
Insurance Documents



EFFECTIVE: 01/01/2020

No Cost Language Services. You can get an interpreter and get documents read to you in your language. For help, call us at the number listed on your ID card or 1-800-677-9472. For more help call the CA Dept. of Insurance at 1-800-927-4357 English

Servicios de idiomas sin costo. Puede obtener un intérprete y que le lean los documentos en español. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 1-800-677-9472. Para obtener más ayuda, llame al Departamento de Seguros de CA al 1-800-927-4357. Spanish

خدمات ترجمة بدون تكلفة. يمكنك الحصول على مترجم وقرائة الوثائق لك باللغة العربية. للحصول على المساعدة، اتصل بنا على الرقم المبين على بطاقة عضويتك أو على الرقم 1-800-677-9472. للحصول على المزيد من المعلومات، اتصل بإدارة التأمين لولاية كاليفورنيا على الرقم 1-800-927-4357 Arabic.

Անվճար Լեզվական Օգնություններ: Դուք կարող եք թարգման ձեռք բերել և փաստաթղթերը ընթերցել տալ ձեզ համար հայերեն լեզվով: Օգնության համար սեզ զանգահարեք ձեր ինքնության (ID) տոմսի վրա նշված կամ 1-800-677-9472 համարով: Լրացուցիչ օգնության համար 1-800-927-4357 համարով զանգահարեք Կալիֆոռնիայի Ապստոլականության Բաժանմունք: Armenian

免費語言服務。 您可獲得口譯員服務，用中文把文件唸給您聽。欲取得協助，請致電您的保險卡所列的電話號碼，或撥打 1-800-677-9472 與我們聯絡。欲取得其他協助，請致電 1-800-927-4357 與加州保險部聯絡。 Chinese

Cov Kev Pab Txhais Lus Tsis Them Nqi. Koj yuav thov tau kom muaj neeg los txhais lus rau koj thiab kom neeg nyeem cov ntawv ua lus Hmoob. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj nyob hauv koj daim yuaj ID los sis 1-800-677-9472. Yog xav tau kev pab ntxiv hu rau CA lub Caj Meem Fai Muab Kev Tuav Pov Hwm ntawm 1-800-927-4357 Hmong

無料の言語サービス 日本語で通訳をご提供し、書類をお読みします。サービスをご希望の方は、IDカード記載の番号または 1-800-677-9472 までお問い合わせください。更なるお問い合わせは、カリフォルニア州保険庁、1-800-927-4357までご連絡ください。 Japanese

សេវាកម្មភាសាពិតប្រាកដ អ្នកអាចទទួលបានអ្នកបកប្រែភាសា និងអានឯកសារជូនអ្នកជា ភាសាខ្មែរ ។ សម្រាប់ជំនួយ សូមទូរស័ព្ទមកយើងខ្ញុំតាមលេខដែលមានចេញលេខលើកាត់ស្តាប់ការខ្វះខាតរបស់អ្នក ឬលេខ 1-800-677-9472 ។ សម្រាប់ជំនួយបន្ថែមទៀត សូមទូរស័ព្ទទៅក្រសួងធានារ៉ាប់រងរដ្ឋកាលីហ្វ័រញ៉ា តាមលេខ 1-800-927-4357 Khmer

무료 통역 서비스. 귀하는 한국어 통역 서비스를 받으실 수 있으며 한국어로 서류를 낭독해주는 서비스를 받으실 수 있습니다. 도움이 필요하신 분은 귀하의 ID 카드에 나와있는 안내 전화: 1-800-677-9472 번으로 문의해 주십시오. 보다 자세한 사항을 문의하실 분은 캘리포니아 주 보험국, 안내 전화 1-800-927-4357번으로 연락해 주십시오. Korean

خدمات مجاني مربوط به زبان. میتوانید از خدمات یک مترجم شفاهی استفاده کنید و بگوئید مدارک به زبان فارسی برایتان خوانده شوند. برای دریافت کمک، با ما از طریق شماره تلفنی که کارت شناسائی شما قید شده است و یا این شماره 1-800-677-9472 تماس بگیرید. برای دریافت کمک بیشتر، به CA Dept. of Insurance (اداره بیمه کالیفرنیا) به شماره 1-800-927-4357 تلفن کنید. Persian

ਮੁਫਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ: ਤੁਸੀਂ ਦੁਬਾਰਾ ਦੋ ਚੀਜ਼ਾਂ ਸੇਵਾਵਾਂ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਦਸਤਾਵੇਜ਼ਾਂ ਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਸੁਣ ਸਕਦੇ ਹੋ। ਕੁਝ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਤੁਹਾਡੇ ਆਈਡੀ (ID) ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਜਾਂ 1-800-677-9472 'ਤੇ ਸਾਨੂੰ ਫੋਨ ਕਰੋ। ਵਧੇਰੇ ਮਦਦ ਲਈ ਕੇਲੀਫੋਰਨੀਆ ਡਿਪਾਰਟਮੈਂਟ ਆਫ ਇਨਸੂਰੈਂਸ ਨੂੰ 1-800-927-4357 'ਤੇ ਫੋਨ ਕਰੋ। Punjabi

Бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика, и ваши документы прочтут для вас на русском языке. Если вам требуется помощь, звоните нам по номеру, указанному на вашей идентификационной карте, или 1-800-677-9472. Если вам требуется дополнительная помощь, звоните в Департамент страхования штата Калифорния (Department of Insurance) по телефону 1-800-927-4357. Russian

Walang Gastos na mga Serbisyo sa Wika. Makakakuha ka ng interpreter o tagasalin at maipababasa mo sa Tagalog ang mga dokumento. Para makakuha ng tulong, tawagan kami sa numerong nakalista sa iyong ID card o sa 1-800-677-9472. Para sa karagdagang tulong, tawagan ang CA Dept. of Insurance sa 1-800-927-4357 Tagalog

Các Dịch Vụ Trợ Giúp Ngôn Ngữ Miễn Phí. Quý vị có thể được nhận dịch vụ thông dịch và được người khác đọc giúp các tài liệu bằng tiếng Việt. Để được giúp đỡ, hãy gọi cho chúng tôi tại số điện thoại ghi trên thẻ hội viên của quý vị hoặc 1-800-677-9472. Để được trợ giúp thêm, xin gọi Sở Bảo Hiểm California tại số 1-800-927-4357. Vietnamese.



Dear Valued Customer:

Thank you for giving American Fidelity Assurance Company the opportunity to help serve your insurance needs. We appreciate having you as a customer, and congratulate you on your wise decision to protect yourself and your family with this coverage.

This is your new Group Critical Illness Limited Benefit Certificate. Please review the documents carefully. Feel free to contact a Customer Service Representative at 800-662-1113 if you have any questions or are in need of assistance. You can also visit us on the Web at www.americanfidelity.com for any of your insurance needs.

Notice for insureds living in a community property state (Alaska, Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Puerto Rico, Texas, Washington, and Wisconsin):

If you have designated a beneficiary other than your spouse, we may be required to pay a portion of the proceeds to your spouse at the time of your death, unless your spouse has signed a spousal waiver form. To obtain a spousal waiver form, please visit our website or call a Customer Service Representative.

Sincerely,

A handwritten signature in cursive script that reads "Jeanette Rice". The signature is written in black ink and is positioned above the printed name of the signatory.

