SECURECARE

GROUP INSURANCE

Dental ▪ Vision

# Certificate of Coverage

## Employee Benefits Booklet

www.securecaredental.com

# American National Insurance Company of Texas

**One Moody Plaza • Galveston, Texas • 77550**

(called “We”, “Our” and “Us”)

**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 National Insurance Company of Texas. 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 National Insurance Company of Texas, One Moody Plaza, Galveston, TX 77550.

President Secretary

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

**WARNING:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information may be guilty of insurance fraud.

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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 every 36 months;
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. sealant or preventive resin restoration, limited to:
   a. Insureds under age 16; and
   b. one application every 36 months; 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 and resin based composite filling material; (Restorations of the mesiolingual, distolingual, mesiobuccal and distobuccal surfaces will be considered single surface restorations.)
3. antibiotic injections administered by Dentist;
4. oral surgery, including customary postoperative care for:
   a. partial or complete 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 extraction;
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 and repairing inlays, onlays and crowns;
7. re-cementing bridges;
8. repairs to full or partial dentures or bridges, limited to one repair 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. This benefit is payable as a Class/Type III service, whether or not the covered oral surgery is payable as a Class/Type II or III service, and is subject to the same Waiting Period that applies to the covered oral surgery;
10. restorative services and supplies, limited to:
    a. metal, porcelain or resin inlays, onlays, and crowns, only for the tooth with extensive caries or fracture and only if the tooth is unable to be restored with an amalgam or resin based 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 if such inlay, onlay, or crown is more than five years old . However, this five-year waiting period 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), and such extraction is made 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. If the missing tooth was extracted or lost before the Insured is covered under the Policy, there will be a 36-month waiting period, from the Insured's Effective Date of coverage, before coverage will be provided for the missing tooth. However if the missing tooth is extracted or lost while the Insured is covered under the Policy, this 36 month waiting period limitation will not apply.
    b. placement of an endosteal implant body, a prefabricated abutment, and an implant-related crown for the purpose of replacing a single missing tooth, excluding 3rd molars. Coverage will be limited to one implant body and prefabricated abutment per quadrant, per policy lifetime; when more than one implant body, prefabricated abutment and implant-related crown are submitted within the same quadrant coverage will be limited to the implant-related crown only. If the missing tooth was extracted or lost before the Insured is covered under the Policy, there will be a 36-month waiting period, from the Insured's Effective Date of coverage, before coverage will be provided for the missing tooth.
    c. When replacing a natural tooth/teeth where there is/are bilateral missing tooth/teeth or will be bilateral missing tooth/teeth as part of a proposed Treatment Plan due to an extraction, the benefit provided will be for, and limited to, a removable partial denture, regardless of whether (1) the replacement is for one side or both sides of the mouth, or (2) the replacement is performed on the same date or different dates;
    d. replacement of full or partial dentures or fixed bridgework, only if such appliance or bridgework is more than five years old and cannot be made serviceable;
    e. 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. If the missing tooth was extracted or lost before the Insured is covered under the Policy, there will be a 36-month waiting period, from the Insured's Effective Date of coverage, before coverage will be provided for the missing tooth.
    f. 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;
    g. replacement of an endosteal implant body for the purpose of replacing a single missing tooth, a prefabricated abutment, or an implant-related crown only if such implant body, abutment or implant related crown is more than five years old and cannot be made serviceable.

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, limited to:
    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, limited to two per Calendar Year (takes the place of a prophylaxis benefit);
    c. root scaling and root planing, limited to once per quadrant in any 12-month period;
    d. gingivectomy, gingival flap procedure, and mucogingival surgery;
    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. 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.
14. Procedures related to implants (other than what is listed as covered in COVERED DENTAL SERVICES, CLASS/TYPE III Major Services, item 11.), and any complications as of the result of implants; removal of implants; precision or semi-precision attachments; denture duplication; overdentures and any associated surgery; or other customized services or attachments.
15. Services provided for any type of temporomandibular joint (TMJ) dysfunctions, muscular, skeletal deficiencies involving TMJ or related structures, myofascial pain.
16. Orthognathic surgery.
17. Orthodontic treatment, unless identified as covered in the Schedule of Dental Benefits applicable to the Insured.
18. Treatment of malignancies.
19. General anesthesia and intravenous sedation, regardless of the age of the patient, except in conjunction with covered oral surgical procedures.
20. The services of anesthetists or anesthesiologists.
21. Hospital services.
22. Prescribed drugs.
23. Any instruction for diet, plaque control, or oral hygiene.
24. Dental disease, defect or injury caused by a declared or undeclared war, or any act of war.
25. Charges for failure to keep a scheduled visit, or for the completion of any claim forms.
26. Services or supplies payable in whole or in part under any medical plan.
27. 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.
28. 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).
29. Expenses provided or paid for by any governmental program or law, except as to charges which the person is legally obligated to pay.
30. Services for which there would be no charge in the absence of insurance, or any service or treatment provided without charge.
31. Interpretation of a diagnostic image by a practitioner not associated with the capture of the image.

