AmFirst Life Insurance Company

Dental Care Plan

Travel and Fitness Association, Inc.

Effective Date: 03/01/2026

AmFirst Life Insurance Company

201 Robert S. Kerr Ave., Suite 600
Oklahoma City, Oklahoma 73102

Administrative Offices:
P.O. Box 14067 Jackson, MS 39236

For Inquiries, Information, or Complaints, Please Call 800-800-1397

(Herein called the Company)

Certificate of Insurance of Your Group Dental Program

This booklet is a summary of your group dental program. Please read it carefully. It only summarizes the detailed provisions of the group dental contract issued by **AmFirst Life Insurance Company** ("AmFirst") and cannot modify the Contract in any way.



David R. White, RHU
Chairman
AmFirst Life Insurance Company

Benefits may be limited if services are received from a non-participating provider.

IMPORTANT NOTICE

To obtain information or make a complaint, You may contact AmFirst Life Insurance Company at:

AmFirst Life Insurance Company
Administrative Office: P. O. Box 14067
Jackson, Mississippi 39236
1 (800) 800-1397

You may contact the California Department of Insurance to obtain information on companies, coverages, rights or complaints at:

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street, South Tower
Los Angeles, CA 90013
Consumer Hotline: 800-927-HELP (4357) or
213-897-8921 or www.dca.ca.gov

The California Department of Insurance should be contacted only after discussions with the Company, or its agent or other representative, or both, have failed to produce a satisfactory resolution to the problem.

Table of Contents

Group Highlights 5
Definitions 7
Choice of Dentist 9
Who Is Eligible? 9
Continuation of Benefits 10
Deductible 11
Maximum Amount 11
Premiums 11
Benefits, Limitations & Exclusions 11
Coordination of Benefits 15
Claims 17
Predeterminations 17
Claims Appeal 18
Cancellation of Program 18
Proof of Loss 18
Time of Payment 19
To Whom Benefits are Paid 19
Legal Actions 19
APPENDIX A 20

AmFirst Life Insurance Company

Group Highlights

Applicant Name: Travel and Fitness Association, Inc.

Address: P. O. Box 14067
Jackson, Mississippi 39236

Effective Date: 03/01/2026

Contract Term: Does Not Apply.

Effective Day of Month: First day of the month following completion of enrollment.

Open Enrollment Period: Does Not Apply.

Premiums

Monthly Amount:

For each Primary Enrollee.

For each Primary Enrollee with
One Dependent Enrollee.

For each Primary Enrollee with more than
One Dependent Enrollee.

Payment Breakdown

Primary Enrollee shall pay 100% of Premiums for personal coverage. Primary Enrollee shall pay 100% of Premiums for Dependent coverage.

Applicant may charge person electing continued coverage pursuant to Title X of P. L. 99 as permitted by law.

Premium Basis

Premiums are based on the number of covered Primary Enrollees at the beginning of each contract term.

A 15% reduction in the number of Primary Enrollees over 3 consecutive months in a contract term, may affect the premium.

Benefits

	Policy Yr. 1	2	3+
Type I Procedures (Diagnostic & Preventive Benefits)	80%	90%	100%
Type II Procedures (Basic Benefits)	60%	70%	80%
Type III Procedures (Major Benefits)			
Oral Surgery	0%	40%	50%
Endodontics	0%	40%	50%
Periodontics	0%	40%	50%
Prosthodontics (Removable & Fixed)	0%	40%	50%
Type IV Procedures Orthodontics	0%	40%	50%

These percentages are based on the Usual, Customary & Reasonable Charges (UCR), Allowance up to the 85th Percental of UCR.

Note - Procedures subject to the waiting period are not covered and do not apply toward the deductible during the waiting period.

$20.00 Co-Pay per person per office visit, excluding Orthodontics.

Waiting Periods

Type I Procedures	0 months
Type II Procedures	6 months
Type III & IV Procedures	12 months

Orthodontic Benefits are limited to Dependent Enrollee children six (6) years to age 19.

Deductible Amount: Does Not Apply

Maximum Amount

$6,5000.00 per Enrollee per Calendar Year for Prosthodontic Benefits.
$ 400.00 per Enrollee per Calendar Year for Orthodontic Benefits.
$ 1,500.00 per Enrollee per Lifetime for Orthodontic Benefits.
$6,5000.00 per Enrollee per Calendar Year for All Benefits (Type I, II, III & IV Combined)

AmFirst will receive credit for any amount paid for Orthodontic Benefits only under the Applicant's previous dental care plan for the same or similar benefits. These amounts will be credited towards the maximum amounts payable for Orthodontic Benefits.

