Gulf Guaranty Life Insurance Company

(Hereinafter called: We, Our or Us)
7 Riverbend Place
Flowood, Mississippi 39232

CERTIFICATE OF INSURANCE

We certify that coverage is provided for each Covered Person in accordance with the terms of the Policy.

This Certificate of Insurance replaces any previous certificate of insurance issued to You for the coverage described in this Certificate of Insurance. All benefits are subject to the terms of the Policy.

This Certificate of Insurance provides limited benefits and is not intended to cover all medical expenses. PLEASE READ YOUR CERTIFICATE OF INSURANCE CAREFULLY!

Signed at Our Home Office in Jackson, Mississippi

President:

SUPPLEMENTAL MEDICAL EXPENSE INSURANCE CERTIFICATE
LIMITED BENEFIT COVERAGE

This is supplemental medical expense coverage to the Employer's major medical or comprehensive medical plan. It pays limited benefits for Hospital confinements and certain outpatient expenses that are otherwise covered under the Employer's Other Medical Plan but not payable due to the Deductible and Coinsurance provisions of that plan.

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Certificate of Insurance
Gulf Guaranty Life Insurance Company
Alabama Dental Association
Policy# LICG221561
Effective Date: April 1, 2022

The following benefits apply to covered employees subject to all provisions of this Policy/Certificate of Insurance.

SCHEDULE OF BENEFITS

Annual MedPlus Policy Deductible	Single	$500
	Family	$1,000
Annual MedPlus Policy Benefit	Single	$6,300
	Family	$12,600
MedPlus Policy Coinsurance		100%
Primary Health Plan: BCBSAL - BS 4000		
Deductible		$4,000
Out of Pocket		$6,800
Coinsurance		80%

This plan pays 100% of eligible charges[1] which are consistent with the Primary Health Plan deductible and coinsurance. The maximum benefit is limited to $6,300 per person per calendar year for all services combined.

[1]Eligible charges refer to any charges which are eligible under the Primary Health Plan. Charges which are not covered under the Primary Health Plan will not be covered by this plan. No more than 100% of eligible charges will be paid by both plans.

SECTION 1
DEFINED TERMS

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

Accident means sudden, unexpected, and unintended injury:
(a) which is independent of any Sickness;
(b) over which the Covered Person has no control; and
(c) that takes place while the Covered Person's coverage is in force.

Active Service means that You are:
(a) doing in the usual manner all of the regular duties of Your employment on a full-time basis on a scheduled workday; and
(b) these duties are being done at one of the places of business where You normally do such duties or at some location to which Your employment sends You.

You will be said to be on Active Service on a day which is not a scheduled workday if You would be able to perform in the usual manner all of the regular duties of Your employment if it were a scheduled workday.

Calendar Year means the period from January 1 through December 31 of the same year.

Certificate means the individual Certificate issued to You. It describes the coverage under the policy.

Coinsurance Percentage means the applicable percentage specified in the Schedule of Benefits that We will use in computing the amount payable for Covered Charges.

Covered Charges means those charges that:
(a) are incurred by a Covered Person because of Accident or Sickness;
(b) are for necessary treatment services and medical supplies and recommended by a Physician;
(c) are not more than any dollar limit set forth in the Schedule;
(d) are incurred while insured under the Policy, subject to any Extension of Benefits; and
(e) are not excluded under Section 4.

Covered Persons means You and Your Dependents who are insured under the Policy.

Dependent means Your:
(a) married spouse who is under age 70 and lives with You;
(b) child (natural, step, or adopted) who is less than 26 years of age;

(c) child (natural, step, or adopted) who becomes incapable of self-sustaining employment because of mental or physical incapacity prior to reaching the limiting age for dependent children. The child must be dependent on You for support and maintenance. Coverage will continue as long as Your insurance stays in force and the child remains incapacitated. Proof may be required from time to time but not more than once a year after the child attains age 27; or
(d) child (natural, step, or adopted) who is not living with You, but You are legally required to support such a child, and the child would otherwise qualify under (b) or (c) above.

The term Dependent does not include Your grandchild unless required by law.

Effective Date means the date described in the Policy. The date shown in Your Certificate is Your Effective Date. The Effective Date will start at 12:01 a.m. the place of business of the Policyholder.