## 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.

**Adverse Benefit Determination.** A denial of benefits under the Policy, including any reduction or termination by the Policy of a course of treatment (other than by Policy amendment or termination), a failure to make a payment based on a determination of the Claimant's eligibility to participate in the Policy, and a denial, reduction, or termination of (or a failure to provide or make payment in whole or in part for) a benefit resulting from the application of a utilization review or a failure to cover an item or service because it is determined to be experimental, investigational, or not medically necessary or appropriate.

**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.

**Claimant.** An individual who makes a claim for benefits under the Policy. The term Claimant includes an Insured's authorized representative.

**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 Covered 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).**

1. Your lawful spouse, or common law spouse (where permitted by law).
2. Your natural, step, or adopted child who is under age 26.
3. Your unmarried grandchild who is under age 19 and living with You in a regular grandparent-grandchild relationship, whom You claim as an exemption on Your federal income tax return.
4. A child who has been placed with You for the purpose of adoption.
5. A handicapped child of Yours 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 r 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.

**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 the Policy. Coverage will begin at 12:01 a.m. at the main place of business of the Policyholder.

**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.

**Final Adverse Benefit Determination.** An Adverse Benefit Determination that has been upheld by Our Third Party Administrator at the completion of the appeals process.

**FMX – Full Mouth X-Rays.** The total of any 14 periapical and posterior bitewing images.

**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 Allowable Charge.** The maximum dollar amount We have deemed allowable for the purpose of determining benefits payable under the Policy for a Covered Dental Service. The Maximum Allowable Charge may be less than the amount actually billed by the provider.

**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.

**Policyholder.** The employer who holds the Policy. The Policyholder is named on the face page of the Policy.

**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., Phoenix, Arizona.

**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 National Insurance Company of Texas.

**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 employer pays all of the premium for coverage on You, coverage will begin 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 You pay all or part of the premium for coverage on You, coverage will begin 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.

**DUAL ELIGIBILITY**
In no event may a person be covered more than once under the Policy.

<u>If Your Employer pays all of Your premium.</u>
If You and Your spouse/common law spouse:

1. are both eligible for coverage under the Policy as Insureds; and
2. have no Dependent children,

then You and Your spouse/common law spouse will both be covered as employees. Dependent coverage is not available or applicable in this situation.

If both You and Your spouse/common law spouse:

1. are eligible for coverage under the Policy as Insureds; and
2. have Dependent children,

then You and Your spouse/common law spouse will both be covered as employees. Either You or Your spouse/common law spouse (but not both) may elect Dependent coverage for Your Dependent children, and such Dependent coverage will not apply to the other spouse/common law spouse.

<u>If You pay all or part of Your premium.</u>
If You or Your spouse/common law spouse:

1. are both eligible for coverage under the Policy as Insureds; and
2. have no Dependent children,

then:

1. You and Your spouse/common law spouse may both elect individual (employee only) coverage; or
2. either You or Your spouse/common law spouse may elect coverage for both (with the other spouse/common law spouse being covered as a Dependent), and the other spouse/common law spouse may not enroll for coverage.

If both You and Your spouse/common law spouse:

1. are eligible for coverage under the Policy as Insureds; and
2. have Dependent children,

then either You or Your spouse/common law spouse (but not both) may elect Dependent coverage, and such Dependent coverage will not apply to the other spouse/common law spouse.

If an eligible employee has a Dependent child who is also eligible as an employee, both You and Your Dependent child will be covered as employees. If the employee elects Dependent coverage, such Dependent coverage will not apply to any other Dependent child who is already covered as an employee.

**Dual Eligibility / Divorce**
If:

1. both You and Your spouse/common law spouse are covered as Insureds under the Policy; and
2. have covered Dependent children; and
3. later become divorced,

such covered Dependent children may be covered only by the parent who is required by law to provide health coverage for such Dependent children. If there is no legal requirement to provide health coverage for such Dependent children, either parent may elect Dependent coverage. Such Dependent children may be listed as Dependents under only one parent's coverage.

Any child who was a step-child of Yours will no longer be eligible for coverage, unless You have adopted such child.

**Dual Eligibility / Termination of Employment**
If You and Your spouse/common law spouse are covered as Insureds under the Policy and one of You terminates employment, the remaining employee will be permitted to immediately enroll the terminating spouse/common law spouse and any of his or her eligible Dependents who were enrolled under the terminating spouse/common law spouse coverage. Such new coverage will be deemed continuation of prior coverage, and will not operate to reduce or increase any coverage to which the person was entitled while enrolled as the employee or the Dependent of the terminated employee.

