American Public Life Insurance Company

A member of the American Fidelity Group

2305 Lakeland Drive, Flowood, Mississippi 39232

POLICYHOLDER SERVICE

For information concerning coverage and support or assistance resolving complaints, contact American Public Life Insurance Company at **800.256.8606**

POLICYHOLDER: **Suwannee County School Board**

ADDRESS: **P O Box 1118, Farmington, CT 06034**

POLICY NUMBER: **18193**

EFFECTIVE DATE: **May 01, 2016**

ISSUE DATE: **May 01, 2016**

POLICY ANNIVERSARY DATE: **May 01**

CONSIDERATION: In consideration of the application for this group Policy and the timely payment of premiums, American Public Life Insurance Company (herein called the Company) agrees to make available Group Hospital Indemnity Insurance for eligible persons under the Policy.

CERTIFICATE OF INSURANCE: A person who enrolls for coverage will be issued a Certificate of Insurance. The Certificate of Insurance may be returned to the Company within 30 days after its receipt. If returned, the Certificate will be void from its beginning and any premium paid will be refunded.

WHEN A PERSON BECOMES INSURED: Each eligible person shall become insured on the Effective Date shown in the Certificate Schedule. 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. When a claim is paid, any premium due and unpaid is deducted from the claim payment if the claim is incurred during the Grace Period.

RENEWABILITY: This Policy is renewable at the option of the Company. The Policyholder or the Company may terminate the Policy after the first Policy Anniversary Date..

CONTINUATION: While this Policy is in force, Certificates issued under this Policy will continue, subject to the Termination provision, provided premiums are paid when due.

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

Signed for American Public Life Insurance Company.

Assistant Secretary

Vice President

Any person who knowingly, and with intent to injure, defraud or deceive an insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

THIS POLICY PROVIDES LIMITED BENEFITS
ALL BENEFITS ARE PAYABLE DIRECTLY TOTHE INSURED.
HOSPITAL INDEMNITY INSURANCE

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Policy GM HI-4005

HOSPITAL INDEMNITY INSURANCE

SCHEDULE OF BENEFITS

DESCRIPTION OF COVERAGE

BENEFITS	Option 1 BENEFIT AMOUNT MO. PREM.
Hospital Confinement Benefit Daily Indemnity Benefit	$ 50.00
OPTIONAL BENEFIT RIDERS	
Intensive Care/Coronary Care Rider Daily Indemnity Benefit	$ 100.00
Emergency Accident Rider Maximum Benefit Per Visit:	$ N/A
Wellness & Diagnostic Test Benefit Rider * Wellness Maximum Benefit:	$ N/A
Diagnostic Testing Maximum Benefit	$ N/A
***Maximum Combined Benefits for Wellness & Diagnostic Tests Benefits**	$ N/A
Ann. 1st Occurrence Hospital Rider :	$ 1500.00
Outpatient Sickness Rider Maximum Benefit Per Visit	$ N/A
Maximum Visits Per Calendar Year 5 per Adult, 5 for all Dependent children 10 for all persons combined	
Surgical & Anesthesia Benefit Rider Surgical Schedule Maximum	$ N/A
TOTAL PREMIUM	

PRE-EXISTING PERIOD: 12 MONTHS

PRE-EXISTING CONDITIONS EXCLUSION PERIOD: 12 MONTHS

DEFINITIONS

Additional Definitions may be contained in the Benefit Provisions or any attached Endorsement or Rider.

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

Accident or Injury means sudden, unexpected and unintended Injury:
(a) which is directly caused by an Accident;
(b) which is independent of any Sickness or disease;
(c) over which the Insured Person has no control; and
(d) that takes place while the Insured Person's coverage is in force.

Actively At Work means the person is performing the normal duties of his/her principal occupation, at his/her usual place of business, on a full time basis (at least 18 hours per week).

A person is deemed to be Actively at Work on each day of regular paid vacation during which he/she is not totally disabled, provided he/she was Actively at Work on the last preceding working day.

Calendar Year means the period beginning on the Certificate Date and ending on December 31 of the same year. Thereafter, it is the period beginning on January 1 and ending on December 31 of each following year.

Certificate means the individual Certificate issued to the Insured. It describes the coverage under the Policy. If the Insured is issued more than one Certificate under the Policy, only the last one issued will be in effect.

Certificate Effective Date means the effective date of the individual Certificate issued to an Insured.