President and Chief Operating Officer

AMERICAN FIDELITY ASSURANCE COMPANY

(a Stock Company)

9000 CAMERON PARKWAY. OKLAHOMA CITY, OKLAHOMA 73114

NOTICE

This is a limited benefit policy. The coverage provided under this policy is not comprehensive major medical coverage. It is NOT considered "minimum essential coverage" under the Affordable Care Act.

We are here to serve you . . .

As our policyholder, your satisfaction is very important to us. Should you have a valid claim, we fully expect to provide a fair settlement in a timely fashion. If you have any questions regarding a claim, please call Benefits at 800-662-1113. If you have any other questions regarding your coverage, you may reach our Customer Service department by contacting us at:

**American Fidelity Assurance Company
9000 Cameron Parkway
Oklahoma City, Oklahoma 73114
Toll Free: 800-662-1113**

If your policy or certificate was delivered by an agent or broker, you may contact your agent or broker for assistance.

If you are not satisfied . . .

Should you feel you are not being treated fairly, we want you to know you may contact the California Department of Insurance with your complaint and seek assistance from the governmental agency that regulates insurance. The California Department of Insurance should be contacted only after you have contacted American Fidelity Assurance Company or its representative for a satisfactory solution.

To contact the Department, write or call:

**Department of Insurance
Consumer Services Division
300 South Spring Street
Los Angeles, California 90013**

Consumer Hotline: 1-800-927-HELP

(THIS FORM IS NOT A PART OF YOUR CONTRACT.)



9000 CAMERON PARKWAY, OKLAHOMA CITY, OKLAHOMA 73114

Go paperless! Access your plan certificate and other information at www.americanfidelity.com.

CERTIFICATE OF INSURANCE

American Fidelity Assurance Company (We, Us, Our) hereby certifies that it has issued and delivered to the Policyholder a group Policy, described on the Schedule of Benefits page. The group Policy covers certain eligible persons, as described in the Policy.

This Certificate describes the benefits and provisions of the group Policy and becomes Your Certificate of insurance only if:

- (1) You are eligible for the insurance (see Eligibility on Schedule of Benefits);
- (2) You are on Active Employment on the date it is to take effect; and
- (3) You become insured and remain insured in accordance with all of the provisions of the Policy.

Further, the insurance is to be effective only if the required premium payments are made by You or on Your behalf to Us. (See Section 2, Eligibility and Effective Date.)

No agent may change the Policy or waive any of its provisions.

This Certificate takes the place of any other Certificate previously issued to You under the group Policy. It should be kept in a safe place.

IN WITNESS WHEREOF, We cause this Certificate to take effect on the Effective Date.

President and Chief Operating Officer

Secretary

GROUP CRITICAL ILLNESS LIMITED BENEFIT CERTIFICATE

**THIS CERTIFICATE OFFERS LIMITED BENEFITS.
PLEASE READ YOUR CERTIFICATE CAREFULLY.
ALL BENEFITS ARE PAID DIRECTLY TO YOU.**

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.

FP

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TC

**SCHEDULE OF BENEFITS
PLAN: BBD**

POLICYHOLDER: BANK OF OKLAHOMA, N.A., TRUSTEE FOR THE NATIONAL PUBLIC EMPLOYEES INSURANCE TRUST

POLICY NUMBER: G925-63A

CERTIFICATE EFFECTIVE DATE: Please refer to Your individual application or enrollment form, if any.

ELIGIBILITY: All permanent employees currently specified by the employer, association, or collective bargaining agreement.

CRITICAL ILLNESS BENEFIT

Insured
Please refer to Your individual application or enrollment form

Dependent Child
25% of Your Critical Illness Benefit

CRITICAL ILLNESS: Maximum of one Critical Illness Benefit amount payable per Critical Illness per Covered Person.

Heart Attack	100%
Coronary Artery Bypass Surgery Partial payments for Coronary Artery Bypass Surgery reduces the Heart Attack benefit. At no time will combined payments for any heart related benefits exceed 100% of the Critical Illness Benefit Amount.	25%
Permanent Damage Due To Stroke	100%
End Stage Renal Failure	100%
Major Organ Failure	100%
Permanent Paralysis Due To A Covered Accident	100%

RECURRENT BENEFIT: 50% of the Critical Illness Benefit
Maximum of one Recurrent Benefit payable per Recurrent Diagnosis, per Covered Person, for a recurrent diagnosis of Heart Attack, Major Organ Failure, or Permanent Damage Due to Stroke.

SB

SECTION 1 DEFINITIONS

ACCIDENT means a sudden, unexpected and unintended event, which results in bodily injury, which is independent of disease or bodily infirmity.

ACTIVE EMPLOYMENT means that You are:

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

You will be said to be on Active Employment on a day which is not a scheduled work day only if You are not disabled and would be able to perform in the usual manner all of the regular duties of Your employment if it were a scheduled work day.

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

CORONARY ARTERY BYPASS SURGERY means open heart surgery performed by a Physician to correct Coronary Artery Disease with bypass grafts. Coronary Artery Bypass Surgery does not include balloon angioplasty, laser angioplasty, stenting, valve replacement surgery, or procedures other than Coronary Artery Bypass Surgery.

CORONARY ARTERY DISEASE means a severe narrowing or blockage of one or more coronary arteries.

COVERED PERSON(S) means You and Your eligible Dependent Child whose coverage is in force. (See Section 2 – Eligibility and Effective Date.)

CRITICAL ILLNESS: End Stage Renal Failure, Heart Attack (including Coronary Artery Bypass Surgery), Major Organ Failure, Permanent Damage Due To A Stroke, or Permanent Paralysis Due To A Covered Accident, as defined in the Policy, for which a positive diagnosis is made by a Physician.

CRITICAL ILLNESS BENEFIT AMOUNT: The amount shown on the Schedule of Benefits for the Covered Person.

DEPENDENT CHILD means:

- (a) Your child (natural, step, adopted, or a minor for whom guardianship is granted to You by court or testamentary appointment, other than temporary guardianship of less than 12 months duration) who is less than 26 years of age; or
- (b) Your child who becomes incapable of self-support because of mental or physical handicap while covered under the Policy and prior to reaching the limiting age for dependent children. The child must be dependent on You for support and maintenance. We must receive proof of incapacity within 31 days after coverage would otherwise terminate. Coverage will then continue as long as Your insurance stays in force and the child remains incapacitated. Additional proof may be required from time to time but not more often than once a year after the child attains age 26; or
- (c) any minor under Your charge, care and control, who has been placed in Your home for adoption and is less than 26 years of age.

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

EFFECTIVE DATE means the date described in the Policy. The date shown in Your individual Certificate or Policy will be Your Effective Date of coverage. The Effective Date will start at 12:01 a.m. at the main place of business of the Policyholder.

END STAGE RENAL FAILURE means renal disease resulting in irreversible failure of both kidneys to function and which requires regular dialysis or renal transplantation to sustain life.

HEART ATTACK means an acute Myocardial Infarction due to Coronary Artery Disease resulting in death of a portion of the heart muscle. Diagnosis must be supported by onset of new symptoms and any of the following: EKG changes, elevation of biochemical markers, or imaging studies, consistent with an acute myocardial infarction. In the event of death, an autopsy, medical examiner's confirmation or death certificate identifying Heart Attack will be acceptable.