**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 Your employer pays all of the premium for coverage on Your Dependent(s), 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 You pay all or part of the premium for coverage on Your Dependent(s), 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. If a change in coverage results in an increase in benefits, such change will not apply to covered dental services or supplies provided before the Effective Date of the change.

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.

**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 meet the definition of 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 implant body and implant abutment: the date of placement
6. For all other services: the date the service is performed.

**PRETREATMENT REVIEW**
If the Course of Treatment will exceed $300, prior review is recommended. We should be given the Dentist's Treatment Plan, estimated charges, and diagnostic x-rays. We will determine both the Eligible Expenses and allowable benefit, then provide both You and Your Dentist with this information.

If further treatment is necessary and the charges will exceed $300, then an additional Pretreatment Review is recommended before the Course of Treatment is continued.

If You and Your Dentist do not provide a Pretreatment Review when one is recommended, no benefits are payable for a dental treatment which cannot reasonably be verified as a covered dental service.

Pretreatment Review is not needed for Emergency or Palliative Care, or routine scaling or cleaning of teeth.

**ALTERNATE BENEFIT PROVISION**
If various types of treatment are available, the covered dental charges will be limited to the dental service benefit payable for the least expensive treatment that will produce a professionally adequate result as determined by Us.

**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 whether the provider is a preferred or non-preferred provider (for PPO plans), or a general or specialty dentist. 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

**NOTICE OF CLAIM**
Proper notice of claim must be given to Us through Our Home Office or Our Third Party Administrator.

Notice must include the name of the Claimant.

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 it was not reasonably possible to give notice within that time.

**CLAIM FORM**
When We receive 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 requirements of the Proof of Loss provision by giving Us a statement of the nature and extent of loss within the time limit stated in the Proof of Loss provision.

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 Southwest Preferred Dental Organization, Inc., at the address shown on Your ID card. You may assign Your dental care benefits. Unless You assign Your benefits to a health care provider, payment will be made to You.

**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, BENEFIT DETERMINATION, AND APPEALS**

**Initial Benefit Determinations.** Initial benefit determinations will be rendered by Our Third Party Administrator within 30 days after receipt of claim, unless Our Third Party Administrator notifies the Claimant, prior to the end of the original 30-day period, that an extension of up to 15 days is necessary due to circumstances beyond Our Third Party Administrator's control. If the reason for the extension is because Our Third Party Administrator does not have enough information to decide the claim, the notice must describe the required information, the Claimant must be given at least 45 days from the date the notice is received to provide the necessary information, and the period for making the benefit determination will be tolled from the date the notice is sent to the Claimant until the date that the Claimant responds.

**Contents of Initial Claim Denial Notices.** If an initial claim is denied, the Claimant will be given written notice that includes:

1. the specific reason or reasons for the Adverse Benefit Determination;
2. reference to the plan provisions on which the determination is based;
3. a description of any additional material or information necessary for the Claimant to perfect the claim, and an explanation of why the information is necessary;
4. a description of the plan's review procedures and the time limits applicable to those procedures, including a statement of the Claimant's right to bring a civil action under ERISA Section 502(a) following an Adverse Benefit Determination on review;
5. if an internal rule or guideline was applied in making the determination, an explanation of the rule or a statement that the rule will be provided free of charge upon request; and
6. if the determination is based on a medical necessity or experimental exclusion, an explanation of the scientific or clinical judgment applied to make the determination or a statement that the explanation will be provided free of charge upon request.

**Appealing an Initial Claims Denial.** If the initial claim is denied, the Claimant will have two years days from receipt of notification to appeal the determination. The Claimant may submit written comments, documents, records, and other information relating to the claim for consideration on appeal. The Claimant must be provided, upon request and free of charge, reasonable access to and copies of all other information relevant to the Claimant's claim. For this purpose, information will be considered relevant if it (1) was relied upon in making the benefit determination, (2) was submitted, considered or generated (without regard to whether it was relied upon) in the course of making the benefit determination, (3) demonstrates compliance with the administrative processes and safeguards required in making the benefit determination, or (4) constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the Claimant's diagnosis (without regard to whether the statement or guidance was relied upon).

Appeals should be submitted to the following address:

**American National Insurance Company of Texas**
**Grievances and Appeals**
One Moody Plaza
Galveston, TX 77550

**Decisions on Appeal.** The Claimant must receive notice of the appeals decision within a reasonable period of time, but not later than 30 days after receipt of the request for review. The Claimant will be notified of the eligibility determination as soon as possible, but not later than 36 hours after receipt of the request for review.

If the decision to deny the claim was based in whole or in part on a medical judgment, the Third Party Administrator must consult with a health care professional who has experience and training in the relevant field and who was not involved in the initial determination. Identification of any such health care professional must be provided to the Claimant upon request.