Dental Treatment means treatment of the teeth and/or periodontal area.

Dependent includes:
(a) a married spouse [who is under age 70] and who lives with the Insured; or
(b) a child (natural, step. adopted, foster placement or other court ordered custody placement) who is not eligible for medical coverage as an Insured under the Policy and who:
    (1) is less than 25 years old and who lives with the Insured. Coverage will be provided until the end of the calendar year in which the child reaches age 25; or
    (2) is less than 25 years old and going to an accredited school part-time or full time. Coverage will be provided until the end of the calendar year in which the child reaches age 25. Such child must be dependent on the Insured for principal support and maintenance; or
    (3) is incapable of self-support because of mental retardation or physical handicap 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 child attains age 27; or
    (4) is not living with the Insured, but the Insured is legally required to support such child, and the child would otherwise qualify under (1), (2), or (3) above.

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

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

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

Inpatient means confinement in a Hospital for at least 24 continuous hours in duration.

Insured (You, Your) mean the person shown in the Certificate Schedule of Benefits. The Insured must be either:
    (1) employed by, or be a contractor of the Policyholder and normally work 18 or more hours per week and be Actively At Work on the Certificate Effective Date; or,
    (2) be a member in or employed by the association, if the Policy is issued to an association.

Master Application means that 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 the Policy.

Maximum Benefit Period means the period of time during which the Daily Benefit is payable for one Period of Confinement. The Maximum Benefit Period is shown in the Policy Schedule.

Mental or Emotional Disorder means a neurosis, psychoneurosis, psychopathy, psychosis or mental or emotional disease or disorder of any kind.

Period of Confinement means continuous confinement in a Hospital. Periods of Confinement for the same or a related cause which are separated by less than 90 days will be considered the same Period of Confinement. Each Period of Confinement must begin while coverage is in force for the Insured Person confined.

Physician means a practitioner of the healing arts who:
(a) is licensed; and
(b) is not related to the Insured Person; and,
(c) renders treatment for which benefits are provided by this Policy .

A Physician does not include a family member of an Insured Person. Family member means the Insured, the Insured's spouse, child, sibling, parent or parent-in-law.

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

Policy Effective Date means the date shown in the Master Policy schedule.

Policyholder means the association, employer, or contracting company who holds the Policy.

DEFINITIONS CONTINUED

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

during the twelve (12) month period of time immediately before the Effective Date of the Insured Person's coverage. The term "Pre-Existing Condition" will also include conditions which are related to such disease, or physical condition.

Pre-Existing Conditions specifically named or described as permanently excluded in any part of this contract are never covered. Pre-Existing Conditions specifically named or described as excluded for a limited time will be covered after the excluded period expires.

Routine follow up care to determine whether a breast cancer has recurred in a person who has been previously determined to be free of breast cancer does not constitute medical advice, diagnosis, care, or treatment for purposes of determining pre-existing conditions unless evidence of breast cancer is found during or as a result of the follow up care.

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

Sickness means illness or disease which first manifests itself after coverage becomes effective for the Insured Person. Sickness includes pregnancy or complications of pregnancy.

We, Our, or Us mean American Public Life Insurance Company.

ELIGIBILITY AND EFFECTIVE DATE

Eligibility: A person is eligible for insurance under the Policy if he/she works either under contract to or as an employee of the Policyholder, or is a member in or employed by the association, if the Policy is issued to an association. The person must qualify as an eligible Insured as defined in the Master Application; and be Actively at Work on his/her effective date of coverage.

Insured's Effective Date: A person must use forms provided by Us when applying for insurance. The insurance will take effect on the requested Certificate Effective Date; or the Certificate Effective Date assigned by Us upon approval of the Insured's application, whichever is later, the Insured is Actively at Work; and premium has been paid.

If the Insured is not Actively at Work due to an Accident or Sickness when coverage is to take effect, it will take effect on the first day of the calendar month after the date the Insured returns to active work.

Dependent Eligibility: If Dependent coverage is available under the Policy, Dependent's of the Insured will be eligible for insurance on the date the Insured becomes eligible for insurance, or the date a person becomes a Dependent. The Insured must complete any required forms within 31 days of the date the Dependent becomes eligible.

Dependent Effective Date: 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.

A newborn child will become covered for Accident and Sickness automatically on the day he or she is born as long as the Insured's coverage was in force on that date. Accident or Sickness includes prematurity, congenital defects and birth abnormalities of the newborn child. 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.