Employee means a person employed by the Employer working at least [30] hours per week.

Grace Period means 31 days will be allowed for each premium payment after the first premium. Coverage will stay in force during this time. The coverage under the Policy will terminate at the end of the Grace Period if the premium has not been paid.

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; and
(b) is accredited by the Joint Commission on Accreditation of Hospitals.

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

Hospital Emergency Room means a portion of a Hospital where emergency diagnosis and treatment of Sickness or injury due to an Accident is provided.

Hospital Outpatient Facility means an area contained within a Hospital building that is owned and operated by the Hospital and not otherwise excluded under the terms of this Policy where patients receive diagnostic testing or treatment without being admitted to the Hospital on an inpatient basis.

Freestanding Outpatient Surgery Center means a freestanding facility other than a Physician's Office where surgical and diagnostic services are provided on an ambulatory basis.

Magnetic Resonance Imaging (MRI) Facility means a freestanding diagnostic imaging facility that provides diagnostic testing using magnetic resonance imaging.

Inpatient means confinement in a Hospital for at least 23 continuous hours in duration.

Insured (You, Your) means any person who is eligible for insurance under Section 2 and is insured under the Policy by virtue of:
(a) employment by the Policyholder; or
(b) employment by a member company who is a member of an association who holds the Master Policy.

Maximum Benefit Per Calendar Year is equal to the amount of the Maximum In-Hospital Benefit Calendar Year maximum. The Maximum Benefit Per Calendar Year is the maximum amount payable in a Calendar Year for In-Hospital Covered Charges and Outpatient Covered Charges combined, as shown in the Schedule of Benefits. In-Hospital Covered Charges and Outpatient Covered Charges are also subject to their individual Calendar Year maximums as shown in the Schedule of Benefits.

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

Other (or Another) Medical Plan means any basic medical, comprehensive medical, or managed care policy provided through the Policyholder through which a Covered Person has coverage. The term Other Medical Plan does not include TRICARE, Medicare, or Medicaid.

Physician means a practitioner of the healing arts who:
(a) is practicing within the scope of his or her license in the state where licensed; and
(b) is not related to the Covered Person.

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

Policyholder means the employer or association who holds the Policy.

Policy Deductible means the amount of Covered Charges for benefits otherwise payable under the Policy that must be satisfied by the Covered Person each Calendar Year before benefits are payable under the Policy.

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

Sickness means illness or disease which starts while the Covered Person's coverage is in force and is the direct cause of the loss.

SECTION 2
ELIGIBILITY AND EFFECTIVE DATE

Your Eligibility - You are eligible to be insured under the Policy if You:
- (a) are on Active Service as an employee or Policyholder, or an employee or a member of the Policyholder;
- (b) qualify as an eligible insured, as defined in the Policyholder's application;
- (c) are covered under Another Medical Plan; and
- (d) are under age 70 (If you are employed by an employer employing less than 20 employees).

Evidence of coverage under Another Medical Plan may be required.

Your Effective Date – If You are eligible, Your Insurance will take effect on:
- (a) the requested Effective Date; or
- (b) the Effective Date assigned by Us upon approval of Your written application, whichever is later, if;
  - (1) Our underwriting rules are met;
  - (2) You are on Active Service;
  - (3) You are covered under Another Medical Plan; and
  - (4) premium has been paid.

Dependent Eligibility – If Dependent coverage is available under the Policy, You will be eligible for such coverage:
- (a) the day You become eligible for coverage; or
- (b) the day You acquire Your first Dependent;

  whichever is later provided the Dependent(s) to be insured is/are covered under Another Medical Plan.

Dependent coverage may be elected by:
- (a) completing and signing an application within 31 days of the date the Dependent becomes eligible; and
- (b) by completing any required form of payroll deduction authorization.

Dependent Effective Date – The Effective Date of coverage for each eligible Dependent will be the first of the month following:
- (a) Our acceptance of the application; and
- (b) receipt of the first premium.

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

A newborn child will become covered for Accident and Sickness automatically on the day he or she is born as long as Your coverage was in force on that date. Accident and Sickness includes pre-maturity, congenital defects and birth abnormalities of a newborn

child. The newborn's coverage will not continue past the 31-day period following his or her birth unless:

(a) We are notified by the end of the 31-day period of the addition of such newborn child; and
(b) any applicable premium has been paid.