Heart attack does not include congestive heart failure, atherosclerotic heart disease, angina, cardiac arrest, or any other disease or injury involving the cardiovascular system.

INSURED (You or Your) means a person whose coverage has been applied for and is in force under the terms of the Policy.

MAJOR ORGAN FAILURE means the diagnosis by a Physician of failure of the heart, liver, lung, or entire pancreas due to end stage organ failure, which results in the Covered Person being placed on the United Network for Organ Sharing (UNOS) list for a transplant.

OCCURRENCE DATE must occur on or after the Covered Person's Effective Date and while coverage is in force. The Occurrence Date for each of the Critical Illnesses is as follows:

- Heart Attack - the date the death of a portion of the heart muscle occurred based on the applicable criteria listed under the Heart Attack definition;
- Coronary Artery Bypass Surgery - the date the Covered Person undergoes Coronary Artery Bypass Surgery;
- Major Organ Failure - the date the Covered Person is placed on the UNOS list for transplantation;
- Permanent Damage Due To A Stroke - the date new neurological deficits from the Stroke are diagnosed as permanent;
- End Stage Renal Failure - the date End Stage Renal Failure is diagnosed;
- Permanent Paralysis Due To A Covered Accident - the date paralysis is diagnosed as permanent.

PERMANENT DAMAGE DUE TO A STROKE means permanent neurological damage to the brain which results from an acute or sub-acute interruption of blood flow to brain tissue, including infarction of brain tissue due to embolism, thrombus or bleeding. Diagnosis should be made by a physician, demonstrated by imaging (CT or MRI), and must result in permanent neurological deficits. Permanent Damage Due to a Stroke does not include Transient Ischemic Attacks (TIA).

PERMANENT PARALYSIS DUE TO A COVERED ACCIDENT (or Paralysis) means injuries to the spinal cord due to a Covered Accident which result in the loss of use of two or more limbs. Paralysis must be diagnosed as permanent, total, and irreversible.

PHYSICIAN means a medical practitioner of the healing art(s) which is recognized by applicable state law, who:

- (a) is practicing within the scope of his or her license;
- (b) is certified or credentialed by the appropriate medical or professional board that provides certification or credentials for practitioners who perform the type of treatment or service appropriate for Your Sickness or Accident; and
- (c) possesses the necessary training and qualifications according to generally accepted medical standards, to evaluate and treat Your condition.

The term Physician does not include You, anyone related to You by blood or marriage, or anyone living in Your household.

POLICY means the Policy issued to the Policyholder that covers You.

POLICYHOLDER means the association, employer, labor union, or trustee who holds the Policy.

RECURRENT DIAGNOSIS: A second Occurrence Date for a Heart Attack, Permanent Damage Due To A Stroke, or Major Organ Failure, for which a Critical Illness Benefit Amount was previously paid under the Policy.

The first Occurrence Date and the Recurrent Diagnosis must:

- (a) occur while Your coverage is in force; and
- (b) be separated by at least 180 days.

SCHEDULE OF BENEFITS (or Schedule) means the benefit schedule set forth in the Policy or Certificate.

SICKNESS: Any illness or disease which is the direct cause of the Critical Illness and begins while the Covered Person's coverage is in force.

TRANSIENT ISCHEMIC ATTACK (or TIA) means a neurological condition or event with the signs and symptoms of a Stroke, but which disappear within 24 hours with no residual signs, symptoms, deficits, or abnormalities that are revealed or shown on neuroimaging studies. TIA's are not covered by the Policy.

DEF

SECTION 2
ELIGIBILITY AND EFFECTIVE DATE

ELIGIBILITY

All persons who:

- (a) are on Active Employment as employees of the employer; or members or employees of a member of the Policyholder;
- (b) qualify as eligible Covered Persons as defined by the employer or Policyholder; and
- (c) meet the definition of Eligibility as stated in the Schedule,

will be enrolled automatically by the Employer.

EFFECTIVE DATE: WHEN COVERAGE BEGINS

Coverage for all Covered Persons will begin on the date You become eligible if Your employer has paid all applicable premiums.

Any change in coverage will apply only to a Critical Illness that begins after the Effective Date of such change, subject to all the provisions of the Policy.

EFF-EMPPD

SECTION 3 BENEFITS

CRITICAL ILLNESS

A benefit is payable once per Covered Person for each Critical Illness shown on the Schedule of Benefits. After the Occurrence Date of the first Critical Illness payable under the Policy or any attached riders, a benefit for each subsequent Critical Illness will only be payable if the Occurrence Date:

- (a) is for a Critical Illness for which a Critical Illness Benefit Amount has not been previously paid;
- (b) is separated by more than 90 days following the last Critical Illness Occurrence Date; and
- (c) occurs while the Covered Person is insured under the Policy, Certificate or any attached riders.

Any critical illness not specifically listed in the Critical Illness definition is not payable under the Policy. If the Occurrence Date of two or more Critical Illnesses is separated by less than 90 days, We will pay only one Critical Illness Benefit Amount. We will pay for the Critical Illness that occurred first. Critical Illnesses with a Critical Illness Benefit Amount of less than 100% are not subject to this requirement.

HEART ATTACK: Following the Occurrence Date of a Covered Person's Heart Attack, We will pay the percentage of the Critical Illness Benefit Amount as shown on the Schedule of Benefits. The Heart Attack must occur after the Covered Person's Effective Date.

If a Covered Person receives a benefit for a Coronary Artery Bypass Surgery and is later diagnosed with a Heart Attack, We will pay the Heart Attack benefit less the amount received for such Coronary Artery Bypass Surgery. For all heart related benefits combined, We will not pay more than 100% of the Critical Illness Benefit Amount shown on the Schedule of Benefits for the Covered Person.

Coronary Artery Bypass Surgery: Following the Occurrence Date of a Covered Person's Coronary Artery Bypass Surgery, We will pay the percentage of the Critical Illness Benefit Amount as shown on the Schedule of Benefits. The Coronary Artery Bypass Surgery must occur after the Covered Person's Effective Date. This benefit is payable only once per Covered Person per lifetime. If a Covered Person has previously received a benefit for Heart Attack, then 100% of the heart related benefits have been exhausted and this benefit is not payable. The Coronary Artery Bypass Surgery Occurrence Date is not subject to the 90-day separation period.

PERMANENT DAMAGE DUE TO A STROKE: Following the Occurrence Date of a Covered Person's Permanent Damage Due To A Stroke, We will pay the percentage of the Critical Illness Benefit Amount as shown on the Schedule of Benefits. The stroke and the Permanent Damage Due to a Stroke must occur after the Covered Person's Effective Date.

MAJOR ORGAN FAILURE: Following the Occurrence Date of a Covered Person's Major Organ Failure, We will pay the percentage of the Critical Illness Benefit Amount as shown on the Schedule of Benefits. The Major Organ Failure must occur after the Covered Person's Effective Date.

END STAGE RENAL FAILURE: Following the Occurrence Date of a Covered Person's End Stage Renal Failure, We will pay the percentage of the Critical Illness Benefit Amount as shown on the Schedule of Benefits. The End Stage Renal Failure must occur after the Covered Person's Effective Date.