ELIGIBILITY AND EFFECTIVE DATE CONTINUED

Coverage for newborn children will also include:

(a) coverage for: a newly-born child adopted by You, from the moment of birth, if a petition for adoption was filed within 31 days of the birth of the child;
(b) and a child adopted by You (foster child or other child in court ordered custody, that is placed in compliance with Chapter 63) from the date of petition for adoption or placement in Your residence. However, coverage for such child shall not be required in the event that the child is not ultimately placed in Your residence.

You must notify Us, in writing, of the birth of the child or the placement of the child in Your residence within 30 days after the birth or placement. If timely notice is given, We will not charge and additional premium for coverage of the newborn or adopted child for the duration of the notice period. If timely notice is not given, We will charge the additional premium from the date of birth for newborns or the date of placement in Your residence for an adopted child. We will not deny coverage for a child due to Your failure to notify Us within the 30 day period.

If We accept any premium covering a period after eligibility ends, We will continue coverage until the end of the period for which the premium were paid.

HOSPITAL CONFINEMENT BENEFITS

We will pay the Daily Benefit Amount, as shown in the Schedule of Benefits, for each day an Insured Person is confined as an Inpatient to a Hospital for Injury or Sickness if the following are satisfied for each Period of Confinement. The Hospital Confinement must:
(a) be due to a covered Injury or covered Sickness; and,
(b) begin while this Policy is in force for the Insured Person; and,
(c) be for at least 24 hours; and,
(d) be at the direction of or under the supervision of a Physician.

Benefits payable will not exceed the Maximum Total Benefit of 180 Days for any one Period of Confinement, unless such confinement is due to a Mental or Emotional Disorder. If the confinement is due to a Mental or Emotional Disorder, benefits payable will not exceed the Maximum Total Benefit of 30 days for any one Period of Confinement.

LIMITATIONS AND EXCLUSIONS

We do not cover hospital confinements or other losses in the Policy or Riders attached thereto:
(a) due to hernia, adenoids, tonsils, varicose veins, appendix, disorder of the reproduction organs or elective sterilization within six months after the Insured Person's Effective Date unless due to an emergency;
(b) for an Injury or Sickness paid under Workers Compensation, an Employers Liability Law, benefits provided by the Federal Employee Liability Act or similar law;
(c) for an Injury or Sickness due to war or act of war, whether declared or undeclared;
(d) for injuries that are intentionally self-inflicted;
(e) for an Injury or Sickness incurred while committing or attempting to commit a felony;
(f) for an Injury or Sickness incurred while engaging in an illegal occupation;
(g) for cosmetic care, except when the Hospital confinement is due to medically necessary reconstructive plastic surgery. Medically necessary reconstructive plastic surgery is defined as:
  1. surgery to restore a normal bodily function.
  2. surgery to improve functional impairment by anatomic alteration made necessary as a result of a congenital birth defect.
(h) which are primary for rest care, convalescent care or for rehabilitation;
(i) due to being intoxicated. (Intoxication means that which is determined and defined by the laws and jurisdiction of the geographical area in which the loss or cause of loss was incurred);

LIMITATIONS AND EXCLUSIONS CONTINUED

(j) for Injury sustained or Sickness, which manifests itself while on full-time duty in the armed forces. Upon notice, We will refund the proportion of unearned premium paid while in such forces;
(k) for treatment of alcoholism or drug addiction;
(l) which are rendered outside the United States, its possessions, or Canada, except for emergency care for acute onset of Sickness or accidental Injury sustained while traveling for business or pleasure;
(m) for which payment is not legally required, except for:
1. Medicaid;
2. treatment of non-service connected disabilities in Veteran Administration hospitals; and,
3. inpatient care rendered to armed services retirees and dependents in military medical facilities of the United States Government. nor,
(n) Pre-Existing Conditions, unless the Insured Person has satisfied the Pre-Existing Condition Exclusion Period shown in the Schedule.

TERMINATION OF COVERAGE

Termination of Certificate: Insurance coverage under a Certificate will terminate on the earliest of:
(a) the date the Insured no longer qualifies as an Insured;
(b) the last day of the period for which a premium has been paid, subject to the Grace Period;
(c) the date the Policy terminates;
(d) the date the Insured retires;
(e) the date the Insured ceases to be Actively at Work, as defined in the Policy ;
(f) the date the Insured ceases employment, or terminates his/her contract with the employer through whom he/she originally became insured under the Policy; or
(g) the date We receive the Insured's written request for termination.

