITION WHEN ANY HEART CONDITION WAS DIAGNOSED OR TREATED PRIOR TO THE END OF THE 30-DAY PERIOD FOLLOWING THE COVERED PERSON'S EFFECTIVE DATE OF THIS RIDER. (THE HEART CONDITION CAUSING THE CONFINEMENT NEED NOT BE THE SAME CONDITION DIAGNOSED OR TREATED PRIOR TO THE EFFECTIVE DATE.)

FOR A NEWBORN CHILD BORN WITHIN THE 10-MONTH PERIOD FOLLOWING THE EFFECTIVE DATE OF THIS RIDER, NO BENEFITS, UNDER THIS HOSPITAL INTENSIVE CARE UNIT RIDER, WILL BE PROVIDED FOR CONFINEMENTS THAT BEGIN WITHIN THE FIRST 30 DAYS FOLLOWING THE BIRTH OF SUCH CHILD.

Effective Date: 09-01-2014

This rider is issued in return for the application and receipt of the first premium for this rider. This rider is 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.

DEFINITIONS

INTENSIVE CARE UNIT (ICU) means only that part of the Hospital that:
1. provides the highest level of medical care; and
2. is restricted to those patients who are critically ill or injured; and
3. is separated and apart from the surgical recovery room and from rooms, beds and wards used for patient confinement; and
4. is permanently equipped with special life-saving equipment for the care of the critically ill or injured; and
5. maintains constant and continuous observation of the patients by nursing staffs assigned exclusively to the ICU on a full time basis.

These units must be listed as ICUs in the current edition of the American Hospital Association Guide or be eligible to be listed. This guide lists three types of facilities that meet this definition:
1. Intensive Care Unit
2. Cardiac Intensive Care Unit; and
3. Infant Neonatal Intensive Care Unit.

We will not pay benefits for confinements in units such as: Surgical Recovery Rooms, Progressive Care, Burn Units, Intermediate Care, Private Monitored Rooms, Observation Units, Step-Down (Telemetry) Units or Psychiatric Units not involving intensive medical care; or other facilities which do not meet the standards for ICU as defined above.

PERIOD OF CONFINEMENT, for the purpose of this rider, means all consecutive calendar days a Covered Person is confined as an Inpatient in an ICU or Step-Down Unit, or any combination thereof. Successive confinements in an ICU or Step-Down Unit, or any combination thereof, will be considered the same confinement if they are due to the same or related causes, and are separated by less than 30 days from the last day of the last confinement.

STEP-DOWN (TELEMETRY) UNIT means a specifically designated part of a Hospital that provides medical care to patients whose medical conditions do not require Intensive Care Unit confinement but do require services beyond that provided in regular Hospital private or semi-private rooms, observation rooms or surgical recovery units. Hospital private or semi-private rooms, private monitored rooms, observation rooms or surgical recovery units are not considered Step-Down Units.

BENEFITS

While this rider is in force, if any Covered Person is confined in an ICU or Step-Down Unit as defined in this rider, we will pay daily benefits as described below. Benefits will be paid beginning with the first day of ICU or Step-Down Unit confinement due to accident or sickness when such confinement begins after the Effective Date of this rider. If any Covered Person is confined to an ICU or Step-Down Unit, we will pay a daily benefit for each day room and board is charged. Benefits will be paid up to the maximum number of days, shown in the Schedule of Benefits, for any combination of ICU and Step-Down Unit confinements. Benefits will not be paid for an ICU or Step-Down Unit confinement that begins prior to the Effective Date of this rider.

INTENSIVE CARE UNIT BENEFIT: The indemnity amount payable under this rider for each day of ICU confinement is shown on the Schedule of Benefits.

STEP-DOWN UNIT BENEFIT: The indemnity amount payable under this rider for each day of Step-Down Unit confinement is shown on the Schedule of Benefits.

PREMIUM

The premium shown in the Policy/Certificate Schedule is payable under the same conditions as the premium for the Policy/Certificate.

TIME LIMIT ON CERTAIN DEFENSES

After two years from the Effective Date of this rider, no misstatements (except fraudulent misstatements) made by you in the application for this rider will be used to void the rider or to deny a claim for loss that begins after the end of such two year period.

