SECURECARE DENTAL

GROUP INSURANCE

Certificate of Coverage

Employee Benefits Booklet

www.securecaredental.com

American Fidelity Assurance Company

A member of the American Fidelity Group

2000 North Classen Boulevard, Oklahoma City, Oklahoma 73106

GROUP DENTAL INSURANCE CERTIFICATE

This Certificate of Insurance covers persons who meet the Eligibility requirements for the insurance, and who become and remain insured under the Policy. Benefits for each Insured are payable only for Eligible Expenses. Insurance is to be effective only if the required premium payments are made by You or on Your behalf.

The Policy under which this Certificate is issued may be amended or canceled at any time, as stated in its provisions. This may take place without the consent of, or notice to, any person who claims rights or benefits under the Policy. No agent has the right to change the Policy, or to waive any part of it.

This Certificate replaces any other certificates for the benefits described inside. As a Certificate, it is not a contract of insurance. It only summarizes the provisions of the Policy, and is subject to the Policy's terms.

This Certificate explains the plan of insurance underwritten by American Fidelity Assurance Company. Read it closely to become familiar with Your coverage. Certain provisions of the Policy are quoted or described in this Certificate. All provisions of the Policy, whether mentioned or not, apply to the insurance evidenced by this Certificate.

The laws of the state of issue of the Policy govern the Policy.

Signed for American Fidelity Assurance Company, 2000 North Classen Boulevard, Oklahoma City, Oklahoma 73106.

President

Secretary

• NON-PARTICIPATING GROUP POLICY PROVIDING ACCIDENT & HEALTH BENEFITS •

For your protection, Arizona law requires the following statement to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

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COVERAGE SUMMARY

SCHEDULE OF DENTAL BENEFITS – Inserted

COVERED DENTAL SERVICES

CLASS/TYPE I. Preventive Services Include:

1. routine oral examinations of mouth and teeth, limited to two per Calendar Year;
2. prophylaxis (removal of plaque, calculus and stains from tooth structure), limited to two per Calendar Year;
3. topical fluoride, limited to:
   a. one per Calendar Year; and
   b. Insureds under age 16;
4. diagnostic x-rays, full (FMX) or panoramic, limited to one in any three-year period;
5. bitewing x-rays, limited to two per Calendar Year;
6. space maintainers to preserve space between teeth caused by premature loss of primary tooth (baby tooth). This does not include use for orthodontic treatment;
7. sealants, limited to:
   a. Insureds under age 16; and
   b. one application every three years; and
   c. permanent molars only;
   and
8. emergency palliative treatment to relieve pain.

CLASS/TYPE II. Basic Services, Include:

1. simple extraction of one or more teeth;
2. fillings (restorations) using amalgam, silicate, acrylic, synthetic porcelain and composite filling materials; (Restorations of the mesiolingual, distolingual, mesiobuccal and distobuccal surfaces will be considered single surface restorations.)
3. antibiotic injections administered by Dentist; and
4. oral surgery, including customary postoperative care for:
   a. removal of one or more teeth, including impacted teeth;
   b. extraction of tooth root;
   c. alveolectomy, alveoplasty, and frenectomy;
   d. excision of periocoronal gingiva, exostosis, or hyperplastic tissue, and excision of oral tissue for biopsy;
   e. reimplantation or transplantation of a natural tooth; and
   f. excision of a tumor or cyst and incision and drainage of an abscess or cyst.

CLASS/TYPE III. Major Services Include:

1. appliances – occlusal guards (night guards only for bruxism) and provisional splints, limited to one in any five-year period;
2. occlusal adjustment, performed with covered surgery;
3. study models, limited to one in any three-year period;
4. crown build-up for non-vital teeth (teeth with root canal therapy);
5. pin retention;
6. re-cementing inlays, onlays and crowns;
7. re-cementing bridges;
8. repairs to full or partial dentures or bridges, limited to one in any two-year period, and not more than 20% of cost of replacement. Repairs within one year of placement are not covered;
9. general anesthesia and analgesic, including intravenous sedation, in connection with a covered oral surgery.
10. restorative services and supplies, limited to:
    a. metal or porcelain inlays, onlays, and crowns, only for the tooth with extensive caries or fracture and is unable to be restored with an amalgam, silicate, acrylic, synthetic porcelain, or composite filling material. Crowns for the purpose of periodontal splinting are not covered. Metal or porcelain inlay, onlay, or crown is not covered when tooth was prepared before Insured was covered under the Policy;
    b. replacement of an existing inlay, onlay, or crown, only after at least five years from restoration initially placed or last replaced. However, this limitation will not apply if replacement of an existing inlay, onlay or crown cannot be made serviceable due to the extraction of one or more adjacent natural teeth, excluding 3rd molars, while the Insured is covered under the Policy;
    c. stainless steel crowns; and
    d. post and core;

and

11. prosthetic services, limited to:
    a. initial placement of full or partial dentures or fixed bridgework (including acid etch metal bridges), only if the denture or bridgework includes replacement of a natural tooth extracted or lost while the Insured is covered under the Policy. This limitation will not apply after the Insured is covered under the Policy for 36 months;
    b. replacement of full or partial dentures or fixed bridgework that cannot be made serviceable, only after at least five years from the date denture or bridgework was initially placed or last replaced. Duplicate prosthetic appliance or replacement of any lost, missing or stolen prosthetic appliance is not covered;
    c. addition of one or more teeth to an existing partial denture, only if to replace one or more natural teeth extracted or lost while the Insured is covered under the Policy. This limitation will not apply after the Insured is covered under the Policy for 36 months; and
    d. relining or rebasing of existing removable full or partial dentures, only after at least one year from the date the denture was placed, and only once in any two-year period.

Endondontic and Periodontic Services (Services may be Class/Type II or III. See Schedule of Dental Benefits for specific coverage classification applicable to the Insured.)

1. Endodontic treatment of diseases of the tooth, pulp, root, and related tissue, as follows:
    a. root canal therapy (not covered, if pulp chamber was opened before the Insured was covered);
    b. pulpotomy;
    c. apicoectomy; and
    d. retrograde fillings;

    and
2. Periodontic services, limited to:
    a. periodontal maintenance prophylaxis following surgery, limited to two per Calendar Year;
    b. full mouth debridement, two per Calendar Year (takes the place of a prophylaxis benefit);
    c. root scaling and root planing, once per quadrant of mouth in any 12-month period;
    d. gingivectomy, gingival curettage, and mucogingival;
    e. osseous surgery including flap entry and closure; and
    f. pedical or free soft tissue grafts

EXPENSES NOT COVERED

No benefits are payable under the Policy for the procedure, service, or supply listed below. Additionally, such listed procedures, services, and supplies will not be recognized toward satisfaction of any Deductible amount.