Termination of Dependents: Insurance coverage on a Dependent will terminate on the earliest of:
(a) the date the coverage under the Certificate terminates;
(c) the date the Dependent no longer meets the definition of Eligible Dependent, as defined in the Policy ;
(d) the date the Policy is modified so as to exclude Dependent coverage; or
(e) the date We receive the Insured's written request for termination.

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

Termination of Policy: We may end the coverage of a Policyholder if fewer persons are insured than the Policyholder's application requires. The Policyholder or We may terminate the Policy on any premium due date after the first Policy Anniversary Date, subject to 60 days written notice.

Termination Without Prejudice: If termination of coverage occurs because of termination of the Insured's employment or contract with the Policyholder, such termination shall be without prejudice to any Hospital confinement which commenced while this Policy was in force**.**

PREMIUMS

The first premium is due on or before the Certificate Effective Date. Thereafter, premiums are due on or before the premium due date. Premiums may be remitted to Our Home Office or Our authorized agent. The premium rates may be changed by Us on the first anniversary date of the Policy or any premium due date thereafter. Such change will be for all Certificates issued under this Policy. No such increase in rates will be made unless 60 days prior notice is given to the Policyholder.

If a change in benefits increases the Company's liability, premium rates may be changed on the date the liability is increased.

GENERAL PROVISIONS

Entire Contract; Changes: The entire contract is made up of this Policy, the Master Application of the Policyholder, the Insured Person's application (if any) attached to the Certificate, and any riders and endorsements.

Statements made by the Policyholder or the Insured are representations and not warranties, if fraud was not intended. No such statements will be used to avoid the insurance, reduce benefits, or defend a claim under the Policy unless the statement is in writing signed by Policyholder or the Insured; and a copy of that statement is given to the Insured or the beneficiary.

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

Time Limit on Certain Defenses: After two years from the Insured Person's effective date, no statements made in the application, except fraudulent misstatements, will be used to void the Certificate or deny a claim for loss incurred commencing after such two-year period.

No claim for loss incurred after two years from the 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 effective on the date of loss, had existed prior to the effective date.

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

The Policyholder or the Insured may, by writing to Us, cancel the coverage under the Policy at any time on any future premium due date; or on any date during the Grace Period.

If coverage is cancelled on a premium due date, the Grace Period will not apply.

Legal Actions: No legal action may be brought to recover under this Policy less than 60 days after written proof of loss has been furnished as required or after the expiration of the applicable statute of limitations from the time written proof of loss is required to be furnished.

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

CLAIMS

Notice of Claim: Written notice of claim must be given to Us within 60 days after the loss occurs or begins when there is a claim for covered charges, or as soon as reasonably possible. We must receive written notice at our Home Office at 2305 Lakeland Drive, Jackson, Mississippi 39332 or to any authorized agent. Information sufficient to identify the Insured Person shall be deemed notice to Us.

Claim Forms: When We receive notice of claim, We will send 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.

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 in the absence of legal capacity, may proof be given later than one year after the loss.

Time of Payment of Claims: We will pay all benefits due for any loss covered under this Policy as soon as We receive written proof of loss.

We will reimburse all claims or any portion of any claim from You or Your assignees, for payment under this Policy, within 45 days after receipt of the claim by Us. If a claim, or a portion of a claim, is contested by Us, You or Your assignees will be notified, in writing, that the claim is contested or denied within 45 days after receipt of the claim by Us. The notice will identify the contested portion of the claim and the reasons for the contest.

Upon receipt of the additional information requested from You or Your assignees, We will pay or deny the contested claim, or portion of the contested claim, within 60 days. We will pay or deny any claim no later than 120 days after receiving the claim. We will pay simple interest at the rate of 10 % per annum on all overdue payments.

Upon written notification from You, We will investigate any claim of improper billing by a Physician, Hospital or other health care provider. We will determine if You were properly billed for only those procedures and services that You actually received. If We determine that You have been improperly billed, We will notify You and the provider of Our findings and will reduce the amount of payment to the provider by the amount determined to be improperly billed. If a reduction is made due to notification by You, We will pay You 20% of the amount of the reduction up to $500.

Payment of Benefits: 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: We have the right to have an Insured Person examined as often as is reasonably necessary while a claim is pending. We will pay for such examination.

NOTICE OF THE RIGHT TO APPEAL

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

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

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