Coverage for newborn children will also include coverage for:

(a) a newly-born child adopted by You, from moment of birth; and
(b) a child adopted by You from the date of placement of adoption.

Coverage for the adopted child will not continue past 31 days after date of birth or placement for adoption unless:

(a) We are notified by the end of the 31-day period of the addition of such adopted child; and
(b) any applicable additional premium has been paid.

SECTION 3
WHAT IS ELIGIBLE FOR COVERAGE

In-Hospital Benefit: We will pay benefits for Covered Charges incurred by a Covered Person if:

(a) the Covered Person is covered by Another Medical Plan when such Covered Charges are incurred, except as provided in the Absence of Other Plan provision, described in this Section; and
(b) such Covered Charges are incurred while the Covered Person is an Inpatient.

Benefits payable are limited to:

(a) any out-of-pocket deductible amounts incurred under the Other Medical Plan;
(b) any out-of-pocket coinsurance amounts the Covered Person actually incurs, after meeting the deductible, under the Other Medical Plan; and
(c) any out-of-pocket amount the Covered Person actually incurs under and applied to the deductible of the Other Medical Plan for treatment of a Mental or Emotional Disorder, limited to 30 days per Calendar Year;

up to the Maximum In-Hospital Benefits shown in the Schedule.

Benefits are limited to the Maximum Benefit Per Calendar Year listed on the Schedule for any In-Hospital Covered Charges and Outpatient Hospital Covered Charges combined.

Absence of Other Medical Plan: Coverage under the Policy will be terminated for such Covered Person, and any other person in the same family unit whose Other Medical Plan coverage is not in effect. Such Covered Person(s) will not be entitled to any Extensions or Continuations described in Section 5, except COBRA Continuation, where applicable.

Outpatient Hospital Benefit: We will pay benefits for Covered Charges incurred by a Covered Person if:

(a) the Covered Person is covered by Another Medical Plan when such Covered Charges are incurred, except as provided in the Absence of Other Plan provision, described in this Section; and
(b) such Covered Charges are incurred while the Covered Person is not Inpatient.

Benefits payable are limited to:

(a) any out-of-pocket deductible amounts incurred under the Other Medical Plan; and
(b) any out-of-pocket coinsurance amounts the Covered Person actually incurs, after meeting the deductible, under the Other Medical Plan up to the Maximum Outpatient Hospital Benefit shown in the Schedule.

Benefits are limited to the Maximum Benefit Per Calendar Year listed on the Schedule for any In-Hospital Covered Charges and Outpatient Hospital Covered Charges combined.

After satisfaction of the Outpatient Deductible shown in the Schedule of Benefits, We will pay the Coinsurance Percentage of out-of-pocket expenses for Covered Outpatient Services up to the Maximum Outpatient Benefit shown on the Schedule of Benefits if the Covered Person is covered by Another Medical Plan at the time the Covered Charges are incurred. If per occurrence, the Deductible will apply to each Covered Outpatient Service that is separated by 24 hours or more.

Covered Outpatient Services are:

(a) Outpatient treatment in a Hospital Emergency room without subsequently being considered an Inpatient and limited to two (2) visits per Calendar Year per Covered Person and six (6) visits per Calendar Year per family;
(b) Outpatient surgery performed in a Hospital Outpatient Facility or a Freestanding Outpatient Surgery Center;
(c) Outpatient diagnostic testing performed in a Hospital Outpatient Facility or Magnetic Resonance Imaging (MRI) Facility; and
(d) Outpatient treatment of a Mental or Emotional Disorder performed in a Hospital Facility, limited to thirty (30) days of treatment per Calendar Year.

