SECURECARE

GROUP INSURANCE

Dental ▪ Vision

Certificate of Coverage

Employee Benefits Booklet

www.securecarevision.com

American National Life Insurance Company of Texas

One Moody Plaza • Galveston, Texas • 77550

(called “We”, “Our” and “Us”)

GROUP VISION 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 Life 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 Life Insurance Company of Texas, One Moody Plaza, Galveston, TX 77550.

President Secretary

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

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 fraud.

TABLE OF CONTENTS

COVERAGE SUMMARY

SCHEDULE OF VISION BENEFITS – Inserted

COVERED VISION SERVICES

Benefits are payable under the Policy incurred by an Insured as shown in the Schedule of Vision Benefits. Covered benefits include charges made by a Provider for the following vision care services while an Insured is covered under the Policy. The benefits payable under the Policy vary depending upon whether it is an In-Network Provider or an Out-of-Network Provider rendering the services.

EYE EXAMINATION Services include:

1. Case history – chief complaint, eye and vision history, medical history.
2. Entrance distance acuities.
3. External ocular evaluation including slit lamp examination.
4. Internal ocular examination.
5. Tonometry.
6. Distance Refraction – objective and subjective.
7. Binocular coordination and ocular motility evaluation.
8. Evaluation of papillary function.
9. Biomicroscopy.
10. Gross visual fields
11. Assessment and plan
12. Advise an Insured on matters pertaining to vision care.
13. Form completion – school, motor vehicle, etc.
14. A Dilated Fundus Examination (DFE), a diagnostic procedure used in the detection and management of diabetes and glaucoma.

Eye examinations from an In-Network Provider are subject to the Copayments shown in the Schedule of Vision Benefits. Benefits under the Policy for eye examinations from an Out-of-Network Provider are reimbursable only to the Insured up to the Allowance shown in the Schedule of Vision Benefits. An Insured is responsible for any amount in excess of the Allowance shown in the Schedule of Vision Benefits.

FITTING OF EYEGLASSES

If vision correction is recommended by a Provider, Covered Expenses will include the fitting of eyeglasses and follow-up adjustments.

MATERIALS include frames and the following lenses:

1. Plastic single vision, bifocal, trifocal or lenticular lenses of any size or prescription, including contact lenses.

   The above Materials are subject to the Copayments for In-Network Benefits shown in the Schedule of Vision Benefits.

2. Optional In-Network items. These Materials are subject to the Copayment for Optional In-Network items shown in the Schedule of Vision Benefits.
   a. Tinting of Plastic Lenses.
   b. Scratch Resistant Coating.
   c. Fashion, Designer and Premier Frames.
   d. Ultraviolet Coating.
   e. Progressive Lenses.
   f. Anti-Reflective Coating
   g. Polycarbonate Lenses.
   h. Polarized Lenses.
   i. High Index Lenses.
   j. Plastic Photosensitive Lenses.
   k. Scratch Protection Plan

3. Benefits under the Policy for frames and lenses from an In-Network Provider are payable up to the Allowance shown in the Schedule of Vision Benefits. Benefits under the Policy for frames and lenses from an Out-of-Network Provider are reimbursable only to the Insured up to the Allowance shown in the Schedule of Vision Benefits. An Insured is responsible for any amount in excess of the Allowances shown in the Schedule of Vision Benefits when seeing either

an In-Network Provider or an Out-of-Network Provider.

4. Medically necessary contact lenses prescribed for an Insured are subject to prior approval. When using an In-Network Provider, the Provider must obtain prior approval before the lenses are dispensed in order for benefits to be payable. If the Insured is using an Out-of-Network Provider to dispense medically necessary contact lenses, the Insured or the Provider on the Insured's behalf must obtain prior approval in order for the Insured to receive reimbursement.

LOW VISION PROGRAM Services include:

1. Comprehensive low vision evaluation in addition to comprehensive eye examination when the comprehensive eye examination indicates a need for such an evaluation.
2. Follow-up visits.
3. Low Vision Aids.