1. Any service or supply not shown in the list of Covered Services, within the Schedule of Benefits.
2. Any procedure begun after an Insured's insurance under the Policy terminates, or for any prosthetic dental appliance finally installed or delivered more than 30 days after Your or Your Dependent(s) insurance under the Policy terminates.
3. Any procedure begun or appliance installed before an Insured became covered under the Policy.
4. Any prosthetic appliance or modification of any prosthetic appliance for when the impression was made before the Insured was covered under the Policy.
5. Procedures begun but not completed.
6. Any treatment which is elective or primarily cosmetic in nature and/or not recognized as a generally accepted dental practice by the American Dental Association, as well as any replacement of prior cosmetic restorations.
7. Any procedure We determine which is not Medically Necessary, does not offer a favorable prognosis, does not have uniform professional endorsement, or which is experimental in nature.
8. The correction of congenital malformations, including anodontia and cleft palate.
9. The replacement of lost or discarded or stolen appliances, or any duplicate device or appliance.
10. Cast restorations, inlays, onlays and crowns for teeth that are not broken down by extensive decay or accidental injury, or for teeth that can be restored by other means (such as an amalgam or composite filling).
11. The restoration of 3rd molars, except fillings.
12. Crowns, inlays and onlays used to restore teeth with micro fractures or fracture lines, undermined cusps, or existing large restorations without overt pathology.
13. Replacement of bridges, unless the bridge is more than five years old and cannot be made serviceable.
14. Replacement of full or partial dentures, unless the prosthetic appliance is more than five years old and cannot be made serviceable.
15. Replacement of crowns, inlays or onlays, unless the prior restoration is more than five years old and cannot be made serviceable.
16. Replacement of occlusal guards (night guards) unless the occlusal guard is more than five years old and cannot be made serviceable.

17. Appliances, services or procedures relating to:
    a. the change or maintenance of vertical dimension;
    b. correction of attrition, abrasion, erosion or abfraction;
    c. bite registration;
    d. bite analysis; or
    e. splints, other than provisional splints.
18. Implants of any type, and all related procedures; removal of implants; precision or semi-precision attachments; denture duplication; overdentures and any associated surgery; or other customized services or attachments.
19. Services provided for any type of temporomandibular joint (TMJ) dysfunctions, muscular, skeletal deficiencies involving TMJ or related structures, myofascial pain.
20. Orthognathic surgery.
21. Orthodontic treatment, unless identified as covered in the Schedule of Dental Benefits applicable to the Insured.
22. Treatment of malignancies.
23. General anesthesia and intravenous sedation, regardless of the age of the patient, except in conjunction with covered oral surgical procedures.
24. The services of anesthetists or anesthesiologists.
25. Hospital services.
26. Prescribed drugs.
27. Any instruction for diet, plaque control, or oral hygiene.
28. Dental disease, defect or injury caused by a declared or undeclared war, or any act of war.
29. Charges for failure to keep a scheduled visit, or for the completion of any claim forms.
30. Services or supplies payable in whole or in part under any medical plan.
31. Services rendered or supplies furnished by someone who is related to an Insured by blood (e.g., sibling, parent, grandparent, child), marriage (e.g., spouse or in-law) or adoption, or is normally a member of the Insured's household.
32. Expenses compensable under Workers' Compensation or Employers' Liability Laws, or by any coverage provided or required by law (including, but not limited to, group, group-type and individual automobile "No-Fault" coverage).
33. Expenses provided or paid for by any governmental program or law, except as to charges which the person is legally obligated to pay.
34. Services for which there would be no charge in the absence of insurance, or any service or treatment provided without charge.

DEFINED WORDS/TERMS

When used, the masculine includes the feminine, the singular includes the plural, and the plural includes the singular, unless the context clearly indicates the contrary.

Active Work or **Actively At Work.** Your performance of all customary job duties based on all of the following:
1. Your usual place of employment;
2. Your principal occupation;
3. Working the full number of hours and full rate of pay as set by the employment practices of Your Employer, and regularly scheduled to work at least 30 hours each week as an employee of the Employer; and
4. Having worked at least 15 out of the 20 work days preceding the Effective Date for Your Certificate.

ADA Code. The American Dental Association code assigned to a particular dental procedure.

Benefit CLASS/TYPE. The separation of dental procedures by nature and scope. This may be by category groupings or by ADA Codes.

Calendar Year. The period of January 1 through December 31 of any year.

Certificate. This document, which is a description of benefits under the Policy. If there is a conflict between the Policy and this Certificate, the Policy will control.

Child. Your natural child, legally adopted child, step-child, or foster child. To qualify, Your child must depend on You for his main support and care. For the purpose of this definition, a child is considered to be a child of an Insured if the Insured is a party in a suit in which adoption of the child by him is being sought.

Coinsurance or **Co-Payment.** A percentage or set dollar amount of Eligible Expenses. It is payable by You once You have met any applicable Deductible requirement. If it applies, it is shown in the Schedule of Dental Benefits.

Course of Treatment. A planned program of dental care provided to an Insured. It is provided by one or more Dentists over a specified length of time, resulting from the same initial diagnosis. Treatment may occur during one or more sessions. It includes complications arising from and during such treatment.

Coverage. Either of the following which applies under the terms of the Policy:

1. The nature and scope of insurance for an Insured; or
2. Any Certificate, rider, or endorsement regarding a particular type of benefit.

Coverage Summary. The information shown in the Schedule of Dental Benefits, and the Coverage Dental Services and Expenses Not Covered Section of this Certificate.

Day or **Date.** The 24-hour period beginning at 12:01 a.m., Standard Time, at the Policyholder's Participating Employer's place of business or the Insured's residence. This has meaning when used for eligibility date, effective date, or termination of insurance.

Deductible. The amount of Eligible Expenses each Insured must satisfy before benefits are payable under the Policy. If it applies, it is shown in the Schedule of Dental Benefits.

Individual Calendar Year Deductible. The Deductible to be satisfied by each Insured each Calendar Year. It is subject to the Family Deductible. If Benefits are not payable for Eligible Expenses that are incurred during the last month of a Calendar Year because the Individual Calendar Year Deductible was not met, those Eligible Expenses, which the Insured paid, will be carried over to the next Calendar Year. This carryover provision applies only when the Policyholder has been continuously covered for one Calendar Year.

Individual Lifetime Deductible. A limit on the Individual Calendar Year Deductible, if any. The accumulation of an Insured's Calendar Year Deductibles may reach the limit shown in the Schedule of Dental Benefits. Then, no further Deductible requirements will be applied thereafter.

Family Deductible. A limit on the Individual Calendar Year Deductible, if any. Within a covered Family Unit, the total of all Insureds' Individual Calendar Year Deductibles may reach the limit shown in the Schedule of Dental Benefits. Then, no further Deductible requirements will be applied for the rest of that Calendar Year for Insureds within that Family Unit.

Dental Benefit. Payments by Dental Class/Type for incurred Eligible Expenses, as shown in the Schedule of Dental Benefits. Such payments are subject to Coinsurance, Co-Payments, Deductibles, Waiting Periods, and other benefit limitations. These limits are expressed in the Schedule of Dental Benefits either as Scheduled Benefits or as Usual, Reasonable and Customary expenses.