SECTION 4
WHAT IS NOT ELIGIBLE FOR COVERAGE

We will pay no benefits for any expenses incurred for:

- (a) suicide or any attempt thereof, while sane or insane;
- (b) any intentionally self-inflicted injury or Sickness;
- (c) rest care or rehabilitative care and treatment;
- (d) routine newborn care, including routine nursery charges;
- (e) voluntary abortion except with respect to You or Your covered Dependent spouse:
    - (1) where You or Your Dependent spouse's life would be endangered if the fetus were carried to term; or
    - (2) where medical complications have arisen from an abortion;
- (f) pregnancy of a Dependent child;
- (g) participation in a riot, civil commotion, civil disobedience, or unlawful assembly. This does not include a loss which occurs while acting in a lawful manner within the scope of authority;
- (h) commission of a felony;
- (i) participation in a contest of speed in power driven vehicles, parachuting, or hang gliding;
- (j) air travel, except:
    - (1) as a fare-paying passenger on a commercial airline on a regularly scheduled route; or
    - (2) as a passenger for transportation only and not as a pilot or crew member;
- (k) Accident that occurs while intoxicated or Sickness that results from intoxication (Whether or not a person is intoxicated is determined and defined by the laws and jurisdiction of the geographical area in which the loss occurred.);
- (l) alcoholism or drug use, unless such drugs were taken on the advice of a Physician and taken as prescribed;
- (m) sex changes;
- (n) experimental treatment, drugs, or surgery;
- (o) an act of war, whether declared or undeclared, or while performing police duty as a member of any military or naval organization (This exclusion includes any Accident sustained or Sickness contracted while in the service of any military, naval, or air force of any country engaged in war. We will refund the pro rata unearned premium for such period the Covered Person is not covered due to military service.);
- (p) Accident or Sickness arising out of and in the course of any occupation for compensation, wage or profit (This does not apply to those sole proprietors or partners not covered by Worker's Compensation.);
- (q) dental or vision services including treatment, surgery, extractions, or x-rays, unless:
    - (1) resulting from an Accident occurring while the Covered Person's coverage is in force and if performed within 12 months of date of such Accident; or
    - (2) due to congenital disease or anomaly of a covered newborn child;

(r) routine examinations, such as health exams, periodic checkups, or routine physicals;
(s) any expense for which benefits are not payable under the Covered Person's Other Medical Plan;
(t) elective cosmetic surgery;
(u) drugs (prescription and non-prescription);
(v) sterilization and reversal of sterilization;
(w) any expense that does not meet the definition of Covered Charges;
(x) any expense or service that exceeds the maximum benefit amount, as shown in the Certificate Schedule of Benefits, or number of visits that exceeds the number of visits, as shown in the Certificate Schedule of Benefits;
(y) Physician's charges that are eligible or covered under the Other Plan's co-payment provision.

SECTION 5
WHEN COVERAGE ENDS

Insured's Coverage: Insurance coverage on an insured will end on the earliest of these dates:

(a) the end of the last period for which the required premium has been paid,
(b) the date this Policy is terminated;
(c) the date the Insured retires;
(d) the date the Insured ceases to be an Employee as defined in Section 1; or
(e) the date the Insured's coverage under Another Medical Plan ends.

Coverage on Dependent(s): Insurance coverage on a Dependent will end on the earliest of these dates:

(a) the date the Insured's coverage terminates;
(b) the end of the last period for which the required premium has been paid;
(c) the date the Dependent no longer meets the definition of Dependent, as defined in Section 1;
(d) the date the Dependent's coverage under Another Medical Plan ends; or
(e) the date this Policy is modified so as to exclude Dependent coverage.

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

Continuation of Coverage: If a Covered Person's coverage under the Policy terminates such coverage may be continued provided that:

(a) the Covered Person's coverage is being continued under the Other Medical Plan;
(b) the Covered Person's continues to be covered under the Other Medical Plan; and
(c) the required premium is paid for the Covered Person.

Continued Coverage under the Policy will end on the earliest to occur of the following:

(a) the Covered Person's coverage being continued under the Other Medical Plan terminates;
(b) the Covered Person ceases to be covered under the Other Medical Plan; or
(c) the premium for the Covered Person has not been paid as required under the Policy.

SECTION 6
PREMIUMS

Premiums are due in advance by the Policyholder on a monthly basis. Premiums are payable to the Company at its Home Office. Payment of a premium by the Policyholder will not maintain the insurance in force beyond the period for which it is paid except for the Grace Period provision applicable to the Policyholder.

The premium rates may be changed by the Company. If the rates are changed the Company will give the Policyholder at least 60 days advance written notice. If a change in benefits contained in the Policy or Other Medical Plan increases the Company's liability, premium rates may be changed on the date the Company's liability is increased.