**Contents of Notice of Decision on Appeal.** Any notice of an adverse benefit determination from an appeal must include:

1. the specific reason or reasons for the adverse benefit determination;
2. reference to the plan provisions on which the determination is based;
3. a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents and other information relevant to the Claimant's claim;
4. a statement describing the second-level appeal procedures and the Claimant's right to obtain information about such procedures, and a statement of the Claimant's right to bring an action under ERISA Section 502(a);
5. if the determination is based on a medical necessity or experimental exclusion, an explanation of the scientific or clinical judgment applied to make the determination, or a statement that the explanation will be provided free of charge upon request;
6. if an internal rule or guideline was applied in making the determination, an explanation of the rule, or a statement that the rule will be provided free of charge upon request; and
7. a statement that "you or your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your state insurance regulatory agency."

**Making a Second Appeal.** Second appeals are required before a Claimant may pursue an external review or file a lawsuit. If a Claimant's first appeal for benefits is denied and the Claimant wants to appeal further, the Claimant will have 60 days from receipt of the denial notification to appeal in writing to Our Third Party Administrator.

The Claimant's second appeal must outline the issues and include any additional information and related documents. The provisions described above with respect to appealing an initial claim denial will also apply to second appeals.

**Exhaustion.** All issues must be raised on appeal or will forever be waived. For each issue raised, a Claimant must exhaust all internal claims and appeals processes applicable to a claim for major medical benefits as described in this section before pursuing external review. In addition, for each issue raised, a Claimant must exhaust all claims and appeals processes applicable to a claim for benefits as described in this section before pursuing litigation. Under no circumstances may any lawsuit be brought more than 180 days following the final adverse benefit determination under the plan.

**Mitigation of Potential Conflicts of Interest.** All claims and appeals must be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. An appeals decision must not afford deference to the initial adverse benefit determination or first appeal (if applicable) and must not be conducted by any individuals who made the initial determination or first appeal or their subordinates. The review must take into account comments, documents, records, and other information submitted, regardless of whether the information was previously considered on initial review or first appeal.

In making a claims determination, Our Third Party Administrator must interpret plan provisions in good faith in the best interest of plan participants and beneficiaries and must not take into account either the amount of benefits that will be paid to a Claimant or the financial impact on the company or insurance company. Decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual involved in a claims determination will not be made based upon the likelihood that the individual will support the denial of benefits.

**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.

**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. If 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, whether or not 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.

**American National Insurance Company of Texas**
**One Moody Plaza • Galveston, Texas • 77550**

# 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 <u>not</u> 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

# AMERICAN NATIONAL LIFE INSURANCE COMAPNY OF TEXAS

One Moody Plaza Galveston, Texas 77550
(herein called the "Insurer")

Effective Date: [_____]
(if different from Policy or Certificate)

## ORTHODONTIC COVERAGE RIDER

The Policy or Certificate to which this Rider is attached is hereby amended as follows:

This Rider covers persons who meet Eligibility requirements and who become and remain insured under the Policy. Benefits are payable only for Eligible Expenses. In consideration of the payment of any Rider premium, the Company will provide the coverage described below.

**DEFINITIONS**

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

**Active Comprehensive Orthodontic Treatment (herein also referred to as "Treatment")**
Active Comprehensive Orthodontic Treatment begins with the insertion of the appliance (the banding date). The treatment procedure codes shown below include the placement of the appliance, adjustments/follow-up (monthly visits), the removal of the appliance, construction of the retainer, and any other follow-up treatment to maintain the achieved anatomical, functional and aesthetic results and/or stabilize the dentition after removal of the appliance. Whenever it is necessary to allocate benefits, pro- ration will be done on the basis of the Maximum Allowable Treatment Time Period for Active Comprehensive Orthodontic Treatment.

D8070 – Comprehensive orthodontic treatment of the transitional dentition
D8080 – Comprehensive orthodontic treatment of the adolescent dentition
D8090 – Comprehensive orthodontic treatment of the adult dentition

**Diagnostic Records**
The pre-treatment records are tools used by orthodontic providers to make an accurate diagnosis and develop the treatment plan. The records include study models, diagnostic photographs, cephalometric and panoramic films.

**Initial Consultation**
To facilitate a complete and comprehensive orthodontic treatment plan, the orthodontic documents medical/dental history, dental occlusion, overall dental condition, and the relationship between the teeth and skeletal structure.

**Maximum Allowable Treatment Time Period**
A time period of 24 continuous months for usual and customary orthodontic care. The Maximum Allowable Treatment Time Period begins when Treatment (banding) begins.

**Orthodontic Services**
All necessary services provided by a licensed Dentist to reduce or eliminate an existing malocclusion.