Dental Hygienist. A person who is licensed to practice dental hygiene.

Dentist. A legally qualified person licensed to practice as a dentist or oral surgeon, and who is operating within the scope of such license. It includes any physician or other doctor licensed to provide dental services in the locale where the service is performed. It does not mean an Insured's relative by blood or marriage, or a person who ordinarily lives in the household of an Insured.

Dependent(s). Any of the following persons, when You can consider them dependents according to the Internal Revenue Service, receiving at least 51% support and care from You:

1. Your lawful spouse.
2. Each unmarried Child under age 19 in a regular parent-child relationship.
3. Each unmarried grandchild under age 19 living with You in a regular grandparent-grandchild relationship whom You claim as an exemption on Your federal income tax return.
4. Each unmarried Child, age 19 or over but less than age 25, if attending full-time an accredited:
   a. College or university;
   b. Vocational, technical, trade school or institute; or
   c. Secondary school.

   A class schedule or letter from registrar's office with 1) name of institution, 2) student's name, 3) number of credit hours, and 4) semester/quarterly period must be provided for documentation of full-time student status.
5. Each handicapped person who is and continues to be both of the following.
   a. Incapable of self-sustaining employment by reason of a physical or mental handicap; and

b. Chiefly dependent on You for support and maintenance.

For coverage to continue, we reserve the right to require written proof of continued incapacity and dependency. We may request such proof as often as we wish, but not more often than once each two years.

The term Dependent excludes any person serving in the Armed Forces of any country. It also excludes any person otherwise Eligible as an Insured under the Policy.

Disabled. An individual who is limited solely because of an injury or sickness, as follows:

1. If an employee,
   a. from engaging in any employment or occupation for which he is or becomes qualified by reason of education, training or experience; and
   b. who is not, in fact, engaged in any employment or occupation for wage or profit.
2. If a Dependent, from engaging in the normal activities of a person of like age in good health.

Effective Date. The date on which a particular coverage begins to apply for an Insured under this Certificate. This will take place on the first date on which all the following are true:

1. The applicant meets all Eligibility requirements for the coverage.
2. The applicant has applied for the coverage and We have approved it, as necessary.
3. We approve a Late Entrant's application and any evidence of insurability required.
4. Any Waiting Period requirement has been met.
5. Any Deferred Effective Date provision has been met.
6. The required premium for the coverage has been paid.

Eligibility. Circumstances under which You may apply for and maintain coverage under the terms of the Policy. Such requirements may vary by type of coverage. Eligibility Rules are shown in the General Provisions.

Eligible Expenses. Medically Necessary expenses incurred by an Insured while Your insurance is in force under the terms of the Policy. Such expenses must be incurred for dental care or supplies furnished within the scope of the license of the dental care provider. They also must not be excluded herein.

Emergency Care. A dental emergency or palliative treatment. It is for the diagnosis and treatment of pain and / or injury, and is limited to stabilizing the patient's condition.

Employer. Your employer, shown as the Policyholder.

Experimental. Dental services, supplies or a Course of Treatment, when provided for any of the following reasons.

1. To discover unknown outcomes.
2. To confirm techniques not generally accepted.
3. To conduct trial procedures in tentative stages of development.
4. To develop experience data currently considered insufficiently reliable.

Family Unit. You with Your Dependents, to the extent coverage is in force under the terms of the Policy.

FMX – Full Mouth X-Rays. The total of any 10 films, including bitewings or a panoramic x-ray.

Incurred Date. The date an Eligible Expense is incurred, while the applicable coverage is in force

Injury. A non-occupational accident occurring from an outside force.

Insured. You or Your Dependents, to the extent coverage is in force under the terms of the Policy.

Late Entrant. An Eligible person for whom application is made:

1. For You, more than 31 days after becoming Eligible; or
2. For Your Dependents,
   a. more than 31 days after becoming Eligible; or
   b. after You have requested termination of Dependent coverage.

Maximum Benefit Amount. The limit on benefits for Eligible Expenses an Insured may receive under the Policy. If it applies, it is shown in the Schedule of Dental Benefits.

1. **Calendar Year Maximum Benefits.** Applied during each Calendar Year, for all Benefit Classes/Types combined.
2. **Maximum Lifetime Benefits.** Applied throughout the lifetime of each Insured, for all Benefit Classes/Types combined.

Medically Necessary. The Course of Treatment, services, or supplies furnished, as prescribed by a Dentist, which meet all of the following.

1. Consistent with the symptoms, diagnosis and treatment of the patient's condition.
2. Appropriate, considering the standards of acceptable dental practice.
3. Not solely for the convenience of an Insured, Dentist, or other provider.
4. The most appropriate supply or level of service which can be safely provided to the patient.
5. Not for procedures which can be performed with equal efficiency at another type of facility.
6. Not solely for educational or vocational training.
7. Not Experimental.

Palliative Treatment. See Emergency Care.

Policy. The contract of insurance for dental services. We have issued it to the Policyholder, as identified by its Policy Number.

Pretreatment Review. A procedure of communicating the amount of Eligible Expenses covered by the Policy. This is done in advance of certain non-emergency dental treatments, based on a Treatment Plan.

Prophylaxis. Removal of plaque, calculus and stains from tooth structure.

Schedule of Dental Benefits. Summary of benefits and limitations payable by Us included under this Certificate.

Scheduled Benefit. A set dollar amount of eligible expense payable by Us for each specific procedure when a Co-Payment is applicable.

Third Party Administrator. Policy Benefits will be administered by:

Southwest Preferred Dental Organization, Inc.
3625 North 16th Street, Suite 206
Phoenix, Arizona 85016

Treatment Plan. A written report of examination of an Insured for a proposed Course of Treatment. It is made by a Dentist or Dental Hygienist because of dental disease, defect, or Injury to the teeth. The report must include:

1. examination findings; and
2. a description of the planned treatment determined necessary.

Usual, Reasonable, and Customary (URC). The least expensive of the following for the service, treatment, or supply provided, if identified in the Schedule of Dental Benefits:

1. the usual amount charged by the treating Dentist or Dental Hygienist; or
2. the usual, customary and regular charge by Dentists or Dental Hygienists of similar training and experience in the area where such expenses are incurred. Area means a common locale based on zip code, for a fair cross section of individuals, groups, or entities.

Waiting Period. A period of time before an applicant receives coverage under the Policy. The period begins after the applicant meets Eligibility and makes application (if required). The Schedule of Dental Benefits may indicate different Waiting Periods for different Benefit Classes/Types. There is no Waiting Period for benefits resulting from Injury.

We, Our, Us. American Fidelity Assurance Company.

You, Your, Yours. The Certificate holder.

GENERAL PROVISIONS

ELIGIBILITY
To be eligible for coverage under the Policy, an Employee must be in an Eligible Class as defined by Us and the Policyholder. He must be Actively At Work as an Employee of the Policyholder. Coverage will be delayed if the Employee is confined for medical care or treatment in an institution or at home on the day which would ordinarily be his effective date. This delay is described in the Deferred Effective Date provision.