EXCLUSIONS AND LIMITATIONS

For a newborn child born within the 10-month period following the effective date of this rider, no benefits, under this Hospital Intensive Care Unit Rider, will be provided for confinements that begin within the first 30 days following the birth of such child.

No benefits, under this Hospital Intensive Care Unit Rider, will be provided during the first two years following the effective date of this rider for confinements caused by any heart condition when any heart condition was diagnosed or treated prior to the end of the 30-day period following the covered person's effective date of this rider. (The heart condition causing the confinement need not be the same condition diagnosed or treated prior to the effective date.)

EXCLUSIONS: We will not pay benefits for any loss caused by or resulting from:

1. intentionally self-inflicted bodily injury, suicide or attempted suicide, whether sane or insane;
2. alcoholism or drug addiction;

3. any act of war, declared or undeclared, or any act related to war, or active service in the armed forces, or military service for any country at war; (If coverage is suspended for any Covered Person during a period of military service, we will refund the pro-rata portion of any premium paid for any such Covered Person upon receipt of the Policyholder's written request.)
4. participation in any activity or event while intoxicated or under the influence of any narcotic unless administered by a Physician or taken according to the Physician's instructions; or
5. participation in, or attempting to participate in, a felony, riot or insurrection (a felony is defined by the law of the jurisdiction in which the activity takes place).

TERMINATION OF RIDER COVERAGE

This rider will terminate and coverage will end for all Covered Persons on the earliest of:

1. the end of the grace period if the premium for this rider remains unpaid;
2. the date the Policy or Certificate to which this rider is attached terminates;
3. the end of the Certificate Month in which we receive a request from the Policyholder to terminate this rider;
4. the date of your death.

Coverage on an Eligible Dependent terminates under this rider when such person ceases to meet the definition of Eligible Dependent, as defined in the Policy/Certificate.

Signed for American Public Life Insurance Company.

President, Chief Operating Officer

American Public Life Insurance Company

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

PORTABILITY AMENDMENT RIDER

If the Policy is no longer in force, then portability coverage is not available.

This rider is 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 following portability option is hereby added to your Certificate:

When the Insured no longer meets the definition of Insured, he or she will have the option to continue this coverage, including any attached riders. No Evidence of Insurability will be required. Portability must meet the following conditions:

1. the Certificate has been continuously in force for the last 12 months; and
2. we receive a request and payment of the first premium for the portability coverage no later than 30 days after the date the Insured no longer qualifies as an eligible Insured. All future premiums due will be billed directly to the Insured. The Insured is responsible for payment of all premiums for the portability coverage; and
3. the Policy, under which this Certificate was issued, continues to be in force on the date the Insured ceases to qualify for coverage.

The benefits, terms and conditions of the portability coverage will be the same as those elected under the Certificate immediately prior to the date the Insured exercised portability. Portability coverage may include any Eligible Dependents who were covered under the Certificate at the time the Insured ceased to qualify as an eligible Insured. No new Eligible Dependents may be added to the portability coverage except as provided in the Newborn and Adopted Children provision. No increases in coverage will be allowed while the Insured is exercising his or her rights under this rider.

Coverage under this rider will terminate in accordance with the provisions of Section 8 – Termination of Coverage in your Certificate.

CANCELLATION BY THE INSURED: After this portability option has been elected, the Insured may cancel the Certificate at any time. Written notice must be mailed or delivered to us. Cancellation will take effect the end of the Certificate Month in which we receive a request from you to cancel this rider. Any premium collected beyond the cancellation date will be refunded promptly. This will not prejudice any claim that originated prior to the date Cancellation took effect.

Signed for American Public Life Insurance Company.