Termination

Less than Two (2) Primary Enrollee(s).

State of Issue: Mississippi

Definitions

Terms when capitalized in this document have defined meanings, given either in the section below or within the contract sections.

"Applicant" – the association or other organization or group contracting to obtain Benefits.

"Approved Amount" – the total fee chargeable for a Single Procedure.

"Attending Dentist's Statement" – the standard form used to file a claim or request Predetermination of Benefits provided under the Contract.

"Benefits" – the amounts that AmFirst will pay for dental services under Article 4.

"Calendar Year" – the 12 months of the year from January 1 through December 31.

"Contract" – this agreement between AmFirst and Applicant, including the Application and the attachments listed in Article 9.

"Contract Allowance" – the maximum amount allowed for a Single Procedure. It is the lesser of the Dentist's submitted fee, and the Scheduled Maximum, if any, and the Dentist's fee filed with AmFirst in the Participating Dentist Agreement, if any, or the UCR.

"Contract Term" – the period during which the Contract is in effect, as shown in the Group Highlights page.

"Contract Year" – the 12 months starting on the Effective Date and each subsequent 12-month period thereafter. Deductibles and maximums will be determined using this 12-month period rather than on a calendar year basis.

"Dentist" – a person licensed to practice dentistry when and where services are performed.

"Dependent Enrollee" – an Eligible Dependent enrolled in the plan to receive Benefits.

"Domestic Partner" - two adults who have chosen to share one another's lives in an intimate and committed relationship of mutual caring. A domestic partnership shall be established when both persons file a Declaration of Domestic Partnership with the Secretary of State pursuant to this division.

"Effective Date" – the date the program starts, as shown in Appendix A.

"Eligible Dependent" – a dependent of an Eligible Person eligible for Benefits under Article 2.

"Eligible Person" – a person as listed in Appendix A, designated by the Applicant as eligible for Benefits under Article 2.

"**Enrollee**" – an Eligible Person ("Primary Enrollee") or an Eligible Dependent ("Dependent Enrollee") enrolled to receive Benefits.

"Non-Preferred, Non-Network, Non-Contracting, Non-Participating Dentist" – a Dentist who has not agreed to provide services in accordance with the terms and conditions established by AmFirst and any member of the AmFirst Dental Plans Association with which AmFirst contracts to assist it in administering the Benefits

described in this Contract. A Non-Participating Dentist may charge more than the Contract Allowance. The fee allowed for Non-Participating Dentists is the fee agreed to by Participating Dentists. See Participating Dentist.

"**Open Enrollment Period**" – the month(s) of the year, as shown in Appendix A, during which Eligible Persons may change coverage for the next Calendar Year.

"Predetermination" – AmFirst shall estimate the amount of Benefits under the Contract for the services proposed, assuming the patient is eligible.

"Preferred, Network, Contracting, Participating Dentist" – a Dentist who in executing a Participating Dentist Agreement has agreed to provide services in accordance with the terms and conditions established by AmFirst and any member of the AmFirst Dental Plans Association with which AmFirst contracts to assist it in administering the Benefits described in this Contract. Participating Dentists have agreed to charge no more than the Contract Allowance. The network will meet the adequacy and accessibility requirements set forth in California law.

"Premiums" – the amounts payable monthly by the Applicant as required in the Contract.

"Primary Enrollee" – an Eligible Person enrolled in the plan to receive Benefits.

"Procedure Number" – the number given to a Single Procedure in the AmFirst Dental Uniform Procedure Code and Nomenclature attached as Appendix B.

"Qualifying Family Status Change" – a change which occurs as a result of i) marriage, divorce or legal separation; ii) a child's birth or adoption; iii) a change in spouse's employment; iv) a death in the family; v) a court order requiring dependent coverage; or vi) termination of employment.

"Scheduled Maximum" – the maximum Contract Allowance for each dental procedure, as shown in Appendix B, if any.

"Single Procedure" – a dental procedure that is assigned a separate Procedure Number. For example: a single x-ray file (Procedure 0220), or a complete upper denture (Procedure Number 5110).

"UCR" – "usual, customary and reasonable" which have the following meanings:

Usual – A "usual" fee is that fee regularly charged and received for a given service by an individual Dentist, i.e., his own usual fee. If more than one fee is charged for a given service, the fee determined to be the usual fee shall not exceed the lowest fee which is regularly charged or which is offered to patients.