EFFECTIVE DATE OF YOUR COVERAGE
If Your insurance is non-contributory, coverage begins on the first day of the month following Your enrollment, provided:

1. You are Eligible;
2. You have satisfied any Waiting Period;
3. Your enrollment is complete and made by written application in a form acceptable to Us. Such application must be received at Our Home Office, or at the office of Our Third Party Administrator;
4. the Policyholder has paid Your first premium, and such premium has been received by Our Third Party Administrator; and
5. You are Actively At Work on such date. If You are not Actively At Work on such date, coverage is subject to the Deferred Effective Date provision.

If Your insurance is contributory (i.e., You pay all or part of the premium for coverage on You), coverage begins on the first day of the month following Your enrollment, provided:

1. You are Eligible;
2. You have satisfied any Waiting Period;
3. Your enrollment is complete and made by written application in a form acceptable to Us. Such application must be received at Our Home Office, or at the office of Our Third Party Administrator;
4. You have paid Your first premium, and such premium has been received by Our Third Party Administrator; and
5. You are Actively At Work on such date. If You are not Actively At Work on such date, coverage is subject to the Deferred Effective Date provision.

EFFECTIVE DATE OF DEPENDENT COVERAGE
Each person who is a Dependent becomes Eligible on the later of the following:

1. The date You become Eligible.
2. The date such person becomes a Dependent.

If insurance for Your Dependent(s) is non-contributory, coverage begins on the first day of the month following enrollment of Your Dependent(s), provided:

1. Your dependent is Eligible;
2. Your enrollment is complete and made by written application in a form acceptable to Us. Such application must be received at Our Home Office, or at the office of Our Third Party Administrator;
3. the Policyholder has paid the first premium for Dependent coverage, and such premium has been received by Our Third Party Administrator; and
4. Your Dependent is not Disabled on such date. Otherwise, coverage for Your Dependent is subject to the Deferred Effective Date provision.

If insurance for Your Dependent(s) is contributory, coverage begins on the first day of the month following enrollment of Your Dependent(s), provided:

1. Your dependent is Eligible;
2. Your enrollment is complete and made by written application in a form acceptable to Us. Such application must be received at Our Home Office, or at the office of Our Third Party Administrator;
3. You have paid the first premium for Dependent coverage, and such premium has been received by Our Third Party Administrator; and
4. Your Dependent is not Disabled on such date. Otherwise, coverage for Your Dependent is subject to the Deferred Effective Date provision.

DEFERRED EFFECTIVE DATE
This section modifies the Eligibility provisions in the Effective Date of Your Coverage and Effective Date of Dependent Coverage sections.

You may be both disabled as the result of injury or sickness and away from work on the date Your insurance would take effect. In this event, Your coverage will begin on the first day of the month next following the date You complete two consecutive weeks of Active Work for Your Employer.

On the date insurance would otherwise become Effective, a Dependent may be: 1) confined because of injury or sickness in a hospital or other institution; or 2) confined at home or elsewhere so as to be unable to carry out the regular and customary activities of a person in good health and of the same age. Then, the insurance of Your Dependent will begin on the later of:

1. the first day of the month coincidental with or next following a period during which Your Dependent has not been confined as set forth above; or
2. the first day of the month coincidental with or next following the date We receive evidence of Your Dependent's complete recovery at Our Home Office.

CHANGE IN YOUR COVERAGE

Benefits may change when coverage is revised, added or deleted. However, such change will not cover dental services or supplies provided before the Effective Date of the change, if both of the following are true.

1. We received a Treatment Plan before the date of the change.
2. We provided Pretreatment Review.

Your coverage may change due to a change in Your Eligibility or a change in the amount of insurance payable under the Policy. Then Your new coverage will take effect on the first day of the month coinciding with or next following the Effective Date of such change.

However, You may be both disabled as the result of injury or sickness and away from work on the date Your insurance would take effect. In this event, the change will take effect on the first day of the month next following the date You complete two consecutive weeks of Active Work for Your Participating Employer.

Notice of such change must be given to Us or Our Third Party Administrator within 30 days after the date of change in classification or amount. Otherwise, We may require satisfactory evidence of insurability before accepting such change.

CHANGE IN DEPENDENT COVERAGE

Dependent coverage may change due to a change of classification or a change in the amount of insurance payable under the Policy. Then new coverage will take effect on the first day of the month coinciding with or next following the Effective Date of such change.

However, Your Dependent may be: 1) confined because of injury or sickness in a hospital or other institution; or 2) confined at home or elsewhere so as to be unable to carry out the regular and customary activities of a person in good health and of the same age. Then the change in insurance of Your Dependent will begin on the later of:

1. the first day of the month coincidental with or next following a period during which Your Dependent is no longer confined as set forth above; or
2. the first day of the month coincidental with or next following the date We receive evidence of Your Dependent's complete recovery at Our Home Office.

NEWBORN INFANTS

A newborn Dependent child is covered from the moment of birth. If any additional premium is required, a notice of birth and the premium must be sent to Us. This must be done within 31 days after the date of birth to continue coverage thereafter.

ADOPTED CHILDREN

A Dependent child placed with You for adoption is covered from the date of such placement. Placement for adoption means personally assuming and retaining a legal obligation to support a child in anticipation of adoption. It may be either total or partial support.

Such coverage will continue, unless the placement is disrupted prior to legal adoption, and the child is removed from placement. Disrupted placement means the termination of the legal obligation for total or partial support.

If any premium is required, a notice of placement for adoption and the premium must be submitted to Us. This must be done within 31 days after the date of such placement to continue coverage thereafter.

LATE ENTRANTS

Coverage under the Policy for Late Entrants will become effective on the date after three months following the date we accept such enrollment. This provision will not apply to handicapped Dependents.

Thereafter, for the next six consecutive months, Late Entrants will be covered only for Class/Type I services (Preventive and Diagnostic) and Class/Type II services (Basic Restorative) exams, cleanings, and fluoride applications only (procedures numbered D0110, D0120, D0130, D1110, D1120, and D1201).

END OF COVERAGE
Coverage for an Insured under the Policy can end voluntarily or automatically.

In either instance, the following applies to an Insured's overall coverage as well as to each Benefit Class/Type separately. Coverage termination will not prejudice any existing claim.

If You voluntarily end Your insurance, You may wish to re-enroll at a later date. In this event, We reserve the right to require a two-year Waiting Period, beginning on the date Your insurance ended. Alternatively, We reserve the right to require evidence of insurability from You and any of Your Dependents.

Unless You voluntarily end Your insurance coverage, it will cease automatically for You. Coverage will end on the earliest of the following dates.

1. The date the Policy ends.
2. The last day of the month in which You cease to meet Eligibility.
3. The date You enter into the Armed Forces of any country.
4. The last day of the month for which a premium has been paid by You or on Your behalf.