President, Chief Operating Officer

3206

☐ Plan Sponsor Set-Up
☐ Master Application

American Public Life Insurance Company

(2305 Lakeland Drive • Flowood, Mississippi • 39232)
Phone: (800) 256-8606 • Fax: (877) 807-0911

Home Office Use Only: (6/10)
Group Number: _____
Effective Date: _____
No. of Insureds: _____
Guarantee Issue: _____
Take-Over: _____
Setup Date: _____

GENERAL INFORMATION

1. Plan Sponsor/Policyholder: Port Neches-Groves Independent School District
2. Mailing Address: 620 Avenue C City Port Neches State TX Zip 77651
3. Physical Address: 620 Avenue C City Port Neches State TX Zip 77651
   (If different than mailing address)
4. Plan Sponsor/Policyholder Contact Name: Becky Romero, Administrative/Benefits Secretary
5. Contact Phone: (409) 722-4244 x 1725 Fax: (409) 724-7452 6. E-mail Address: bromero@pngisd.org
7. Group Type: ☐ Association ☒ Employer ☐ Other (describe) _____
8. Tax I.D.#: 74-6001932 9. SIC Code: _____ 10. Year Established? 1911
11. Nature of Business: School District 12. Subsidiary & Affiliated Organizations: ☒ No ☐ Yes (attach information)
13. For Associations Only: ☐ Eligibility Determined at employer level
14. Current Employees/Members are Eligible: ☒ Immediately ☐ After ____ Days Employment (Full-Time Employee means 35 hours per week.)
15. New Employees/Members are Eligible After ____ Days Employment 1st of the month following employment date
16. Number of Currently Eligible Employees/Members 600 17. Requested Effective Date September 1, 2014
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): Cancer insurance - Philadelphia American Life
19. Will the insurance applied for replace any existing insurance? ☒ Yes ☐ No If "yes" list type of insurance, carrier, and termination date: Cancer insurance - Philadelphia American Life
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.) _____
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: annually on the plan anniversary.
24. I hereby request American Public Life Insurance Company to issue and deliver the Group Certificates of Insurance for the coverage applied? ☒ Yes ☐ No

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: aliciab@fbsbenefits.com Date of 1st Deduction: _____
Send Billing To: Name Alicia Boothe Phone #: (469) 385-4649
(List Billing Contact and Address if different than above)
Billing Address: 2121 N. Glenville Drive City Richardson State Texas Zip 75082

GROUP PRODUCT SELECTION

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

	[Plan 1] X	[Plan 2] X	[Plan 3]	[Plan 4]
Cancer Plan Benefits				
Cancer Screening Benefits	$ [50]	$ [50]	$ [50]	$ [50]
Cancer Treatment Benefits	$ [10,000]	$ [10,000]	$ [10,000]	$ [10,000]
Surgical Benefits	$ [3,000]	$ [3,000]	$ [3,000]	$ [3,000]
Patient Care Benefits	$ [100]	$ [100]	$ [100]	$ [100]
Miscellaneous Benefits	$ [.75] per mile	$ [.75] per mile	$ [.75] per mile	$ [.75] per mile

GROUP PRODUCT SELECTION (cont.)

Benefit Riders	[Plan 1 cont.]	[Plan 2 cont.]	[Plan 3 cont.]	[Plan 4 cont.]
[Internal Cancer First Occurrence	☒ Yes ☐ No $ [2,500]	☒ Yes ☐ No $ 5000 KT	☐ Yes ☐ No $ [2,500]	☐ Yes ☐ No $ [2,500]
[Heart Attack/Stroke First Occurrence	☒ Yes ☐ No $ [2,500]	☒ Yes ☐ No $ [2,500]	☐ Yes ☐ No $ [2,500]	☐ Yes ☐ No $ [2,500]
[Hospital ICU	☐ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

MASTER APPLICATION AGREEMENT

If this application is approved by American Public Life Insurance Company, group insurance will take effect: (a) on the Policy 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.

Signature of Plan Sponsor Official

Cheryl Hernandez, Business Manager
Title

April 23, 2014
Date

Agent Signature

Agent Number

Employer groups may be subject to certain State and/or Federal Employment related laws (including ERISA, IRS Sections 69 and 125, and COBRA) and the Employer is solely responsible for compliance of these laws including any required benefit payments not covered by an Insurance Plan.

FRAUD 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.

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 are 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

IMPORTANT INFORMATION ABOUT COVERAGE UNDER THE
TEXAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION
(For insurers declared insolvent or impaired on or after September 1, 2011)

Texas law establishes a system to protect Texas policyholders if their life or health insurance company fails. The Texas Life and Health Insurance Guaranty Association ("the Association") administers this protection system. Only the policyholders of insurance companies which are members of the Association are eligible for this protection which is subject to the terms, limitations, and conditions of the Association law. (The law is found in the *Texas Insurance Code*, Chapter 463.)