Benefits are payable up to the allowance, subject to the maximum shown in the Schedule of Vision Benefits. This benefit is subject to prior approval. The Insured or the attending Provider must obtain approval prior to the initial low vision evaluation. After prior approval, covered low vision services provided by either an In-Network or Out-of-Network Provider will be covered according to the benefits in the Schedule of Vision Benefits.

EXPENSES NOT COVERED

No benefits are payable under the Policy for the procedure, service, or supply listed below..

1. Any service or supply not shown in the list of Covered Services.
2. For services or supplies not recommended by a Provider.
3. For periodic vision examinations, except as provided for in the Schedule of Vision Benefits.
4. For eye examinations required by an employer as a condition of employment.
5. For services or Materials provided in connection with special procedures such as orthoptics and visual training, or in connection with medical or surgical treatment.
6. For lenses which do not provide vision correction.
7. For charges for the replacement of lost or stolen lenses or frames which would not otherwise be covered.
8. Incurred as a direct or indirect result of war (declared or undeclared).
9. Incurred as a result of an intentionally self-inflicted injury or injury sustained while committing a crime.
10. For services or supplies furnished to an Insured before the effective date of an Insured's coverage under the Policy or after the date an Insured's coverage under the Policy ends.
11. For services or supplies which are not generally accepted in the United States as being necessary and appropriate for the treatment of a patient's sickness or injury.
12. For any medical treatment rendered outside the United States.
13. For services rendered by practitioners who do not meet the definition of Provider.
14. Charges for failure to keep a scheduled visit, or for the completion of any claim forms.
15. For expenses covered by any other group insurance, a health maintenance organization, hospital or medical services prepayment plan available through an employer, union or association.
16. Services, Materials or supplies payable in whole or in part under any medical plan.
17. 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.
18. 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).
19. Expenses provided or paid for by any welfare plan or governmental program or a plan required by law, except as to charges which the person is legally obligated to pay.
20. Services for which there be no charge in the absence of insurance, or any service or treatment provided without charge.
21. For medically necessary contact lenses prescribed for an Insured for which prior approval was not obtained.

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.

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.

Allowance. The maximum amount payable under the Group Policy after applicable Copayments, as shown in the Schedule of Vision Benefits, for eye examinations, the fitting of eyeglasses or Materials received and/or purchased by an Insured.

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. The person making a demand for payment of benefits.

Collection Frames. A specific selection of frames designated under the categories of Fashion, Designer and Premier. The Policy will pay in accordance with the Schedule of Vision Benefits.

Copayment. A set dollar amount of Eligible Expenses. If it applies, it is shown in the Schedule of Vision Benefits.

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 Vision Benefits, and the Covered Vision 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.

Dependent means an Employee's family as follows:
1. The lawful spouse, if not legally separated or divorced. The term "Spouse" as used throughout the Certificate will also mean the Employee's legal Domestic Partner as defined under Nevada law.
2. Unmarried children (whether natural, adopted or stepchildren) under the limiting age of 26; or
3. Unmarried children for whom the Employee is required to provide insurance under a medical support order or an order enforceable by a court.

The term Dependent excludes any person serving in the Armed Forces of any country.

Handicapped Dependent. Each handicapped person who is and continues to be both of the following.
1. a. Incapable of self-sustaining employment by reason of a physical or mental handicap; and
   b. Chiefly dependent on You for support and maintenance.
2. Proof of such child's incapacity and dependency shall be furnished to the insurer by the member of the insured group within 31 days after such child attains the specified limiting age and as often as the insurer may thereafter require, but no more than once a year beginning 2 years after such child attains the specified limiting age.

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. Expenses incurred by an Insured while Your insurance is in force under the terms of the Policy. Such expenses must be incurred for vision care or Materials furnished within the scope of the license of the Provider. They also must not be excluded herein.

Employer. Your employer, shown as the Policyholder.

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

Frequency. The period of time between which benefits are available for covered services under the Policy.

In-Network Provider. Providers of optometric services who have entered into a contract with Us or Our subcontracted vendor to provide eye examinations and/or Materials on a Scheduled Fee basis as shown in the Schedule of Vision Benefits.

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.

Materials. Frames and lenses provided to a Covered Person for vision correction under the terms and conditions of the Group Policy

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

Non-Collection Frames. Any frames, other than those defined as Collection, that are supplied by the Provider directly, by a Provider's private stock or by an outside vendor. The Policy will pay in accordance with the Schedule of Vision Benefits.