Unless You voluntarily end Dependent insurance coverage, it will end automatically for Your Dependents. Coverage will end on the earliest of the following dates:

1. The date of termination of Your insurance.
2. The date Your Dependent becomes Eligible as an employee under the Policy.
3. The date Your Dependent ceases to be a Dependent.
4. The date Dependent coverage is discontinued under the Policy for one or more classes of employees.
5. The date Your Dependent enters the Armed Forces of any country.
6. The last day of the month for which a premium has been paid by You or on Your behalf for Your Dependent's coverage.
7. In the case of a Dependent child or grandchild for whom coverage is being continued due to mental or physical inability to earn his own living, the earliest to occur of:
    a. cessation of such incapacity;
    b. failure to furnish any required proof of the uninterrupted continuance of such incapacity or to submit to any required examination; or
    c. upon no longer being dependent on You for more than one half of his support and maintenance, or no longer residing with You.

We will refund any unearned premium upon termination of coverage.

We shall have the right to terminate the coverage of any Insured who submits a fraudulent claim under the Policy.

EXCEPTION
An Insured's coverage may terminate due to an approved leave of absence or military leave. Then We will waive the following, provided the Insured re-applies within 31 days after resuming Active Work:

1. Waiting Period
2. Evidence of insurability requirement
3. Late Entrants limitation.

PREMIUMS
Premiums for coverage under the Policy are payable as described therein. Coverage for all Insureds covered under a Policyholder's coverage will terminate on the premium due date, subject to the Grace Period provision, if premiums on behalf of all of the Policyholder's Insureds are not submitted to the Administrator. Premiums may be changed by Us on any Policy Anniversary date or on any premium due date if We notify the Policyholder of the change at least 60 days before such premium due date. If premiums are payable on a basis other than monthly, and if a change occurs during a premium payment period which affects premiums, a pro rata charge or credit will be made for such change on the next closest premium due date. Premium adjustments may also be arrived upon by any other method agreeable to both the Policyholder and Us.

GRACE PERIOD
If the Policyholder does not pay in full any premium on or before its due date, the Policyholder will have a Grace Period in which to pay that premium. A Grace Period is a period of 31 consecutive days following any premium due date, after the first, that is allowed for payment of premium. The Policy will remain in force during the Grace Period if premium is timely paid. If the premium is not paid in full before the Grace Period ends, the Policy will end on the premium due date for which premiums were not paid. On the date the Policy ends, the Policyholder must pay all premiums then due. This Grace Period provision applies only to the group as a whole, and not to Insureds as individuals.

Before the end of the Grace Period, We will honor a request to cancel Your coverage. This request must come in writing from the Policyholder. Coverage will then end on the last day of the month for which premium has been paid.

AGENCY
Neither We nor the Policyholder, nor the Certificate holder, nor any Insured is the agent of the other under the Policy for any purpose.

INCONTESTABILITY
After You have been covered under the Policy for two consecutive years, We will not use any statement made in an individual enrollment application to defend a claim.

LEGAL ACTIONS
To be valid, an action at law or in equity to recover on the Policy must be brought:
1. more than 60 days; but
2. not more than three years

from the time written proof of loss is required to be given.

ASSIGNMENT OF BENEFITS
You may authorize Us to pay benefits directly to a place or person. We will do so if such charges are the basis for the claim. We will not be responsible for the validity of any such assignment. Any payment made according to such assignment and in good faith by Us will discharge Us to the extent of any such payment.

CLAIMS OF CREDITORS
To the extent permitted by law, neither the benefits nor payments under the Policy will be subject to the claim of creditors or to any legal process.

MISSTATEMENT OF AGE
If the true age of a person has been misstated, We will correct both benefits and premiums. We will adjust any benefits purchased and premiums payable under the Policy to those for the correct age. We will do so if the amount of insurance would be affected by such misstated age. Any such change will neither continue insurance ended by valid means nor void insurance otherwise valid and in force. We will make any required change in accordance with applicable laws.

CONFORMITY TO LAW
Any provision of the policy in conflict with the laws to which it is subject is hereby considered amended to conform to the minimum requirements of such laws.

DENTAL INSURANCE

BENEFIT
We will pay Dental Benefits if an Insured incurs an Eligible Expense in excess of the Deductible during a Calendar Year. For each type of service, the Schedule of Dental Benefits shows the amount of such excess We will pay. Payment will be subject to the Waiting Period and Maximum Benefit Amount, if any, shown in the Schedule of Dental Benefits.

EXPENSES INCURRED
An Eligible Expense is considered incurred on the following dates:
1. For full and partial dentures: the date the final impression is taken.
2. For fixed bridges, crowns, inlays and onlays: the date the teeth are first prepared.
3. For root canal therapy: the date the pulp chamber is opened.
4. For periodontal surgery: the date surgery is performed.
5. For all other services: the date the service is performed.

PRETREATMENT REVIEW
If the Course of Treatment will exceed $300, We reserve the right to require Pretreatment Review. We must be given the Dentist's Treatment Plan, estimated charges, and diagnostic x-rays. We will determine Eligible Expenses and state how much We will pay for that Course of Treatment.

Pretreatment Review is not needed for Emergency or Palliative Care, or routine scaling or cleaning of teeth. If further treatment is recommended, then a Pretreatment Review is required before the Course of Treatment is continued.

If You do not request a Pretreatment Review when one is required, We will estimate benefits when a claim is made. We will do this as if a prior review had been requested. In this case, no benefits are payable for a dental treatment which cannot reasonably be verified as Medically Necessary.

ALTERNATE BENEFIT PROVISION
Recognizing that many dental problems can be solved in more than one way, We will pay an amount equal to that applicable for that generally accepted treatment which, in Our sole judgment, will provide adequate dental care at the lowest cost. In determining Our liability, We will be guided by nationally established standards of the dental profession and the Insured's total oral condition.

If You pursue a more expensive course of treatment, this coverage may pay the equivalent of the least expensive treatment for that condition according to generally accepted standards of care. This payment may be applied toward a more expensive course of treatment. Benefits for bilateral missing teeth are based on a removable partial denture.

SERVICES PERFORMED OUTSIDE THE U.S.A.
Any claims submitted for procedures performed outside the U.S.A. must be supplied in English, must use American Dental Association (ADA) codes, and must be in U.S. Dollar currency. Reimbursement will be based on the applicable benefit.

ELIGIBLE EXPENSES
To be an Eligible Expense, the dental service or procedure must be performed by a Dentist or Dental Hygienist. Insureds may choose to receive such services from any such qualified dental provider. The amount of Dental Benefits may vary, depending on the identity of the provider. Any such variation will appear in the Schedule of Dental Benefits.

Any Dental Benefits We pay will be based on Eligible Expenses identified in the Schedule of Dental Benefits. They may be Expenses You incur, incurred on Your behalf, or incurred on behalf of any Dependent Insured.

COORDINATION OF BENEFITS

DEFINITIONS
The following definitions apply only to this Coordination of Benefits section.