It is possible that the Association may not protect all or part of your policy because of statutory limitations.

Eligibility for Protection by the Association

When a member insurance company is found to be insolvent and placed under an order of liquidation by a court or designated as impaired by the Texas Commissioner of Insurance, the Association provides coverage to policyholders who are:

- Residents of Texas (**regardless of where the policyholder lived when the policy was issued**)
- Residents of other states, ONLY if the following conditions are met:
  1) The policyholder has a policy with a company domiciled in Texas;
  2) The policyholder's state of residence has a similar guaranty association; and
  3) The policyholder is *not eligible* for coverage by the guaranty association of the policyholder's state of residence.

Limits of Protection by the Association

Accident, Accident and Health, or Health Insurance:

- For each individual covered under one or more policies: up to a total of $500,000 for basic hospital, medical-surgical, and major medical insurance, $300,000 for disability or long term care insurance, or $200,000 for other types of health insurance.

Life Insurance:

- Net cash surrender value or net cash withdrawal value up to a total of $100,000 under one or more policies on a single life; or
- Death benefits up to a total of $300,000 under one or more policies on a single life; or
- Total benefits up to a total of $5,000,000 to any owner of multiple non-group life policies.

Individual Annuities:

- Present value of benefits up to a total of $250,000 under one or more contracts on any one life.

Group Annuities:

- Present value of allocated benefits up to a total of $250,000 on any one life; or
- Present value of unallocated benefits up to a total of $5,000,000 for one contractholder regardless of the number of contracts.

Aggregate Limit:

- $300,000 on any one life with the exception of the $500,000 health insurance limit, the $5,000,000 multiple owner life insurance limit, and the $5,000,000 unallocated group annuity limit.

These limits are applied for each insolvent insurance company.

Insurance companies and agents are prohibited by law from using the existence of the Association for the purpose of sales, solicitation, or inducement to purchase any form of insurance. When you are selecting an insurance company, you should not rely on Association coverage. For additional questions on Association protection or general information about an insurance company, please use the following contact information.

Texas Life and Health Insurance Guaranty Association
515 Congress Avenue, Suite 1875
Austin, Texas 78701
800-982-6362 or www.txlifega.org

Texas Department of Insurance
P.O. Box 149104
Austin, Texas 78714-9104
800-252-3439 or www.tdi.state.tx.us

(THIS FORM IS NOT A PART OF YOUR CONTRACT)

American Fidelity Group®
Notice of Privacy Policy and Insurance Information Practices

Information Only-No Action Required

Customer Information

The American Fidelity Group® affiliates have a long and distinguished history in the insurance and financial services industry. We understand the importance of protecting your privacy. In this notice, all references to "we" are meant to include all affiliate companies in the American Fidelity Group® including American Fidelity Assurance Company, American Public Life Insurance Company, and North American Insurance Agency, Inc. Since we are insurance and financial services providers, we may collect and receive certain nonpublic personal financial and medical information from customers and other entities on a daily basis. Our handling and protection of nonpublic personal financial and medical information is governed by a wide range of state and federal laws and regulations.

Information you provide to us is afforded the same protection whether we receive it from you in writing, by telephone, in conversation with one of our representatives, or via the Internet.

As a matter of policy, we will only disclose your nonpublic personal financial or medical information to other entities as permitted or required by law.

Confidentiality and Security

We maintain appropriate physical, electronic and procedural safeguards to maintain the confidentiality and security of your nonpublic personal information. We restrict access to nonpublic personal information about you to those employees who need to know that information to provide products or services to you.

Physical and electronic files are kept in secure areas. We educate our employees about the importance of confidentiality and customer privacy. We also enforce employee privacy responsibilities.

Information Collected

The information we collect varies depending on the types of products or services you request and may include:

- Information you provide to us in the application process including such things as your name, address, age, marital status, Social Security Number, annual income, and other financial information.
- Information about your transactions with us, our affiliates, or others such as additional products or services purchased, etc.
- Information provided by your employer, group plan sponsor, or association for any group product you may have.
- Information from consumer reporting agencies, such as credit relationships and history.
- Information from other sources outside the American Fidelity Group® such as medical information, motor vehicle reports, etc.
- Information from visitors to American Fidelity's Nonpublic OnLine Service Center Web Site.