PERMANENT PARALYSIS DUE TO A COVERED ACCIDENT: Following the Occurrence Date of a Covered Person's Paralysis, We will pay the percentage of the Critical Illness Benefit Amount as shown on the Schedule of Benefits. The Accident and the Paralysis must occur after the Covered Person's Effective Date.

BEN

RECURRENT BENEFIT: If a Covered Person receives a Recurrent Diagnosis, We will pay an additional benefit for such Critical Illness equal to 50% of the Critical Illness Benefit Amount.

The first Occurrence Date and the Recurrent Diagnosis must:

- (a) occur while the policy is in force; and
- (b) be separated by at least 180 days.

This benefit is payable once per Covered Person for each Recurrent Diagnosis of a Critical Illness. Once a Recurrent Diagnosis Benefit has been paid for a Critical Illness, no further Occurrence Dates of that same Critical Illness will be payable. Any Critical Illness not specifically listed in the Recurrent Diagnosis definition is not payable under this benefit.

RB

SECTION 4 LIMITATIONS AND EXCLUSIONS

PRE-EXISTING CONDITION LIMITATION

No Critical Illness Benefit will be payable for a Critical Illness which is caused by or resulting from a Pre-Existing Condition when the Critical Illness Occurrence Date occurs before a Covered Person has been continuously covered under the Policy for 12 consecutive months.

PE

PRE-EXISTING CONDITION means a disease, Accident, Sickness, physical condition or mental illness for which a Covered Person has experienced any of the following:

- (a) treatment;
- (b) incurred expense;
- (c) took medication;
- (d) received care or services including diagnostic testing or related measures; or
- (e) received a diagnosis or advice from a Physician,

during the 12-month period immediately before the Covered Person's Effective Date of coverage. The term Pre-Existing Condition will also include conditions which are related to such disease, Accident, Sickness, physical condition or mental illness.

PEDEF

EXCLUSIONS: We will not pay benefits for any Critical Illness resulting from or caused, whether directly or indirectly, by:

- (a) An intentionally self-inflicted Accident or Sickness.
- (b) Suicide or attempted suicide, while sane or insane.
- (c) Participating in a riot, insurrection, rebellion, civil commotion, civil disobedience, or unlawful assembly. This does not include a loss which occurs while acting in a lawful manner within the scope of authority.
- (d) Being intoxicated or under the influence of any narcotic unless administered by a Physician or taken according to the Physician's instructions. Intoxication means that which is determined and defined by the laws and jurisdiction of the geographical area in which the event that caused the Critical Illness occurred.
- (e) Committing, or attempting to commit a felony.
- (f) Being incarcerated in any type of penal institution.
- (g) Alcoholism or drug addiction.
- (h) A diagnosis received outside the United States, or its territories, that cannot be confirmed by a Physician licensed and practicing in the United States.

EXC

**SECTION 5
TERMINATION OF INSURANCE**

Your Coverage: Your Insurance coverage will end on the earliest of these dates:

- (a) the date You no longer qualify as an Insured;
- (b) the end of the last period for which premium has been paid;
- (c) the date the Policy is discontinued;
- (d) the date You retire;
- (e) if You work for an employer employing less than 20 employees on a typical work day in the preceding Calendar Year, the date You attain age 75;
- (f) the date You cease to be on Active Employment, as defined in Section 1;
- (g) the date You cease employment with the employer through whom You originally became insured under the Policy;
- (h) the date of Your death;
- (i) the date 100% of the Critical Illness Benefit Amount for all Critical Illnesses has been paid for You.

Coverage On Your Dependent Child: The coverage on Dependent Child(ren) will end on the earliest of these dates:

- (a) the date Your coverage terminates;
- (b) the end of the last period for which premium has been paid;
- (c) the date the Covered Person no longer meets the definition of Dependent Child, as defined in Section 1;
- (d) the date 100% of the Critical Illness Benefit Amount for all Critical Illnesses has been paid for each Dependent Child.

If termination of coverage occurs because of termination of Your employment or contract with the Policyholder, such termination shall be without prejudice to any Occurrence Date which commenced while this Certificate was in force.

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

We or the Policyholder, may end the Policy and/or optional benefit riders on any premium due date. Thirty-one days advance written notice of such termination must be given.

LEAVE OF ABSENCE: Your coverage may be continued for up to 1 year during a Leave of Absence approved in writing by Your Employer.

TOI

SECTION 6
PREMIUM CALCULATION AND PAYMENT

Premiums will be figured on the basis stated in the Policyholder's application.

The first premium is due on or before Your Effective Date of coverage. Premiums after the first are due on or before the premium due date stated in the Policyholder's application. Premiums may be paid to:

- (a) Our Home Office; or
- (b) an authorized entity of Ours.

The premium may be changed based on experience at the first anniversary date of the Policy or any premium due date after that. No such increase in rate will be made unless 31 days prior notice is given to the Policyholder.

If a change in benefit increases Our liability, premium rates may be changed on the date the liability is increased.

PREM

SECTION 7 CLAIMS

NOTICE OF CLAIM: You should notify Us, in writing, within 30 days after a Covered Person incurs a loss covered by the Policy. If it is not reasonably possible to give notice within this time period, Your claim will not be denied or reduced due to the delay. Send Your written notice to Us at the following address:

American Fidelity Assurance Company
P.O. Box 268898
Oklahoma City, Oklahoma 73126

CLAIM FORMS: Claim forms should be used for filing Proof of Loss. They will be sent to the claimant within 15 days of receipt of Notice of Claim. If Claim Forms are not supplied within 15 days, a claimant can give proof as follows:

- (a) in writing;
- (b) containing the required information as indicated in the Proof of Loss Provision; and
- (c) within the time stated in the Proof of Loss Provision.

PROOF OF LOSS: Proof of Loss must be given to Us within 90 days after the loss. Late proof may be accepted if:

- (a) it was not reasonably possible to give Proof in that time; and
- (b) the proof is given within one year from the date of loss. This 1-year limit will not apply in the absence of legal capacity.

Proof of Loss, provided at Your expense, includes, but is not limited to, the following documentation:

- (a) certification by a Physician of the Critical Illness, as supported by a completed Claim Form provided by the Company, or some other mutually agreed-upon means;
- (b) the Occurrence Date of the Covered Person's Critical Illness;
- (c) the cause of the Covered Person's Critical Illness;
- (d) the objective test results, or documentation satisfactory to Us, confirming the Critical Illness as required in the definition of such Critical Illness; and
- (e) a copy of the death certificate, if the Critical Illness resulted in the Covered Person's death.

TIME OF PAYMENT OF CLAIMS: Benefits for a covered loss will be paid promptly upon receipt of written Proof of Loss.

PAYMENT OF BENEFITS: We will pay all benefits to You. Any benefits that have not been paid at the time of Your death will be paid to Your designated beneficiary, if living, or to the contingent beneficiary. If no such designation is made, or in the event of the death of both the beneficiary and contingent beneficiary, benefits will be paid to Your estate. If benefits are payable to Your estate or to any person who is not competent to give us a valid release, We have the right to pay up to \$1,000 of those benefits to any person related to You by blood or marriage who We believe is justly entitled to such payment. If We make a payment under this provision in good faith, We will be released from liability to the extent of the payment.