**BENEFIT PROVISIONS**
The Company will pay benefits for each eligible Insured, subject to the following:

1. 1. A 12-month Waiting Period applies where no group insured orthodontic coverage was in place for the group immediately prior to the coverage provided by this Rider. If the Policyholder has had prior insured group orthodontic coverage, then the employees and dependents insured by the prior carrier's plan on the day immediately prior to the takeover effective date will receive Waiting Period credit for the Waiting Period of this Rider in accordance with the credit provisions stipulated under the Policy.
2. Treatment must begin on or after the Insured's Effective Date of coverage, and the Waiting Period requirement for orthodontic treatment, if any, must be satisfied. For an Insured who has Treatment in progress prior to their Effective Date of coverage, such Treatment will be covered only if:

a. Treatment began while the Insured was covered under a group dental plan immediately prior to their Effective Date under the Policy; and
b. Treatment has been continuous from initiation of banding; and
c. Treatment is currently ongoing; and
d. the Insured's orthodontist submits a treatment plan as evidence of ongoing Treatment; and
e. the Insured's submits proof that the total amount of benefits paid or payable under the prior group dental plan does not exceed the lifetime maximum benefit provided under this Rider.

3. Banding must begin before an Insured reaches 19 years of age, but not before eight years of age.
4. The benefit payable will not exceed:
   a. 50% of the lesser of:
      i. the Usual, Reasonable and Customary fees; or
      ii. the fees actually charged for the orthodontic services;
      and
   b. $500 in any 12-month period; and
   c. a lifetime maximum of $1,000. This lifetime maximum benefit will be reduced by any amount paid or payable under a group dental plan in effect immediately prior to the Insured's Effective date under the Policy.

**EXCLUSIONS**

In addition to the list of Expenses Not Covered in the Certificate of Coverage, the following are not covered by this Rider:

1. Treatment rendered beyond the Maximum Allowable Treatment Time Period.
2. Diagnostic records and initial consultations.
3. Lost or stolen appliances.
4. Repairs to appliances.

**PAYMENT**

We will automatically make quarterly payments of benefits based on continuous quarterly submission of existing treatment plans. The benefits specified in this Rider will continue to be paid until treatment is completed if the following conditions exist:

1. The Policy remains active.
2. The employee remains covered under the Policy.
3. The Insured has not reached the age of ineligibility as defined in the Policy.
4. The Insured's lifetime maximum has not been exhausted.
5. The Insured continues to be under Treatment.

If an Insured's eligibility or Insured's eligibility for the orthodontic benefits of this Rider benefits is terminated during the quarter, then benefits will be prorated through the end of the last month of eligibility.

**TRANSFERRING FROM ANOTHER ORTHODONTIST (SAME GROUP POLICY RIDER CURRENTLY IN EFFECT)**

Treatment that was begun by one orthodontic provider covered under the Policy may be transferred to another orthodontic provider also covered under the Policy. The Company will pay benefits so long as coverage requirements under the Payment section above have been met. The new orthodontic provider must submit a treatment plan for the remainder of the Treatment period. Such treatment plan must specify the initial month of Treatment. The Company will determine benefits based on the first month of Treatment specified in the new orthodontic provider's treatment plan.

This Rider is subject to all of the provisions of the Policy as long as this Rider does not amend them. This Rider will terminate on the same date as the Policy or Certificate to which it is attached.

Secretary

# *SECURECARE DENTAL*

# ORTHODONTIC SERVICES SCHEDULE

**SecureCare Dental** Plan members are covered by the following non-insured Orthodontic Services Schedule. These benefits are available only through a SecureCare Dental participating Dentist at the specific addresses listed in your Provider Directory.

Dentists have agreed that any treatment imitated under this plan shall be completed, at the election of the member, under terms, conditions and fees provided herein, should the member become ineligible prior to completion of treatment. This non-insured Orthodontic Services Schedule and the fees herein cannot be used in conjunction with or coordinated with an Insured orthodontic Benefit. Orthodontic payments listed on this schedule will change from time to time as the fees paid to participating orthodontists change.