Categories of Parties to Whom We May Disclose Information

As a corporate policy, we do not share your nonpublic personal financial or health information with any nonaffiliated third parties, or among our affiliated American Fidelity Group® companies for marketing purposes. We will not share account numbers or policy numbers with nonaffiliated third parties for use in telemarketing, direct mail, or e-mail marketing. We will only disclose nonpublic personal information about you to certain nonaffiliated third parties, which perform necessary services connected with the administration of our business, or as otherwise permitted or required by law. These nonaffiliated third parties will not receive access to your information without first agreeing in writing to maintain its confidentiality. Additionally, these entities will not be authorized to use your information for any purpose other than that authorized by us and allowed by law.

These nonaffiliated third parties may include other financial institutions, including insurance companies and other service-related entities contractually engaged by any of our affiliated companies to provide administrative, operational, marketing, underwriting or other business-related services for us, regarding our products and services, only.

In addition, we will not share medical information or motor vehicle reports for marketing purposes.

Many employers or other plan sponsors restrict the information that can be shared about their employees or members by companies that provide them with products or services, such as qualified Section 125 or Section 401(k) plans. In our business dealings with associations, we always honor these restrictions. If you have a relationship with us as a result of products or services provided through an employer or other plan sponsor, we will abide by the specific privacy rules imposed by that organization.

None of our affiliates share consumer report-type information protected by the Fair Credit Reporting Act (i.e., information you provide to the affiliate or that such affiliate receives from consumer reporting agencies which is used to determine your eligibility for that affiliate's financial and insurance products) with our other affiliates, or any nonaffiliated third parties, except as permitted or required by law.

If we receive any nonpublic personal financial information about you from any affiliated or nonaffiliated financial institutions, including other insurance companies, we will protect that information utilizing the same principles as outlined in this Privacy Notice, or as otherwise provided by state and federal privacy laws.

Should any of your policies with us terminate, and/or should you become a former customer, we will not disclose any nonpublic personal financial or medical information about you to any nonaffiliated third parties or affiliated American Fidelity Group® companies.

Account Information

We will continue to provide you with important information about your existing accounts, including inserts enclosed with your account statements and other notices regarding the American Fidelity Group® products that you own. You may also receive communications from your account representative, agent or broker.

We are mailing this privacy policy to the address to which we send your product or account information. Please notify us promptly if you have a change of address so that we can update our records and continue to provide you with the outstanding service you deserve.

Accuracy of Your Information That We Possess

We strive to maintain the accuracy of your information. In order to help us maintain accuracy, you have the right to reasonably access your information. If you believe any of your information in our possession is inaccurate you may request that we amend or delete the information that you believe to be erroneous. If we concur with your conclusion we will amend or delete the information in question.

Our Commitment to You

Each year we will send you a copy of our current Notice of Privacy Policy and Insurance Information Practices. We reserve the right to change our Privacy Policy and Insurance Information Practices. If we make any material changes to our policies or practices we will provide you with a copy of a revised notice.

Affiliated American Fidelity Group® Companies

This notice is being provided on behalf of the following American Fidelity Group® affiliates:

Agar Insurance Agency, Inc.
American Fidelity Corporation
American Public Life Insurance Company
American Fidelity Assurance Company
American Fidelity General Agency, Inc.
American Fidelity General Agency of Alabama, Inc.
American Fidelity Limited Agency, Inc.
American Fidelity Property Co.
American Fidelity Securities, Inc.
American Mortgage and Investment Co.
Balliet's, L.L.C.
CELP Limited Agency, Inc.
DentaCare Marketing & Administration, Inc.
First Financial Securities of America, Inc.
N.A.I.A. Insurance Agency, Inc.
N.A.I.A. of Louisiana, Inc.
North American Insurance Agency, Inc.
North American Insurance Agency of Colorado, Inc.
North American Insurance Agency of New Mexico, Inc.
North American Insurance Agency of Tulsa, Inc.
North American Insurance Ltd. Agency, Inc.
Security General Life Insurance Co.

Your Financial Security Network.

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.

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.