PHYSICAL EXAMINATION: While a claim is pending, We have the right to have You:

- (a) examined as often as is reasonably necessary. We will pay for such examination; and/or
- (b) interviewed by Our authorized representative to determine the extent of any Sickness or Accident for which You have made a claim. This right may be used as often as reasonably required.

LEGAL ACTION: No legal action may be brought to recover under the Policy:

- (a) within 60 days after written Proof of Loss has been furnished as required; or
- (b) more than 3 years from the time written Proof of Loss is required to be furnished.

CLAIM OVERPAYMENT: We have the right to recover from You any amount that We determine to be an overpayment. You have the obligation to refund to Us any such amount.

If benefits are overpaid on any claim, You must reimburse Us within 30 days.

If reimbursement is not made in a timely manner, We have the right to:

- (a) recover such overpayments from:
 - (1) You;
 - (2) any other person to or for whom payment was made;
 - (3) Your estate;
 - (4) Your beneficiary;
 - (5) any other organization; and
 - (6) any other insurance company;
- (b) reduce against any future benefits payable to You, Your estate, Your survivors, or Your beneficiary, until full reimbursement is made. Payments for future benefits will continue when the overpayment has been fully recovered;
- (c) refer Your unpaid balance to a collection agency; and
- (d) pursue and enforce all legal and equitable rights in court.

CLAIMS

SECTION 8 GENERAL PROVISIONS

ENTIRE CONTRACT-CHANGES: The entire contract shall include:

- (a) the Policy;
- (b) the application of the Policyholder and each Employer Participation Agreement (if applicable);
- (c) Your application, if any, attached to the Certificate; and
- (d) all endorsements and amendments.

Statements made by the Policyholder or You are representations and not warranties, if fraud was not intended. No such statements will be used to avoid the insurance, reduce benefits, or defend a claim under the Policy unless:

- (a) the statement is in writing; and
- (b) a copy of that statement is given to You.

The terms of the Policy can be changed only by endorsement or amendment signed by an executive officer of Ours. Any amendment that reduces or eliminates coverage must be requested in writing or signed by the Policyholder. No agent may change the Policy or waive its provisions.

TIME LIMIT ON CERTAIN DEFENSES: After 2 years from Your Effective Date of coverage, no statements in the application, except fraudulent misstatements, can be used to:

- (a) avoid the coverage; or
- (b) deny a claim for loss incurred or Critical Illness (as defined in the Policy) that starts after such 2-year period.

GRACE PERIOD: A grace period of 31 days will be allowed for each premium payment after the first premium. Coverage will stay in force during this time. The coverage under the Policy will terminate at the end of the grace period if the premium has not been paid. The Policyholder or subscribing Employer unit must still pay all unpaid premium. This includes the premium due for the grace period.

The Policyholder or subscribing Employer unit may, by writing to Us, cancel the coverage under the Policy:

- (a) on any future premium due date; or
- (b) on any date during the grace period.

If coverage is canceled on a premium due date, the grace period will not apply. If cancellation is during the grace period, the Policyholder or subscribing Employer unit will be liable for any unpaid premium including the pro rata premium for that part of the grace period while coverage was in force.

CERTIFICATES: An Individual Certificate will be issued to You. The Certificate will describe:

- (a) the benefits under the Policy;
- (b) to whom benefits will be paid; and
- (c) the limitations and terms of the Policy.

If more than one Certificate is issued under the Policy to You, only the last one issued will be in effect.

MISSTATEMENT OF FACTS: If relevant facts regarding You are not accurate:

- (a) a fair adjustment of premium will be made; and
- (b) the true facts will decide if and in what amount of insurance coverage is valid.

CONFORMITY WITH STATE LAWS: A provision of the Policy that conflicts with a law of the state of issue is hereby changed to meet the minimum standards of that law.

CHANGE OF BENEFICIARY: You may change the beneficiary at any time by giving Us written notice. The effective date of the beneficiary change will be the date We record the change at Our home office.

GENPROV



9000 Cameron Parkway

Oklahoma City, OK 73114

CANCER CRITICAL ILLNESS LIMITED BENEFIT RIDER

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

You or **Your** as used throughout shall mean the Insured or the Insured's. **We, Us, Our** shall mean the Company.

RIDER SCHEDULE

**INSURED
CANCER CRITICAL ILLNESS BENEFIT**
Please refer to Your individual application or enrollment form

**DEPENDENT CHILD
CANCER CRITICAL ILLNESS BENEFIT**
25% of Your Cancer Critical Illness Benefit

INVASIVE CANCER:

100%

Carcinoma In Situ (or Early Stage Cancer): **25%** of the Invasive Cancer Benefit
Partial payments for Carcinoma in Situ reduces the Invasive Cancer benefit. At no time will combined payments for any Cancer related benefits exceed 100% of the Cancer Critical Illness Benefit Amount.

RIDER DEFINITIONS

CARCINOMA IN SITU (or Early Stage Cancer) means a malignant tumor which has not yet become invasive but is confined to the layer of cells from which it arose.

Carcinoma In Situ includes an early stage of internal cancer in which the tumor, or tumor cells, are confined to the organ or tissue where it first developed. The disease has not invaded other parts of the organ, tissue, or spread to distant parts of the body. Examples of Early Stage Cancer include, but are not limited to:

- (a) for prostate cancer: a diagnosis of Stage A1 or A2, or a diagnosis of T1a or T1b or equivalent staging; or
- (b) for breast cancer: a diagnosis of Tis; or
- (c) for colon cancer: a diagnosis of Stage 0, or Tis, or equivalent staging; or
- (d) for melanoma: a diagnosis of Stage 0, or Tis, or equivalent staging; or
- (e) any other cancer which meets the definition of Early Stage Cancer.

Carcinoma in Situ does not include Skin Cancer as defined in this Rider. Skin Cancer is not covered in this Rider.

Carcinoma In Situ and Early Stage Cancer is not: Myelodysplastic and non-malignant myeloproliferative disorders, Atypia, Non-malignant monoclonal gamopathy, or pre-malignant lesions, benign tumors or polyps.

CRITICAL ILLNESS means, in addition to the Critical Illnesses listed in the Policy, Carcinoma in Situ and Invasive Cancer as defined in this Rider, for which a positive diagnosis is made by a Physician.

INVASIVE CANCER means a disease that is manifested by autonomous growth (malignancy) in which there is uncontrolled growth, function, or spread (local or distant) of cells in any part of the body. For all cancers, the staging, as supported by medical documents including pathology, surgical and clinical information, will be used to determine if the cancer in question meets the definition of Invasive Cancer.

Invasive Cancer does not include Carcinoma in Situ or Skin Cancer as defined in this Rider.

Invasive Cancer is not: Myelodysplastic and non-malignant myeloproliferative disorders, Atypia, Non-malignant monoclonal gamopathy, or pre-malignant lesions, benign tumors or polyps.

OCCURRENCE DATE must occur on or after the Covered Person's Effective Date and while coverage is in force. The Occurrence Date for the Cancer Critical Illness Benefit is the date the Covered Person is diagnosed by a Physician with Carcinoma in Situ or Invasive Cancer.