| **STANDARD ORTHODONTIC CARE PROGRAM** | **MEMBER PAYS** | |
|---|---|---|
| **Services Included in Orthodontic Care Program** | **Under Age 19** | **Age 19 &Over** |
| **Complete Orthodontic Survey Followed by Banding:**<br>D9310 - Consultation D0330 – Panoramic Images<br>D0350 – Oral/Facial Images D0340 – Cephalometric Images<br>D0210 – Intraoral Images D0470 – Diagnostic Casts | $ 450.00 | $ 450.00 |
| **Active Comprehensive Orthodontic Treatment (Banding):**<br>D08070/D08080/D08090 (Class I, II, or III)<br>Treatment up to 24 months following Complete Orthodontic Survey | $ 2,900.00* | $ 3,150.00* |
| **Orthodontic Retention:**<br>D8680 – Removal of appliances, construction and placement of retainer(s) | $ 300.00 | $ 300.00 |
| **TOTAL STANDARD ORTHODONTIC CARE FEE** | $ 3,650.00 | $ 3,900.00 |
| **COVERED SERVICES NOT INCLUDED IN STANDARD ORTHODONTIC CARE PROGRAM FEE**** | | |
| Consultation – D9310 | No Charge | |
| Diagnostic work-up and x-rays (if not done in conjunction with complete treatment – otherwise see "Complete Orthodontic Survey" above)<br>D0210 – Intraoral Images D0340 – Cephalometric Images<br>D0350 – Oral/Facial Images D0470 – Diagnostic Casts<br>D0330 – Panoramic Image | $ 250.00 | |
| Retainer (each arch) – New, lost, or replacement*** | $ 240.00 | |
| Final records (Includes Images and Diagnostic Casts) | $ 205.00 | |
| Space Maintainer – Unilateral – Fixed/Removable – D1520/D1525 | $ 126.00 / $ 140.00 | |
| Space Maintainer – Bilateral – Fixed/Removable – D1515/D1525 | $ 187.00 / $ 189.00 | |
| Reattach brackets and bands (Limit 3x) | No Charge | |
| Replace broken ligature wires (Limit 3x) | No Charge | |

* Patients that require more than 24 months of active banding may have an increase to the Total Standard Orthodontic Care Program Fee based on a pro-rated increase of the Basic Treatment charge. For example, if a 30 month treatment period (6 months longer than the Standard Orthodontic Care Program) were required, there would be a 25% increase in the Fee for "Basic Treatment."

* Patients assumed after treatment has begun by another dentist and requires shorter than 24 months of active banding may have a decrease to the Total Standard Orthodontic Care Program Fee based on a pro-rated decrease of the Basic Treatment charge. For example, if a 18 month treatment period (6 months shorter than the Standard Orthodontic Care Program) were required, there would be a 25% decrease in the Fee for "Basic Treatment."

** These may be charged in addition to the "Standard Orthodontic Care Program Fee."

*** If only a Retainer is needed and the orthodontist providing the new/replacement Retainer did not provide the previous Retainer or Diagnostic Cast, then he/she may charge the Retainer Fee plus not more than the "Complete Orthodontic Survey Fee" fee above.

Services not shown above are provided at a 20% discount from the dentist's usual fees.

## Statement of ERISA Rights

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

- examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all Plan documents, including insurance contracts and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.
- Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Employee Benefit Plan. The people who operate Your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of You and other Plan participants and beneficiaries. No one, including Your employer, or any other person, may discharge You or otherwise discriminate against You in any way to prevent You from obtaining a welfare benefit or exercising Your rights under ERISA.

If Your claim for a welfare benefit is denied in whole or in part, You must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider Your claim.

Under ERISA, there are steps You can take to enforce the above rights. For instance, if You request materials from the Plan and do not receive them within 30 days, You may file suit in a Federal court. In such 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 Plan Administrator. If You have a claim for benefits, which is denied or ignored, in whole or in part, You may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the plan's money, or if You are discriminated against for asserting Your rights, You may seek assistance from the U.S. Department of Labor, or You may file suit in a federal court. The court will decide who should pay court costs and legal fees. If You are successful, the court may order the person You have sued to pay these court costs and fees. If You lose, the court may order You to pay these costs and fees, for example, if it finds Your claim frivolous.

The Plan Administrator has full discretion and authority to determine the benefits and amounts payable and to construe and interpret all terms and provisions of this booklet.

If You have any questions about the Plan, You should contact the Plan Administrator. If You have any questions about this statement or about Your rights under ERISA, health care coverage portability (if applicable), or continuation of health care coverage under COBRA (if applicable), You may also contact:

U.S. Department of Labor
Employee Benefits Security Administration
200 Constitution Avenue, NW, Suite N-5625
Washington, D.C. 20210 (202) 219-8776

# AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS
# NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

We are required by law to protect the privacy of your health information. We are also required to send you this notice, which explains how we may use information about you and when we can give out or "disclose" that information to others. You also have rights regarding your health information that are described in this notice. We are required by law to abide by the terms of this notice.

The terms "information" or "health information" in this notice include any information we maintain that reasonably can be used to identify you and that relates to your physical or mental health condition, the provision of health care to you, or the payment for such health care. We will comply with the requirements of applicable privacy laws related to notifying you in the event of a breach of your health information.