1. **This Plan**: Benefits described in the Policy.
2. **Plan**: Hospital, medical or dental benefits or services provided by one of the following:
   a. Group, franchise or blanket insurance coverage, except school accident coverage.
   b. Group Blue Cross, group Blue Shield, group practice.
   c. Health Maintenance Organization (HMO) plans or other pre-payment coverage, either group practice or individual practice plans.
   d. Any coverage under labor-management trusteed plans, union welfare plans, employer organization plans or employee benefit plans.
   e. Any coverage under a government plan required or provided by law, except Medicaid. Coordination with Medicare will be in accord with federal law.

   We may construe each of the above coverages as a separate Plan. This will occur when the other Plan reserves the right to take into consideration other plans' benefits or services in determining its benefits, or separately for that portion for which it does not reserve the right.
2. **Allowable Expense**: Any necessary service or expense for dental care, all or part of which is included under any Plan covering an Insured. This includes Deductibles, Coinsurance, and Co-Payments. When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.
3. **Claim Determination Period**: A Calendar Year, or portion of a Calendar Year, during which the Insured for which claim is being made has been covered under This Plan.
4. **Primary Plan**: The Plan that must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses.
5. **Secondary Plan**: A Plan that may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expenses.

BENEFITS SUBJECT TO COORDINATION
All benefits provided under This Plan are subject to coordination, within the scope of this section.

DETERMINATION
If any Insured is also covered under one or more other Plans, the benefits under This Plan will be coordinated with benefits payable under all other Plans. This means:

1. one Plan pays its full benefits first (Primary Plan), then the other (Secondary) Plan pays; but
2. total benefits from all Plans will not exceed 100% of the Allowable Expenses.

Benefits payable under This Plan will be reduced when the sum of the following two items exceeds a claimant's Allowable Expenses in a Claim Determination Period:

1. Benefits that would be payable under the Policy in the absence of coordination.
2. Benefits that would be payable under all other Plans containing provisions for coordination. Such benefits include those that would have been payable had a claim been properly made for them.

Benefits of other Plans will be ignored if:

1. the other Plan has a section similar to this section, and that Plan would, according to its rules, determine benefits after This Plan; and
2. the rules of this section would require This Plan to determine its benefits before such other Plan.

ORDER OF BENEFIT DETERMINATION RULES
If the other Plan does not have coordination rules similar to this provision, it must pay its benefits first. If all the Plans have coordination provisions, the order of benefits payable with respect to an Insured under This Plan will be determined according to the following rules:

1. The Plan that covers the person as an employee is the Primary Plan, and the Plan that covers the person as a dependent is the Secondary Plan.
2. If two or more Plans cover a person as a dependent child of parents who are married or are living together (whether or not they have ever been married), benefits for such child are determined in the following order:
   a. The benefits of the Plan of the parent whose birthday falls earlier in a Calendar Year are determined before those of the Plan of the parent whose birthday falls later in that Calendar Year.
   b. If both parents have the same birthday, the benefits of the Plan which has covered the parent longer are determined before benefits of the Plan which has covered the other parent for the shorter period of time.

   However, the other Plan may not have the rule described above, and instead may use a different method. As a result, if the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.
3. If two or more Plans cover a person as a dependent child of parents who are divorced, or separated, or are not living together (whether or not they have ever been married), benefits for such child are determined in the following order:
   a. First, the Plan of the parent with custody of the child.
   b. Then, the Plan of the spouse of the parent with custody of the child.
   c. Then, the Plan of the parent not having custody of the Child.
   d. Finally, the Plan of the spouse of the parent not having custody of the Child.

   However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and if the entity obligated to pay or provide the benefits of the Plan of such parent has actual knowledge of those terms, then the benefits of that Plan are determined first. This does not apply with respect to any Claim Determination Period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.
4. The benefits of a Plan covering a person as an employee who is neither laid-off nor retired (or as such employee's dependent) are determined before those of a Plan which covers that person as a laid-off or retired employee (or as such employee's dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.
5. If none of the above rules determines the order of benefits, the benefits of a Plan which has covered the person for whom claim is made for the longer period of time will be determined before the benefits of a Plan covering the person the shorter period of time.

EFFECT ON THE BENEFITS OF THIS PLAN
When This Plan is the Secondary Plan:

1. We may reduce the benefits so that the total benefits paid or provided by all Plans are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, We will calculate the benefits We would have paid in the absence of other coverage, and apply that calculated amount to any Allowable Expense under This Plan that is unpaid by the Primary Plan. We may then reduce Our payment so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, We will credit any Deductibles that would have been credited in the absence of other coverage.
2. We will not deny coverage or payment of the amount We owe as secondary payer solely on the basis of the failure of another group contract, which is responsible as the Primary Plan, to pay for such Allowable Expenses. This will not require Us to pay the obligations of the Primary Plan.

If benefits under this Policy are reduced, each benefit is reduced by the same proportion. The reduced benefit amounts are then charged against the correct benefit limits and maximums of the Policy.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION
Certain facts are needed to apply the rules of this Coordination of Benefits provision and to determine benefits payable under This Plan and other Plans. We may release or obtain any information which We consider necessary concerning any individual. We may do so without consent or notice to any person. In doing so, we may communicate with any other insurance company, organizations or person. Any person claiming a benefit under This Plan must furnish Us with any information necessary to apply the rules of this Coordination of Benefits provision, and determine benefits payable.

FACILITY OF PAYMENT
A payment made under another Plan may include an amount that should have been paid under This Plan. In this event, We reserve the right, at Our sole discretion, to pay any organizations making these payments any amount We determine to be due. An amount paid in this manner will be considered a benefit paid under This Plan, and We will not have to pay that amount again. To the extent of these payments, We will be fully discharged from liability under This Plan.

The term “payment made” includes providing benefits in the form of services, in which case “payment made” means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY
If the amount of payments made by Us is more than We should have paid under this Coordination of Benefits provision, We will have the right to recover the excess from one or more of the following:
1. Other insurance companies.
2. Other organizations.
3. Persons to or for whom payments were made.

The term “amount of payments made” includes the reasonable cash value of any benefits provided in the form of services.

CLAIMS

PAYMENT OF CLAIMS
We will make all claim payments to You, except in the following instances:
1. You have assigned the benefits under the Policy. In this case, We will pay any unpaid benefits due to the party to whom they have been assigned.
2. You are not then living. In this case, We will pay any unpaid benefits to the estate of the Insured.
3. You are not competent to give a valid release, if claims are otherwise payable to Your estate. In this case, We will pay any claim up to $1,000 to any relative by blood or marriage We deem entitled.
4. If any benefits of the Policy are payable to the estate of an Insured or beneficiary who is a minor or otherwise not competent to give a valid release, We may pay such benefits up to $250 to any relative by blood or connection by marriage of the Insured or beneficiary who We deem to be equitably entitled thereto.

Any payment We made in good faith pursuant to this provision will fully discharge Us to the extent of such payment.

FACILITY OF PAYMENT
All benefits will be paid according to the Payment of Claims provision. However, benefits not validly assigned will be paid according to the following:
1. If You die. In this case, the unpaid benefits will be paid to Your estate.