Customary – a fee is "customary" when it is within the range of usual fees charged and received by Dentists of similar training for the same service within a relevant geographic area. Customary fees may be determined based on fees filed with AmFirst by Participating Dentists. A Customary fee for a Participating Dentist is that fee which is approved by AmFirst in the terms of the Participating Dentist Agreement.

Reasonable – A fee is "reasonable" if it is "usual" and "customary" or if it falls above "usual" and "customary" or both, but is determined to be justifiable considering the special circumstances or extraordinary difficulty of the case in question.

"Uniform Procedure Code" – the AmFirst Uniform Procedure Code and Nomenclature, which is attached to and made a part of the Contract.

"We, Our, or Us" – AmFirst, and will be used without respect to capitalization.

"You, Your, Yours" – the Primary Enrollee and will be used without respect to capitalization.

Choice of Dentist

AmFirst offers you a choice of selecting a Dentist from our panel of Participating Dentists, if applicable, or you may choose a Non-participating Dentist.

A directory of Participating Dentists is available from the Policyholder. You are responsible for verifying whether the Dentist you select is a Participating Dentist. Dentists are regularly added to the panel so a Participating Dentist may not yet be listed. Additionally, you should always confirm that a listed Dentist is still a Participating Dentist.

You may choose to go to any Dentist. Even if you choose a Participating Dentist from our panel, AmFirst cannot guarantee that a particular Dentist will be available.

There may be a difference in the out-of-pocket cost you pay if your Dentist is not a Participating Dentist. A Participating Dentist has contractually agreed not to charge you any amount for services above the Contract Allowance. We pay your Benefits based on the Contract Allowance less any deductibles or maximums that may apply.

If a Dentist is not a Participating Dentist, the amount charged to you may be above that charged by our Participating Dentists. When we pay Benefits for services provided by Non-participating Dentists, we will allow the Contract Allowance, or the fee paid to Participating Dentists. You will then be responsible for any extra amount charged by this Dentist over what Benefits we will pay in addition to any deductibles and maximums specified by the plan. This is called balance billing, that is, the Dentist may bill you for the balance after AmFirst 's payment is made.

Who Is Eligible?

Eligibility for Enrollment

All present, permanent members of the association are eligible on the Effective Date.

All future, permanent members of the association shall become eligible on the calendar day of the month shown on the Group Highlights page after they have obtained membership.

If your dependents are covered, they will be eligible when you are or as soon as they become dependents.

Dependents are your:

a) Lawful spouse. "Lawful spouse" shall include the Insured's domestic partner pursuant to California Family Code § 297.

b) A child from birth to the end of the month of their 26th birthday. "Children" include natural children, stepchildren (including dependent children of a Domestic Partner), adopted children and foster children. Newborn infants are eligible from the moment of birth. Adopted children are eligible from the point of placement in the physical custody of the Eligible Person, as certified by the agency making placement. A child shall automatically be

covered for 31 days after birth or adoption placement. To continue coverage after 31 days, notice of the birth or placement and additional Premium, if any, must be received within the 31-day period.

A child 26 years or older may continue to be eligible as a dependent if the child is:

a) Not self-supporting because of mental incapacity or physical handicap that began before age 26, and

b) The child must be mostly dependent on the Eligible Person for support and maintenance.

Proof of these facts must be given to AmFirst or your Policyholder within 31 days if it is requested. Proof will not be required more than once a year after the child is 21.

Enrollment Requirements

If you are paying all or a portion of premiums for yourself or your dependents then:

a) You must enroll within 30 days after the date you become eligible or during an Open Enrollment Period.

b) All dependents must be enrolled within 30 days after they become eligible or during an Open Enrollment Period.

c) You pay Premiums for Dependent Enrollees in the manner elected by your association and approved by AmFirst until your dependents are no longer eligible or until you choose to drop dependent coverage. Coverage may not be dropped or changed at any time other than during an Open Enrollment Period or if there is a Qualifying Family Status Change.

d) If both you and your spouse are Eligible Persons, one of you may enroll as a Dependent Enrollee of the other. Dependent children may enroll as Dependent Enrollees of only one Primary Enrollee.

Loss of Eligibility

Your coverage ends on the last day of the month your membership in the association terminates, or immediately when this program ends. Your dependents' coverage ends when your coverage ends, or as soon as they are no longer dependents as defined in this certificate.

Continuation of Benefits

AmFirst does not pay Benefits for services received after your coverage ends. But AmFirst will pay for Single Procedures started before that date.