SKIN CANCER means a cancer or malignant neoplasm of the skin that does not invade bone or does not metastasize to internal/visceral organs. For the purpose of this definition, melanoma is not Skin Cancer. For all cancers, the staging, as supported by medical documents including pathology, surgical and clinical information, will be used to determine if the cancer in question meets the definition of Skin Cancer. Skin Cancer is not covered by this rider.

BENEFITS

INVASIVE CANCER: Following the Occurrence Date of a Covered Person's Invasive Cancer, We will pay the percentage of the Cancer Critical Illness Benefit Amount as shown on the Schedule. The Invasive Cancer must occur after the Covered Person's Effective Date.

If a Covered Person receives a benefit for Carcinoma In Situ, and is later diagnosed with Invasive Cancer, We will pay the Invasive Cancer benefit less the amount received for Carcinoma In Situ. For all cancer related benefits combined, We will not pay more than 100% of the Cancer Critical Illness Benefit Amount shown on the Schedule for the Covered Person.

Carcinoma in Situ (or Early Stage Cancer): Following the Occurrence Date of a Covered Person's Carcinoma in Situ, We will pay the percentage of the Cancer Critical Illness Benefit Amount as shown on the Rider Schedule. The Carcinoma in Situ must occur after the Covered Person's Effective Date. This benefit is payable only once per Covered Person's lifetime.

LIMITATIONS AND EXCLUSIONS

The Pre-Existing Limitations and Exclusions stated in the Group Critical Illness Policy to which this Rider is attached are also applicable to the provisions of this Rider.

TERMINATION OF RIDER

Your coverage under this Rider will end on the earliest of:

- (a) the date 100% of Your Cancer Critical Illness Benefit has been paid;
- (b) the date the Certificate to which this Rider is attached terminates;
- (c) the end of the last period for which premium payment has been made to Us;
- (d) the date You notify Us in writing to terminate coverage;
- (e) the date You no longer meet the Eligibility requirements as stated in the Policy;
- (f) the end of the month following Your 75th birthday;
- (g) the date You die;
- (h) the date this Rider is discontinued;
- (i) the date the Policy is discontinued.

This Rider is subject to all 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

**NOTICE OF PROTECTION PROVIDED BY
CALIFORNIA LIFE AND HEALTH INSURANCE GUARANTEE ASSOCIATION**

This notice provides a brief summary regarding the protections provided to policyholders by the California Life and Health Insurance Guarantee Association ("the Association"). The purpose of the Association is to assure that policyholders will be protected, within certain limits, in the unlikely event that a member insurer of the Association becomes financially unable to meet its obligations. Insurance companies licensed in California to sell life insurance, health insurance, annuities and structured settlement annuities are members of the Association. The protection provided by the Association is not unlimited and is not a substitute for consumers' care in selecting insurers. This protection was created under California law, which determines who and what is covered and the amounts of coverage.

Below is a brief summary of the coverages, exclusions and limits provided by the Association. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations or the rights or obligations of the Association.

COVERAGE

▪ **Persons Covered**

Generally, an individual is covered by the Association if the insurer was a member of the Association *and* the individual lives in California at the time the insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payees or assignees, whether or not they live in California.

• **Amounts of Coverage**

The basic coverage protections provided by the Association are as follows.

▪ **Life Insurance, Annuities and Structured Settlement Annuities**

For life insurance policies, annuities and structured settlement annuities, the Association will provide the following:

- **Life Insurance**
 - 80% of death benefits but not to exceed \$300,000
 - 80% of cash surrender or withdrawal values but not to exceed \$100,000
- **Annuities and Structured Settlement Annuities**
 - 80% of the present value of annuity benefits, including net cash withdrawal and net cash surrender values but not to exceed \$250,000

The maximum amount of protection provided by the Association to an individual, for all life insurance, annuities and structured settlement annuities is \$300,000, regardless of the number of policies or contracts covering the individual.

▪ **Health Insurance**

The maximum amount of protection provided by the Association to an individual, as of July 1, 2016, is \$546,741. This amount will increase or decrease based upon changes in the health care cost component of the consumer price index to the date on which an insurer becomes an insolvent insurer. Changes to this amount will be posted on the Association's website www.califega.org.

COVERAGE LIMITATIONS AND EXCLUSIONS FROM COVERAGE

The Association may not provide coverage for this policy. Coverage by the Association generally requires residency in California. You should not rely on coverage by the Association in selecting an insurance company or in selecting an insurance policy.

The following policies and persons are among those that are excluded from Association coverage:

- A policy or contract issued by an insurer that was not authorized to do business in California when it issued the policy or contract
- A policy issued by a health care service plan (HMO), a hospital or medical service organization, a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society
- If the person is provided coverage by the guaranty association of another state
- Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which do not guaranty annuity benefits to an individual
- Employer and association plans, to the extent they are self-funded or uninsured
- A policy or contract providing any health care benefits under Medicare Part C or Part D
- An annuity issued by an organization that is only licensed to issue charitable gift annuities
- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such certain investment elements of a variable life insurance policy or a variable annuity contract
- Any policy of reinsurance unless an assumption certificate was issued
- Interest rate yields (including implied yields) that exceed limits that are specified in Insurance Code Section 1067.02(b)(2)(C)

NOTICES

Insurance companies or their agents are required by law to give or send you this notice. Policyholders with additional questions should first contact their insurer or agent. To learn more about coverages provided by the Association, please visit the Association's website at www.califega.org, or contact either of the following:

California Life and Health Insurance
Guarantee Association
P.O. Box 16860
Beverly Hills, CA 90209-3319
(323) 782-0182

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street
Los Angeles, CA 90013
(800) 927-4357

Insurance companies and agents are not allowed by California law to use the existence of the Association or its coverage to solicit, induce or encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and California law, then California law will control.

(THIS FORM IS NOT A PART OF YOUR CONTRACT)

NOTICE OF THE RIGHT TO APPEAL

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

Your request for review must be filed within 90 days after receipt of the written notice of denial of a claim. A decision will be rendered by American Fidelity Assurance Company, within 90 days after receipt of your request for review. If special circumstances exist or additional information is needed, the decision shall be rendered as soon as possible, but no later than 90 days after receipt of the additional information necessary to evaluate your appeal. The decision, after the review, shall be in writing and shall include specific reasons for the decision. This decision shall also include specific references to the pertinent plan provisions on which the decision was based.