Out-of-Network Provider. Providers of optometric services who have not entered into a contract with Us or Our subcontracted vendor to provide vision care services as shown in the Schedule of Vision Benefits.

Policy. The contract of insurance for vision 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.

Provider. A practitioner who is a legally qualified professional providing eye examinations and refractive and/or post-refractive services within the scope of their license. This term includes an ophthalmologist, a therapeutic optometrist, an optometrist or an optician recognized as such in accordance with the laws of the State in which the services are provided. The Policy recognizes two categories of Providers; In-Network Providers and Out-of-Network Providers, which are defined herein.

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

Third Party Administrator. Policy Benefits will be administered by Southwest Preferred Dental Organization, Inc., Phoenix, Arizona.

Vision Benefit. Payments for incurred Eligible Expenses, as shown in the Schedule of Vision Benefits. Such payments are subject to Copayments, Maximum Charges and other benefit limitations. These limits are expressed in the Schedule of Vision Benefits either as Scheduled Benefits or as Usual, Reasonable and Customary expenses.

We, Our, Us. American National Life 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. 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 Your first premium, and such premium has been received by Our Third Party Administrator; and
4. 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. 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 Your first premium, and such premium has been received by Our Third Party Administrator; and
4. 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
An eligible Dependent's coverage under the Policy will become effective on the latest of the following dates.

1. the Policy effective date;
2. the Employee's effective date of insurance;
3. the date the Employee elects dependent coverage under the Policy; or
4. the Certificate Effective Date shown in the Certificate Schedule of Benefits; or
5. the date the Company approves the Employee's Enrollment Form for dependent coverage.

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 vision 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.

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.

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. 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.

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. Evidence of insurability requirement
2. 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 and claims will be denied. 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.

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.

COORDINATION OF BENEFITS
This Policy does not coordinate benefits with other vision, health care or similar coverage making the benefits provided by this Policy primary. Thus a claim for benefits under this Policy will always be paid without regard to the possibility that another vision, health care or similar plan may cover some expenses.

VISION INSURANCE

BENEFIT
We will pay Vision Benefits if an Insured incurs an Eligible Expense. The Schedule of Vision Benefits shows the amount of Eligible Expense We will pay. Payment will be subject to the limitations, if any, shown in the Schedule of Vision Benefits.

EXPENSES INCURRED
An Eligible Expense is considered incurred on the the date the service is performed or the Materials are furnished..

ELIGIBLE EXPENSES
The vision service or procedure must be performed by a Provider. The amount of Vision Benefits may vary, depending on whether the Provider is an In-Network Provider or Out-of-Network Provider. Any such variation will appear in the Schedule of Vision Benefits.

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

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 the address shown on Your ID card.

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 Life 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 vision care or Materials. 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 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 vision plan in force at the time of application.

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

ERISA RIGHTS
The Employer has established and maintains an employee welfare benefit plan as defined in the Employee Retirement Security Act of 1974, as amended, to provide the benefits described in the Policy to its Employees and their Dependents. These benefits are insured by Us under the Policy, which the Employer endorses. The Employer is the Plan Administrator, Plan Sponsor, named fiduciary, and, if applicable, Plan Trustee, for the Plan. For more information about the plan, consult the Policy. ERISA does not apply to certain plans, such as government plans and church plans.

COMPLAINT NOTICE
We have a customer service program which can provide information to an Employer or Employee, handle complaints and help satisfy concerns. If an Employer or Employee has a complaint or wants to contest the disposition of a claim, he/she may direct such inquiries to Our Customer Service Department. A complaint may be expressed orally or in writing. An

Employer or Employee may register a complaint by contacting Us at the following address or phone number:

Southwest Preferred Dental Organization, Inc.
777 E. Missouri Ave #121
Phoenix, Arizona 85014
Telephone (602)234-3266

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:

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

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

777 E Missouri Ave, Suite 121
Phoenix AZ 85014

Tel: (602) 241-0914 Toll Free: 1-888-429-0914
Fax: (602) 285-0121

www.securecarevision.com