Continuity of Care by a Terminated Provider

Members who are being treated for acute dental conditions, serious chronic dental conditions, or who are children from birth to 36 months of age, or who have received Authorization from a now-terminated provider for dental surgery or another dental procedure as part of a documented course of treatment can request completion of care in certain situations with a provider who is leaving the network of Participating Dentists. Contact Customer Service to receive information regarding eligibility criteria and the policy and procedure for requesting continuity of care from a terminated provider.

Financial Responsibility for Continuity of Care Services

If a Member is entitled to receive services from a terminated provider under the preceding Continuity of Care provision, the responsibility of the Member to that provider for services rendered under the Continuity of Care provision shall be no greater than for the same services rendered by a Participating Dentist in the same geographic area.

Deductible Does Not Apply

Your dental plan features a deductible. This is an amount you must pay out-of-pocket before Benefits are paid. The deductible amounts are listed on the Group Highlights page.

Only the Dentist's fees you pay for covered Benefits will count toward the deductible.

Maximum Amount

The Maximum Amount payable is shown on the Group Highlights page. There may be maximums on a yearly basis, a per services basis, or a lifetime basis.

AmFirst will receive credit for any amounts paid for Orthodontic Benefits. Those amounts shall be deducted from the maximum paid by AmFirst.

However, Orthodontic Benefits, if provided, will end with the next payment due although the maximum has not been reached if the patient loses coverage, if treatment is stopped, or if the Contract with your association is cancelled.

Premiums

You will be responsible for 100% of the cost of premiums for yourself. You will be responsible for 100% of the cost of premiums for your Dependent Enrollees.

AmFirst may cancel this Program 30 days after written notice to you if monthly Premiums are not paid when due.

Benefits, Limitations & Exclusions

Subject to the limitations and exclusions in this Contract, AmFirst shall pay the Benefits for each type of dental service described below when provided by a Dentist and when necessary and customary under generally accepted dental practice standards. AmFirst may use dental consultants to determine generally accepted dental practice standards. Eligibility periods, if any, for specific services are shown in Group Highlights.

Patient Copayment - AmFirst's provision of Benefits is limited to the applicable percentage of Dentist's fees specified in Group Highlights. The Enrollee is responsible for paying the remaining applicable percentage of any such fees, known as the "Patient Copayment". Applicant has chosen to require Patient Copayments under this program as a method of sharing the costs of providing dental Benefits between Applicant and Enrollees. If the Dentist discounts, waives or rebates any portion of the Patient Copayment to the Enrollee, AmFirst shall be obligated to provide as Benefits only the applicable percentages of the Dentist's fees as reduced by the amount of such fees or allowances that is discounted, waived or rebated.

Limitations on All Benefits – Optional Services. Services that are more expensive than the form of treatment customarily provided under accepted dental practice standards are called "Optional Services". Optional Services also

include the use of specialized techniques instead of standard procedures. For example: a crown where a filling could restore the tooth or an inlay instead of a restoration. If an Enrollee receives Optional Services, Benefits will be based on the lower cost of the customary service or standard practice instead of the higher cost of the Optional Service. The Enrollee will be responsible for the difference between the higher cost of the Optional Service and the lower cost of the customary service or standard procedure.

No change in Benefits will become effective during a Contract Term unless Applicant and AmFirst agree in writing.

Exclusions

AmFirst does not pay Benefits for:

a) Cosmetic surgery or procedures for purely cosmetic reasons, or services for congenital (hereditary) or developmental malformations. Such malformations include, but are not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth) and anodontia (congenitally missing teeth).

b) Treatment to restore tooth structure lost from wear, erosion, or abrasion; treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion; or treatment to stabilize teeth. For example; equilibration, periodontal splinting, occlusal adjustment.

c) Any Single Procedure started before the patient is covered under this program.

d) Prescribed drugs, medication or painkillers, except medications customarily administered during exam and treatment.

e) Experimental procedures.

f) Charges by any hospital or surgical or treatment facility and any additional fees charged by the Dentist for treatment in any such facility.

g) Charges for anesthesia, other than by a licensed Dentist for administering general anesthesia in connection with covered oral surgery services.

h) Extra oral grafts (grafting of tissues from outside the mouth to oral tissues).

i) Services for any disturbance of the temporomandibular joints (jaw joints).

j) Treatment by someone other than a Dentist or a person who by law may work under a Dentist's direct supervision.

k) For services provided outside the United States, it territories, or possessions, other than emergency dental treatment, unless the Primary Enrollee resides outside the United States, its territories, or possessions.

l) Treatment of injuries or illness covered by workers' compensation or employers' liability laws; services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law.