We have the right to change our privacy practices and the terms of this notice. If we make a material change to our privacy practices, we will provide to you, in our next annual distribution, either a revised notice or information about the material change and how to obtain a revised notice. We will provide you with this information either by direct mail or electronically, in accordance with applicable law. In all cases, we will post the revised notice on our website **www.AmericanNational.com** We reserve the right to make any revised or changed notice effective for information we already have and for information that we receive in the future.

American National Life Insurance Company of Texas collects and maintains oral, written and electronic information to administer our business and to provide products, services and information of importance. We maintain physical, electronic and procedural security safeguards in the handling and maintenance of information, in accordance with applicable state and federal standards, to protect against risks such as loss, destruction or misuse.

## How We Use or Disclose Information

**We must** use and disclose your health information to provide that information:

• To you or someone who has the legal right to act for you (your personal representative) in order to administer your rights as described in this notice; and

• To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected.

**We have the right to** use and disclose health information for your treatment, to pay for your health care and to operate our business. For example, we may use or disclose your health information:

• **For Payment** of premiums due us, to determine your coverage, and to process claims for health care services you receive, including for subrogation or coordination of other benefits you may have. For example, we may tell a doctor whether you are eligible for coverage and what percentage of the bill may be covered.

• **For Treatment.** We may use or disclose health information to aid in your treatment or the coordination of your care. For example, we may disclose information to your physicians or hospitals to help them provide medical care to you.

• **For Health Care Operations.** We may use or disclose health information as necessary to operate and manage our business activities related to providing and managing your health care coverage. For example, we might talk to your physician to suggest a disease management or wellness program that could help improve your health or we may analyze data to determine how we can improve our services.

• **To Provide You Information on Health Related Programs or Products** such as alternative medical treatments and programs or about health-related products and services, subject to limits imposed by law.

• **For Plan Sponsors.** If your coverage is through an employer sponsored group health plan, we may share summary health information and enrollment and disenrollment information with the plan sponsor. In addition, we may share other health information with the plan sponsor for plan administration purposes if the plan sponsor agrees to special restrictions on its use and disclosure of the information in accordance with federal law.

• **For Underwriting Purposes.** We may use or disclose your health information for underwriting purposes; however, we will not use or disclose your genetic information for such purposes.

• **For Reminders.** We may use or disclose health information to send you reminders about your benefits or care, such as appointment reminders with providers who provide medical care to you.

**We may** use or disclose your health information for the following purposes under limited circumstances:

• **As Required by Law.** We may disclose information when required to do so by law.

• **To Persons Involved With Your Care.** We may use or disclose your health information to a person involved in your care or who helps pay for your care, such as a family member, when you are incapacitated or in an emergency, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object, we will use our best judgment to decide if the disclosure is in your best interests. Special rules apply regarding when we may disclose health information to family members and others involved in a deceased individual's care. We may disclose health information to any persons involved, prior to the death, in the care or payment for care of a deceased individual, unless we are aware that doing so would be inconsistent with a preference previously expressed by the deceased.

• **For Public Health Activities** such as reporting or preventing disease outbreaks to a public health authority.

• **For Reporting Victims of Abuse, Neglect or Domestic Violence** to government authorities that are authorized by law to receive such information, including a social service or protective service agency.

• **For Health Oversight Activities** to a health oversight agency for activities authorized by law, such as licensure, governmental audits and fraud and abuse investigations.

• **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena.

• **For Law Enforcement Purposes.** We may disclose your health information to a law enforcement official for purposes such as providing limited information to locate a missing person or report a crime.

• **To Avoid a Serious Threat to Health or Safety** to you, another person, or the public, by, for example, disclosing information to public health agencies or law enforcement authorities, or in the event of an emergency or natural disaster.

• **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.

• **For Workers' Compensation** as authorized by, or to the extent necessary to comply with, state workers compensation laws that govern job-related injuries or illness.

• **For Research Purposes** such as research related to the evaluation of certain treatments or the prevention of disease or disability, if the research study meets federal privacy law requirements.

• **To Provide Information Regarding Decedents**. We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties.

• **For Organ Procurement Purposes.** We may use or disclose information to entities that handle procurement, banking or transplantation of organs, eyes or tissue to facilitate donation and transplantation.

• **To Correctional Institutions or Law Enforcement Officials** if you are an inmate of a correctional institution or under the custody of a law enforcement official, but only if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

• **To Business Associates** that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required, under contract with us and pursuant to federal law, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract and as permitted by federal law.

• **Additional Restrictions on Use and Disclosure.** Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. "Highly confidential information" may include confidential information under Federal laws governing alcohol and drug abuse information and genetic information as well as state laws that often protect the following types of information:

1. HIV/AIDS;

2. Mental health;

3. Genetic tests;

4. Alcohol and drug abuse;

5. Sexually transmitted diseases and reproductive health information; and

6. Child or adult abuse or neglect, including sexual assault.

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law.