FACTS**WHAT DOES AMERICAN FIDELITY CORPORATION (AFC) DO WITH YOUR PERSONAL INFORMATION?**

Why?	Financial companies choose how they share your personal information. Federal law gives consumers the right to limit some but not all sharing. Federal law also requires us to tell you how we collect, share, and protect your personal information. Please read this notice carefully to understand what we do.
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What?	<p>The types of information we collect and share depend on the product or service you have with us. This information can include:</p> <ul style="list-style-type: none"> • Social Security number and income • account transactions and medical information • insurance claim history and employment information
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How?	All financial companies need to share customers' personal information to run their everyday business. In the section below, we list the reasons financial companies can share their customers' personal information; the reasons AFC chooses to share; and whether you can limit the sharing.
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Reasons we can share your personal information	Does AFC share?	Can you limit this sharing?
For our everyday business purposes – Such as to process your transactions, maintain your account(s), respond to court orders and legal investigations, or report it to credit bureaus	Yes	No
For our marketing purposes – To offer our own products and services to you	Yes	No
For our affiliates to market to you	No	We don't share your information for this purpose
For our affiliates' everyday business purposes – Information about your transactions and experiences	Yes	No
For our affiliates' everyday business purposes – Other information about your insurability	Yes	No
For our affiliates' everyday business purposes – Other information about your creditworthiness	No	We don't share your information for this purpose
For joint marketing with other financial companies	No	We don't share your information for this purpose
For non-affiliated third parties to market to you	No	We don't share your information for this purpose

Questions?	Call 1-866-554-4722 or go to www.americanfidelity.com .
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Who we are	
Who is providing this notice?	American Fidelity Corporation (AFC)
What we do	
How does AFC collect my personal information?	<p>We collect your personal information, for example, when you:</p> <ul style="list-style-type: none"> • Provide information to us in the application process. • Transact business with us, our affiliates, or others, such as additional products or services purchased, etc. • Have information provided by your employer, group plan sponsor, or association for any group product you may have. • Have information provided by consumer reporting agencies, such as credit relationships and history. • Have information provided from other sources outside AFC such as medical information, motor vehicle reports, etc. • Visit AFC's non-public Online Service Center Web Site.
Why can't I limit all sharing?	<p>Federal law gives you the right to limit only:</p> <ul style="list-style-type: none"> • Sharing for affiliates' everyday business purposes – information about your creditworthiness • Sharing for non-affiliated third parties to market to you <p>State laws and individual companies may give you additional rights to limit sharing.</p>

Definitions	
Affiliates	<p>Companies related by common ownership or control. They can be financial and non-financial companies. AFC's affiliates include:</p> <ul style="list-style-type: none"> • American Public Life Insurance Company • American Fidelity Administrative Services, LLC • Health Services Administration, LLC • American Fidelity Assurance Company • American Fidelity General Agency, Inc. • American Fidelity Property Company • American Fidelity Securities, Inc. • Balliet's, LLC
Non-affiliated third parties	<p>Companies not related by common ownership or control. They can be financial and non-financial companies.</p> <ul style="list-style-type: none"> • AFC does not share with non-affiliates so they can market to you.
Joint marketing	<p>A formal agreement between non-affiliated third parties that together market financial products or services to you.</p> <ul style="list-style-type: none"> • AFC does not jointly market financial products or services.

Other important information	
<p>AFC maintains appropriate physical, electronic, and procedural safeguards to maintain the confidentiality and security of your nonpublic personal information. We restrict access to nonpublic personal information about you to those employees who need to know that information to provide products or services to you. Physical and electronic files are kept in secure areas. We educate our employees about the importance of confidentiality and customer privacy. We also enforce employee privacy responsibilities. We apply the same privacy policies to former customers that we apply to current customers.</p>	

HIPAA 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.

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

If you have questions about this notice, please contact the person listed under "Whom to Contact" at the end of this notice.

SUMMARY

In order to provide you with benefits, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides that if American Fidelity Assurance Company receives personal information about your health from you, your physicians, hospitals, and others who provide you with health care services, we are required to keep this information confidential. This notice of our privacy practices is intended to inform you of the ways we may use your information and the occasions on which we may disclose this information to others.

KINDS OF INFORMATION TO WHICH THIS NOTICE APPLIES

This notice applies to individually identifiable protected health information that is created or received by us and that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual, or for which there is a reasonable basis to believe the information can be used to identify the individual (hereinafter referred to as "protected health information").

POLICIES AND/OR RIDERS AFFECTED BY THIS NOTICE

The following policies and/or riders and any combination thereof, provided by American Fidelity Assurance Company are subject to the privacy policies and procedures set forth in this notice: cancer insurance; medical expense insurance; health indemnity insurance; hospital indemnity insurance; dental insurance; long term care insurance; flexible health care spending accounts; Medicare supplement insurance, vision insurance; medical expense reimbursement plans; and any other coverages offered by us that meet the definition of a health plan contained in the HIPAA Privacy Rule.

WHO MUST ABIDE BY THIS NOTICE

All employees, staff, students, volunteers and other personnel whose work involves one of the products covered under this notice and who are under the direct control of American Fidelity Assurance Company must abide by this notice. The people and organizations to which this notice applies (referred to as "we," "our," and "us") have agreed to abide by its terms. We may share your information with each other for purposes of payment and operations activities as described below. When the minimum necessary requirement applies, we will make reasonable efforts to limit your protected health information to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request.

OUR LEGAL DUTIES

- We are required by law to maintain the privacy of your protected health information.
- We are required to provide this notice of our privacy practices and legal duties regarding protected health information to anyone who asks for it.
- We are required to abide by the terms of the notice that is currently in effect.
- We are required to notify affected individuals following a breach of unsecured protected health information.

OUR RIGHT TO CHANGE THIS NOTICE

We reserve the right to change our privacy practices, as described in this notice, at any time. We reserve the right to apply these changes to any protected health information which we already have, as well as to protected health information, we receive in the future. Before we make any material change in the privacy practices described in this notice, we will write a new notice that includes the change. The new notice will include an effective date. We will mail the new notice to all named insureds then covered by a product subject to the notice within 60 days of the effective date. We will also post the revised notice on our website, www.americanfidelity.com, by the effective date of the revised notice.

HOW WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION

We may use your protected health information, or disclose it to others, for a number of different reasons. This notice describes these reasons. For each reason, we have written a brief explanation. We also provide some examples. These examples do not include all of the specific ways we may use or disclose your information.

1. Payment.

We will use your protected health information, and disclose it to others, as necessary to make payment for the health care services you receive. For instance, an employee in our claim-processing department may use your protected health information to pay your claims. We will also send you information about claims we pay and claims we do not pay (called an "explanation of benefits"). The explanation of benefits will include information about claims we receive for the Insured and each dependent who are enrolled together under a single contract or identification number. Under certain circumstances, you may receive this information confidentially: see the "Confidential Communication" section in this notice. We may also disclose some of your protected health information to companies with whom we contract for payment-related services. For instance, if you owe us money, we may give information about you to a collection company with which

we contract to collect bills for us. We will not use or disclose more information for payment purposes than is necessary.

2. Health Care Operations.

We may use and disclose your protected health information for activities that are necessary to operate this organization. This includes reading your protected health information to review the performance of our staff. We may also use your information and the information of other members to plan what services we need to provide, expand, or reduce. We may disclose your protected health information as necessary to others with which we contract to provide administrative services. This includes our lawyers, auditors, accreditation services, and consultants, for instance. While we may use and disclose your protected health information for underwriting purposes, we are prohibited from using or disclosing genetic information of an individual for such purposes.

3. Legal Requirement to Disclose Information.

We may use or disclose your information when we are required by law to do so. This includes reporting information to government agencies that have the legal responsibility to monitor the health care system. For instance, we may be required to disclose your protected health information, and the information of others, if we are audited by the state insurance department.

4. Public Health Activities.

We will disclose your protected health information when required to do so for public health purposes. This includes reporting certain diseases, births, deaths, and reactions to certain medications. It also includes reporting certain information regarding products and activities regulated by the federal Food and Drug Administration. It may also include notifying people who have been exposed to a communicable disease.

5. To Report Abuse.

We may disclose your protected health information when the information relates to a victim of abuse, neglect or domestic violence. We will make this report only in accordance with laws that require or allow such reporting, or with your permission.