2. If any payee, at Our opinion, is not able to give a valid receipt and discharge for any payment, and claim is not made by duly appointed guardian or committee. In this case, We may make such payment or any portion of it to any person or institution who, in Our opinion has rendered services to or cared for such payee.

DISCHARGE
We reserve the right to pay any unpaid benefits due for Eligible Expenses directly to the person giving dental care or supplies. Any payment We make in good faith and according to the above paragraphs will release Us from all further liability, to the extent of such payment. We will not be bound to see to the use of the money so paid.

NOTICE OF CLAIM
Proper written notice and positive proof of loss must be given before We will be liable for any loss. This notice can be given to Us through Our Home Office or Our Third Party Administrator.

Notice must include the name of the claimant.

Written notice of a claim must be given to Us within 45 days after any loss covered by the Policy is incurred. However, failure to file such notice in the time required will not invalidate or reduce any claim, if both of the following are true:
1. It was not reasonably possible to give notice.
2. Such notice is given as soon as reasonably possible.

In any event, proof of loss must be given within one year of such time, unless the claimant lacked legal capacity.

CLAIM FORM
When We receive written notice of claim, We will send the claimant forms for filing proof of loss. If We do not send these forms within 15 days after receiving notice, the claimant will meet the proof of loss requirement by giving Us a written statement of the nature and extent of loss within the time limit stated.

PROOF OF LOSS
Positive proof of loss must be furnished to Us within 90 days after the date of a covered loss. However, failure to file such notice in the time required will not invalidate or reduce any claim, if both of the following are true:
1. It was not reasonably possible to furnish such proof.
2. Such proof is given as soon as reasonably possible.

In any event, proof of loss must be given within one year of such time, unless the claimant lacked legal capacity.

TIME OF PAYMENT OF CLAIM
We will pay all benefits upon receipt of acceptable written proof of loss, subject to any written assignment of benefits received by and satisfactory to Us.

Timely payment of claims will be governed by the state law under which the Policy was issued. Determination and payment of interest due, if any, will be made according to the state under which this Policy was issued.

PHYSICAL EXAMINATION AND AUTOPSY
While a claim is pending, at Our expense We may;
1. examine any pre-operative dental x-rays; and
2. have the Insured whose loss is the basis of claim examined, as often as reasonably necessary.

We also have the right and opportunity to make an autopsy in case of death where it is not forbidden by law.

THIRD PARTY RECOVERY
When a third party or its insurer is liable as a result of the negligence or intentional act of the third party for a loss for which benefits are payable under the Policy, the following will apply:
1. The third party makes payment before We pay, no benefits will be paid under the Policy to the extent of the third party's payment.
2. If the third party does not make payment before We pay:
   a. We will pay any benefits due under the Policy;
   b. when payment is later made by the third party, We are entitled to be repaid first. Your legal representative is obligated to return the payment to Us, less reasonable prorated expenses, such as lawyer's fees and court costs You incur in seeking the third party payment; and
   c. Your obligation to repay Us will be binding upon You or Your legal representative regardless of whether:
      (1) the payment received from the third party or its insurer is the result of a court judgment, arbitration award, compromise settlement or any other arrangement; or

(2) the third party or its insurer admits liability; or
(3) the expenses are itemized in the third party payment; or
(4) You have been made whole for Your losses.

SUBROGATION
We have the right of subrogation to attempt to recover the amount of Our payment. We will not subrogate until You have been made whole for Your losses. This includes the right to file or intervene in a lawsuit. We will give You or Your representative prior written notice of Our intent to file suit. You must cooperate in full with Our effort to seek recovery from the third party. You must do nothing to hinder Our attempt to recover from the third party or to resolve the claim with the third party unless We give prior written consent. Our recovery from the third party will be limited to the lesser of:

1. the amount We paid in benefits under the Policy as a result of the charges; or
2. the amount recovered from the third party.

Our recovery will apply whether or not payment has been made by the third party for all of Your losses.

REPLACEMENT OF EXISTING COVERAGE
The following takeover provisions are applicable when there is group dental plan in force at the time of application.

Waiting Period Credit. When We immediately take over an entire dental group from another carrier, those persons insured by the prior carrier's plan on the day immediately prior to the takeover effective date will receive waiting period credit for the number of continuous uninterrupted months of coverage they had under the prior carrier, if they are eligible for coverage on the effective date of Our plan. For replacement of coverage and other coverage circumstances, the waiting period credit does not apply to Late Entrants, or Re-enrollees.

In circumstances other than replacement of existing coverage the waiting period credit may apply to new Employees.

Calendar Year Maximums and Deductible Credits. Deductible credits will not be granted for the amount of Deductible satisfied under the Employer's previous plan during the current Calendar Year. Any benefits paid under the Employer's previous policy with respect to such replaced coverage will neither be applied to nor deducted from the maximum benefit payable under this Certificate.

Orthodontic Coverage. For the waiting period to be waived for orthodontic coverage, the prior carrier's plan must have insured orthodontia benefits and the provisions of the Orthodontic Rider must be met. Determination of the Calendar Year and lifetime maximum benefits will be made in accordance with the Orthodontic Rider provisions. Waiting periods for Orthodontic Coverage apply to new Employees, Late Entrants, or Re-enrollees.

Maximum Benefit Credit. Any paid benefits applied to the maximum benefit amounts under the prior plan will not be applied to the maximum benefit amounts under this Certificate.

The maximum benefit payable under this Certificate will not be reduced by the amount paid or payable under the prior plan.

Verification. The Policyholder's application must be accompanied by a current month's billing from the current dental carrier, a copy of an in-force certificate, as well as proof of the effective date of each Insured (and dependent), if insured under the Policyholder's previous plan.

Prior Carrier's Responsibility. The prior carrier is responsible for costs for procedures begun prior to the effective date.

HOW TO FILE A CLAIM
To file a claim for benefits for Yourself or Your insured dependents, You must complete a claim form. You can get a claim form from the Employer, or Our Third Party Administrator.

Send the completed claim form and bills to SecureCare Dental. You may assign Your dental care benefits. Unless You assign Your benefits to a health care provider, payment will be made to You.

SecureCare Dental
3625 N. 16th Street, Suite 206
Phoenix, Arizona 85016

HOW TO FILE AN APPEAL ON THE DENIAL OF A CLAIM

Initial benefit determinations will be rendered by Our Third Party Administrator within 30 days. If there are special circumstances beyond Our Third Party Administrator's control, the initial benefit determination shall be rendered as soon as possible, but no later than 45 days after receipt of Your claim.

In the event You receive an adverse benefit determination (denial of benefits, wholly or partially), such adverse benefit determination will be explained in writing and the explanation will include:

1. the specific reason for the adverse benefit determination;
2. reference to the specific policy provision upon which the adverse benefit determination was based;
3. a description of any additional information You might be required to provide and an explanation of why it is needed; and
4. an explanation of Our claim review procedure.