Except for uses and disclosures described and limited as set forth in this notice, we will use and disclose your health information only with a written authorization from you. This includes, except for limited circumstances allowed by federal privacy law, not using or disclosing psychotherapy notes about you, selling your health information to others, or using or disclosing your health information for certain promotional

communications that are prohibited marketing communications under federal law, without your written authorization. Once you give us authorization to release your health information, we cannot guarantee that the recipient to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization at any time in writing, except if we have already acted based on your authorization.

## What Are Your Rights

The following are your rights with respect to your health information:

• **You have the right to ask to restrict** uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. We may also have policies on dependent access that authorize your dependents to request certain restrictions. **Please note that while we will try to honor your request and will permit requests consistent with our policies, we are not required to agree to any restriction.**

• **You have the right to ask to receive confidential communications** of information in a different manner or at a different place (for example, by sending information to a P.O. Box instead of your home address). We will accommodate reasonable requests where a disclosure of all or part of your health information otherwise could endanger you. In certain circumstances, we will accept your verbal request to receive confidential communications; however, we may also require you confirm your request in writing. In addition, any requests to modify or cancel a previous confidential communication request must be made in writing. Mail your request to the address listed below.

• **You have the right to see and obtain a copy** of certain health information we maintain about you such as claims and case or medical management records. If we maintain your health information electronically, you will have the right to request that we send a copy of your health information in an electronic format to you. You can also request that we provide a copy of your information to a third party that you identify. In some cases, you may receive a summary of this health information. You must make a written request to inspect and copy your health information or have your information sent to a third party. Mail your request to the address listed below. In certain limited circumstances, we may deny your request to inspect and copy your health information. If we deny your request, you may have the right to have the denial reviewed. We may charge a reasonable fee for any copies.

• **You have the right to ask to amend** certain health information we maintain about you such as claims and case or medical management records, if you believe the health information about you is wrong or incomplete. Your request must be in writing and provide the reasons for the requested amendment. Mail your request to the address listed below. If we deny your request, you may have a statement of your disagreement added to your health information.

• **You have the right to receive an accounting** of certain disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information made: (i) for treatment, payment, and health care operations purposes; (ii) to you or pursuant to your authorization; and (iii) to correctional institutions or law enforcement officials; and (iv) other disclosures for which federal law does not require us to provide an accounting.

• **You have the right to a paper copy of this notice.** You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

## Exercising Your Rights

If you have any questions about this notice or want information about exercising your rights, **please call American National Life Insurance Company of Texas at 1-281-538-4844.**

• **Submitting a Written Request.** You can mail your written requests to exercise any of your rights, including modifying or cancelling a confidential communication, requesting copies of your records, or requesting amendments to your record, to us at the following address: William J. Hogan, HIPAA Privacy Officer, American National Life Insurance Company of Texas, One Moody Plaza, Galveston, TX 77573, hipaa.compliance.officer@americannational.com, 281.538.4844 for further information about the complaint process

• **Filing a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with us at the address listed above.

**You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint.** We will not take any action against you for filing a complaint.

Effective Date April 4, 2003. Revised May 1, 2017.

**AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS**
One Moody Plaza Galveston, Texas 77550

# DOMESTIC PARTNER 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.

A Domestic Partner of Yours, and any Child(ren) of Your Domestic Partner, will be considered Dependents, except with respect to:

1. special enrollment rights under HIPAA; and
2. COBRA continuation coverage.

The following definition is added to the **DEFINED WORD/TERMS** section:

**Domestic Partner.** A person who is a member of the same or opposite sex as You, and who:

1. is at least 18 years of age; and
2. is competent to contract in his or her state of residency; and
3. is not married to, legally separated from, or a domestic partner of, anyone else; and
4. is not related to You by blood in a way that would prevent marriage in the state of residency.

You and Your Domestic Partner must also:

1. have an exclusive, committed relationship with each other to share responsibility for each other's welfare and financial obligations, with such relationship expected to last indefinitely; and
2. be financially interdependent. You and Your Domestic Partner must certify and be able to provide proof of at least three of the following as evidence of interdependence:
    a. Common ownership of real property, e.g., joint deed or mortgage agreement, or a joint residential lease.
    b. Common ownership of a motor vehicle.
    c. Driver's license listing a common address.
    d. Joint bank accounts or credit card accounts.
    e. Designation of the Domestic Partner as the primary beneficiary for life insurance or retirement benefits.
    f. Designation of the Domestic Partner as durable power of attorney or health care proxy.
    g. Joint wills of the designation of the Domestic Partner as executor and/or primary beneficiary.
    h. Declaration of domestic partnership or common law certification.

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

SECURECARE

GROUP INSURANCE

Dental ▪ Vision


***SECURECARE DENTAL & VISION***

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