6. Government Oversight.

We may disclose your protected health information if authorized by law to a government oversight agency (e.g., a state insurance department) conducting audits, investigations, or civil or criminal proceedings.

7. Judicial or Administrative Proceedings.

We may disclose your protected health information in the course of a judicial or administrative proceeding (e.g., to respond to a subpoena or discovery request).

8. Law Enforcement.

We may disclose a limited amount of your protected health information for law enforcement purposes. This includes providing information to help locate a suspect, fugitive, material witness or missing person, or in connection with suspected criminal activity. We must also disclose your protected health information to a federal agency investigating our compliance with federal privacy regulations.

9. Coroners.

We may disclose your protected health information to coroners, medical examiners, and/or funeral directors consistent with the law.

10. Organ Donation.

We may use or disclose your protected health information for cadaveric organ, eye or tissue donation.

11. Workers' Compensation.

We may disclose your protected health information to workers' compensation agencies if necessary for your workers' compensation benefit determination.

12. Limited Data Sets.

We may use or disclose, under certain circumstances, limited amounts of your protected health information that is contained in limited data sets.

13. Research.

We may use or disclose your protected health information for research purposes, but only as permitted by law.

14. Specialized Purposes.

We may use or disclose the protected health information of members of the armed forces as authorized by military command authorities. We may disclose your protected health information for a number of other specialized purposes. For instance, we may disclose your protected health information for national security, intelligence, and protection of the president.

15. To Avert a Serious Threat.

We may use or disclose your protected health information if we have a good faith basis to believe that the disclosure is necessary to prevent serious harm to the public or to an individual. The disclosure will only be made to someone who is able to prevent or reduce the threat.

16. Family and Friends.

We may disclose your protected health information to a member of your family or to someone else that is involved in your medical care or payment for care. This may include telling a family member about the status of a claim, or what benefits you are eligible to receive. In the event of a disaster, we may provide information about you to a disaster relief organization so they can notify your family of your condition and location. We will not disclose your information to family or friends if you object.

17. Health Benefits Information.

If your employer sponsors your enrollment in American Fidelity's health plan, your protected health information may be disclosed to your employer, as necessary for the administration of your employer's health benefit program for employees. Employers may receive this information only for purposes of administering their employee group health plans, and must have special rules to prevent the misuse of your information for other purposes.

18. Treatment.

We may disclose information to health care providers who are involved in your care. For example, we may disclose information to your physician to help them care for you.

MORE STRINGENT LAW

In the event applicable law, other than the HIPAA Privacy Rule, prohibits or materially limits our uses and disclosures of protected health information, as set forth above, we will restrict our uses or disclosure of your protected health information in accordance with the more stringent standard.

1. Authorization.

We may use or disclose your protected health information for any purpose that is listed in this notice without your written

authorization. We will not use or disclose your protected health information for any other reason that is not described in this notice without your written authorization. Specifically, we must have your written authorization to use or disclose psychotherapy notes except as permitted or required by law and personal information for marketing purposes, in most instances. In addition, we cannot sell your personal information unless we have your written authorization which must state that the disclosure of the information will result in remuneration to us. If you authorize us to use or disclose your protected health information, you have the right to revoke the authorization at any time. For information about how to authorize us to use or disclose your protected health information, or about how to revoke an authorization, contact the person listed under "Whom to Contact" at the end of this notice. You may not revoke an authorization for us to use and disclose your information to the extent that we have taken action in reliance on the authorization or if the authorization was obtained as a condition of obtaining insurance, and we have the right, under other law, to contest a claim under the policy or the policy itself.

2. Request Restrictions.

You have the right to request restrictions on certain of our uses and disclosures of your protected health information for insurance payment or health care operations, disclosures made to persons involved in your care, and disclosures for disaster relief purposes. For example, you may request that we not disclose your protected health information to your spouse. Your request must be in writing and describe in detail the restriction you are requesting. We will consider your request, but we are not required to agree, except for a request to restrict disclosure of protected health information about you to a health plan if the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law and the information pertains solely to a health care item or service for which you or someone acting on your behalf paid the provider in full. We cannot agree to restrict disclosures that are required by law.

3. Confidential Communication.

If you believe that the disclosure of certain information could endanger you, you have the right to ask us to communicate with you at a special address or by a special means. For example, you may ask us to send explanations of benefits that contain your protected health information to a different address rather than to your home. Or you may ask us to speak to you personally on the telephone rather than sending your protected health information by mail. We will agree to any reasonable request. Requests for confidential communications must be in writing, must state that the disclosure of the protected health information could endanger you, must be signed by you or your representative, and sent to us at the address under "Whom to Contact" at the end of the notice.

4. Inspect and Receive a Copy of Protected Health Information.

You have a right to inspect certain protected health information about you that we have in our records and to receive a copy of it. This right is limited to information about you that is kept in records that are used to make decisions about you. For instance, this includes claim and enrollment records. If you want to review or receive a copy of these records, you must make the request in writing, you must state that you are requesting access to your protected health information and either you or your representative must sign the request. We may charge a reasonable fee for the cost of copying and mailing the records. To ask to inspect your records, or to receive a copy, contact us at the address under "Whom to Contact" at the end of this notice. We may deny you access to

certain information. If we do, we will give you the reason, in writing. We will also explain how you may appeal the decision.

5. Amend Protected Health Information.

You have the right to ask us to amend protected health information about you, which you believe is not correct, or not complete. If you want to request that we amend your protected health information you must make this request in writing, it must be signed by either you or your representative, and you must give us the reason you believe the information is not correct or complete. Your request to amend your information must be sent to the address under "Whom to Contact" at the end of this notice. We may deny your request if we did not create the information, if it is not part of the records we use to make decisions about you, if the information is something you would not be permitted to inspect or copy, or if it is complete and accurate.

6. Accounting of Disclosures.

You have a right to receive an accounting of certain disclosures of your information to others. This accounting will list the times we have given your protected health information to others. The list will include dates of the disclosures, the names of the people or organizations to which the information was disclosed, a description of the information, and the reason. We will provide the first list of disclosures you request at no charge. We may charge you for any additional lists you request during the following 12 months. You must tell us the time period you want the list to cover. To be considered, your accounting requests must be in writing, signed by you or your representative, and sent to the address under "Whom to Contact" at the end of this notice.

7. Paper Copy of this Privacy Notice.

You have a right to receive a paper copy of this notice. If you have received this notice electronically, you may receive a paper copy by contacting the person listed under "Whom to Contact" at the end of this notice.

8. Complaints.

You have a right to complain about our privacy practices, if you think your privacy rights have been violated. You may file your complaint with the person listed under "Whom to Contact" at the end of this notice. You may also file a complaint directly with the Secretary of the U. S. Department of Health and Human Services. All complaints must be in writing, must describe the situation giving rise to the complaint, and must be filed within 180 days of the date you know, or should have known, of the event giving rise to the complaint. You will not be subject to any retaliation for filing a complaint.

WHOM TO CONTACT

Contact the person listed below: for more information about this notice; or for more information about our privacy policies; or if you want to exercise any of your rights, as listed on this notice; or if you want to request a copy of our current notice of privacy practices.

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

*This notice is also available on our Web site:
www.americanfidelity.com.*