You, a Dependent, a beneficiary, or a duly authorized representative may appeal any adverse benefit determination by filing a request for review to Our Third Party Administrator. In connection with such a request, documents pertinent to the administration of the Policy may be reviewed, and issues outlining the basis of the appeal may be submitted. You may have representation throughout this review procedure. Appeals should be submitted to the following address:

American Fidelity Assurance Company
Grievances and Appeals
P.O. Box 25070
Oklahoma City, Oklahoma 73125

The procedure for the appeal process is as follows:

1. Submit Your written request within 180 business days of an adverse benefit determination.
2. The review will be conducted in accordance with state law under which this Policy was issued.
3. The decision, after the review, shall be in writing and shall include specific references to the pertinent policy provisions upon which the decision was based. Such decision will be rendered by Our Third Party Administrator no later than 30 days after receipt of Your request for review. The decision will be made on Your request in accordance with state law under which this Policy was issued for:
   a. denied claims of services previously rendered;
   b. claims requesting Pretreatment Review; or
   c. claims for urgently needed services You have not yet received.

The above appeal procedure will pre-empt any state requirements on internal appeals except to the extent that both federal and state requirements can be met.

American Fidelity Assurance Company
A member of the American Fidelity Group
2000 North Classen Boulevard, Oklahoma City, Oklahoma 73106

PREFERRED PROVIDER COVERAGE RIDER

This Rider is issued as part of the Policy and any Certificate to which it is attached. It is subject to all the terms and provisions of the Policy, except as stated below. Nothing contained in this Rider will be held to change, waive or extend any provisions of the Policy except as herein stated. This Rider covers persons who meet Eligibility requirements and who become and remain insured under the Policy. Benefits for each Insured are payable only for Eligible Expenses. In consideration of the payment of any Rider premium, We will provide the coverage described below.

DEFINITIONS. The following are in addition to the definitions in the Policy and Certificate.

1. **PREFERRED PROVIDER (PP)**: A licensed Dentist who has agreed to accept, as full payment, Your co-payment and the agreed upon payment from Us or Our authorized Third Party Administrator. All services rendered by a Preferred Provider will be payable as shown in the Schedule of Dental Benefits.
2. **NON-PREFERRED PROVIDER (NPP)**: A licensed Dentist not rendering services under an agreement to accept, as full payment, Your co-payment and the agreed upon payment from Us or Our authorized Third Party Administrator. All services rendered by a Non-Preferred Provider will be payable as shown in the Schedule of Dental Benefits.
3. **PPO**: An organization of Preferred Providers.
4. **PPO PLAN DESCRIPTION**: The Benefit Provisions section of this Rider that describes how benefits will be paid for Eligible Expenses incurred for the services of a Preferred Provider. The Policy and Certificate describe how benefits will be paid for Eligible Expenses incurred for the services of a Non-Preferred Provider, except a stated in this Rider.

BENEFIT PROVISIONS

We will pay benefits as shown in the Schedule of Dental Benefits. Benefits are limited to Eligible Expenses incurred by an Insured if:

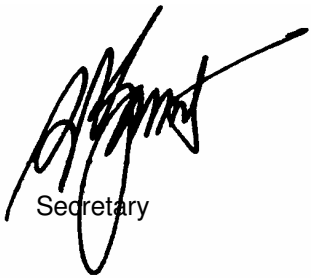
1. Treatment is rendered or care is given by a PP; or
2. Materials are furnished in, at or by a PP.

Use of a PP does not guarantee that all expenses will be covered. A list of PP's will be provided to Insureds annually.

An NPP may be used for any of the following reasons. Then Eligible Expenses will be paid at the applicable benefit levels for an NPP.

1. For services of a provider who is no longer a PP; or
2. When this Rider has terminated; or
3. The Insured elects not to use the services or supplies of the PP.
4. If Emergency Care is necessary, and either: it is outside the PP contract area; or a PP is not available.
5. If a PP refers the Insured Person to a NPP because the PP is unable to render the necessary service.
6. If a NPP is on call in the absence of a PP.

This Rider takes effect and expires with the Policy to which it is attached. It is subject to all the terms, conditions, limitations and exclusions of the Policy that are not inconsistent with it. Nothing contained in this Rider will be held to change, waive or extend any provisions of the Policy except as stated in this Rider.



Secretary

Statement of ERISA Rights

As a participant under the Policy, 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:

(1) Receive Information About Your Plan and Benefits
- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- 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.

(2) Continue Group Health Plan Coverage
- Continue health care coverage for Yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or Your dependents may have to pay for such coverage. Review Your summary plan description and the documents governing the plan on the rules governing Your COBRA continuation coverage rights.
- During periods of leave approved under the Family and Medical Leave Act (FMLA), for any one of the following reasons: (1) the birth of Your son or daughter, and to care for the newborn child; (2) the placement with You of a child for adoption or foster care, and to care for the newly placed child; (3) to care for Your immediate family member (spouse, child, or parent -- but not a parent "in-law") with a serious health condition; and (4) when You are unable to work because of a serious health condition.

Prudent Actions by Plan Fiduciaries

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, Your union, or any other person, may fire You or otherwise discriminate against You in any way to prevent You from obtaining a welfare benefit or exercising Your rights under ERISA.

Enforce Your Rights

If Your claim for a welfare benefit is declined or ignored, in whole or in part, You have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps You can take to enforce the above rights. For instance, if You request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, You may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and to 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 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. In addition, if You disagree with the plan's decision, or lack thereof, concerning the qualified status of a domestic relations order or a medical child support order, You may file suit in 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 costs and fees. If You lose, the court may order You to pay these costs and fees, for example, if it finds Your claim is frivolous.

Assistance With Your Questions

If You have any questions about Your plan, You should contact the Claims Administrator. If You have any questions about this statement or about Your rights under ERISA, or if You need assistance in obtaining documents from the plan administrator, You should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in Your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about Your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration at 1-800-998-7542, or contact the PWBA field office nearest You. Publications are also available online at www.dol.gov/dol/pwba/.

HIPAA NOTICE OF PRIVACY PRACTICES
Effective Date: 04/14/2003

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 Fidelity Assurance Company
P.O. Box 25523
Oklahoma City, Oklahoma 73125
1-866-55-HIPAA

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 Fidelity Assurance 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 Fidelity Assurance 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; long term care insurance; flexible health care spending accounts; Medicare supplement insurance, vision 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 Fidelity Assurance 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 Fidelity Assurance 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 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. **Worker's Compensation.** We may disclose your protected health information to worker's compensation agencies if necessary for your worker's 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 disclose your protected health information for research purposes, but only as permitted by law.

14. **Specialized Purposes.** We may 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 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 may be 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 Fidelity's health plan, your protected 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.

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 this 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 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 you 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 next 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 a 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 in this notice; or
- If you want to request a copy of our current notice of privacy practices.

Privacy Official
P.O. Box 25523
Oklahoma City, Oklahoma 73125
1-866-55-HIPAA

Copies of this notice are also available by sending an e-mail to: Hipaa@af-group.com. This notice is also available on our Web site: www.afadvantage.com.

SECURECARE DENTAL

GROUP INSURANCE

www.securecaredental.com