SECTION 7
GENERAL POLICY PROVISIONS

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

CLAIM FORMS: A claim form should be used for filing proof of loss. We will send the forms needed for filing proof of loss to the claimant within 15 days of receipt of Notice of Claim. If claim forms are not supplied within this stated period of time, a claimant can give proof by sending, in writing, a description of the loss regarding the nature and extent of the loss.

PROOF OF LOSS: Proof of Loss must be given to the Company within 90 days after the loss. The Company will accept late proof if:
(a) it was not reasonably possible to give proof in that time; and
(b) the proof is given within one year from the date of loss. This one year limit will not apply in the absence of legal capacity.

The explanation of benefits under the Other Medical Plan must be submitted with claim forms for all claims.

TIME OF PAYMENT OF CLAIMS: Benefits for a covered loss will be paid within 25 days after receipt of Proof of Loss in the form of a clean claim where claims are submitted electronically and will be paid within 35 days after receipt of Proof of Loss in the form of a clean claim where claims are submitted in paper format. Benefits due under the Policy and claims are overdue if not paid within 25 days or 35 days, whichever is applicable, after the Company receives a clean claim containing necessary medical information and other information essential for the Company to administer the provisions of the Policy.

For purposes of this provision, a "clean claim" means a claim received by the Company for adjudication and which requires no further information, adjustment, or alteration by the provider of the services or the Insured in order to be processed and paid by the Company. A claim is clean if it has no defect or impropriety, including any lack of substantiating documentation or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this provision. A clean claim includes resubmitted claims with previously identified deficiencies corrected.

A “clean claim” does not include any of the following:
(a) a duplicate claim, which means an original claim and its duplicate when the duplicate is filed within 30 days after the original claim;
(b) claims which are submitted fraudulently or that are based upon material misrepresentations;

(c) claims that require information essential for the Company to administer the provisions of the Policy; or
(d) claims submitted by a provider more than 30 days after the date of service. If the provider does not submit claims on behalf of the Insured, then a claim is not clean when submitted more than 30 days after the date of billing by the provider to the Insured.

No later than 25 days after the date the Company actually receives an electronic claim, the Company shall pay the appropriate benefit in full, or any portion of the claim that is clean, and notify the provider (where the claim is owed to the provider) or the Insured (where the claim is owed to the Insured) of the reasons why the claim, or portion thereof, is not clean and will not be paid and what substantiating documentation and information is required to adjudicate the claim as clean. No later than 35 days after the date the Company actually receives a paper claim, the Company shall pay the appropriate benefit in full, or any portion of the claim that is clean, and notify the provider (where the claim is owed to the provider) or the Insured (where the claim is owed to the Insured) of the reasons why the claim, or portion thereof, is not clean and will not be paid and what substantiating documentation and information is required to adjudicate the claim as clean. Any claim, or portion thereof, resubmitted with the supporting documentation and information requested by the Company shall be paid within 20 days after receipt.

For purposes of this provision, the term "pay" means that the Company shall either send cash or a cash equivalent by United States mail or send cash or a cash equivalent by other means such as an electronic transfer, in full satisfaction of the appropriate benefit due the provider (where the claim is owed to the provider) or the Insured (where the claim is owed to the Insured). To calculate the extent to which any benefits are overdue, payment shall be treated as made on the date a draft or other valid instrument was placed in the United States mail to the last known address of the provider (where the claim is owed to the provider) or the Insured (where the claim is owed to the Insured) in a properly addressed, postpaid envelope, or, if not so posted, or not sent by United States mail, on the date of delivery of payment to the provider or Insured.

If the claim is not denied for valid and proper reasons by the end of the applicable time period prescribed in this provision, the Company will pay the provider (where the claim is owed to the provider) or the Insured (where the claim is owed to the Insured) interest on accrued benefits at the rate of 1-1/2% per month accruing from the day after payment was due on the amount of the benefits that remain unpaid until the claim is finally settled or adjudicated. Whenever interest due pursuant to this provision is less than $1.00, such amount shall be credited to the account of the person or entity to whom such amount is owed.

In the event the Company fails to pay benefits when due, the person entitled to such benefits may bring action to recover such benefits and any interest which may accrue as provided in this provision and any other damages as may be allowable by law.

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

ASSIGNMENT OF BENEFITS: The benefits of the Policy may be assigned.

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