Diagnostic and Preventive Benefits (Type I Procedures) - AmFirst shall pay or otherwise discharge the percentage shown in the Group Highlights page of the Contract Allowance for the following services:

Diagnostic: procedures to aid the Dentist in choosing required dental treatment.

Preventive: prophylaxis (cleaning); topical application of fluoride solutions; sealants (topically applied acrylic, plastic or composite materials used to seal developmental grooves and pits in teeth for the purpose of preventing decay, Exams and radiographs.

Limitations on Diagnostic and Preventive Benefits (Type I Procedures)

a) AmFirst will not pay for more than one (1) prophylaxis, (cleaning), done in any six (6) month period that the Enrollee is covered by any AmFirst program.

b) AmFirst will not pay for more than one (1) oral exam done in any six (6) month period that the Enrollee is covered by any AmFirst program.

c) Full-mouth x-rays or panographic x-rays will be provided when required by the Dentist, but no more than one set each 36-month period will be paid by AmFirst.

d) Bitewing x-rays are limited to one (1) set each six (6) month period.

e) Topical applications of fluoride are limited to one (1) each six (6) month period when provided to Enrollees under age 19; furthermore, AmFirst will not pay for topical application of fluoride for an Enrollee 19 years or older.

f) Sealant applications to any one posterior permanent tooth are limited to one (1) each 36-month period.

4.08 **Basic Benefits (Type II Procedures)** AmFirst shall pay or otherwise discharge the percentage shown in Appendix A of the Contract Allowance for the following services:

Preventive: space maintainers.

Restorative: Amalgam (including polishing), silicate restorations, filled or unfilled resin restorations and other restorative services.

Palliative: treatment to relieve pain.

Limitations on Basic Benefits (Type II Procedures) - AmFirst limits space maintainers to covered persons under the age of 16 years, once per consecutive 60 months. Benefit includes all adjustments within six (6) months of installation.

4.10 **Major Benefits (Type III Procedures)** AmFirst shall pay or otherwise discharge the percentage shown in Appendix A of the Contract Allowance for the following services:

Oral Surgery: extractions, surgical extractions, alveoloplasty, vestibuloplasty, surgical incision, and other surgical procedures.

Endodontics: pulp capping, pulpotomy, root canal therapy, and periapical services.

Periodontics: surgical services (including unusual postoperative services) and adjunctive periodontal services.

Prosthodontics: Complete & partial dentures (including routine post-procedure care), adjustments to dentures, repairs to dentures, denture reline procedures, other removable prosthetic devices, bridge pontics, bridge retainers – crowns, and other fixed prosthetic services.

IV Orthodontics: The procedures performed by a Dentist using appliances to treat poor alignment of teeth and/or jaws which significantly interferes with their function.

Limitations on Prosthodontic Benefits

a) The maximum amount paid by AmFirst for each Enrollee during the Calendar year is shown in Group Highlights.

b) AmFirst will not pay to replace any crown, jacket or cast restoration, which the patient received in the previous 5 years.

c) AmFirst will not pay to replace any bridge or denture that the patient received in the previous 5 years. An exception is made if the bridge or denture cannot be made satisfactory due to a change in supporting tissues or because too many teeth have been lost.

d) AmFirst limits Benefits for dentures to a standard partial or complete denture. A "standard" denture means a removable appliance to replace missing natural, permanent teeth.

e) AmFirst will not pay for implants (artificial teeth implanted into or on bone or gums) or their removal; but AmFirst will credit the cost of a standard complete or partial denture that would have been allowed under this plan toward the cost of an implant and related services (copayments apply.)

Limitations on Orthodontic Benefits Type IV

a) The maximum amount paid by AmFirst for each Enrollee during the Calendar year and Enrollee's lifetime is shown in Group Highlights.

b) Payment of Orthodontics is provided monthly.

c) Orthodontic Benefits begin with the first payment due after the person becomes covered, if treatment has begun.

d) Benefits end with the next payment due after the loss of coverage. Benefits end immediately if treatment stops or if this Contract is terminated.

e) Benefits are not paid to repair or replace any orthodontic appliance received under this Contract.

f) X-rays or extractions are not subject to the Orthodontic maximum.

g) Surgical procedures are not subject to the Orthodontic maximum.

h) Orthodontic Benefits are limited to Dependent Enrollees within the ages shown in Group Highlights.

i) Orthodontic Benefits are limited to Dependent Children who have been enrolled in this plan for 12 consecutive months. This provision will be waived for Eligible Persons and their Eligible Dependents who were enrolled in the Applicant's previous plan.

Coordination of Benefits

AmFirst matches the Benefits under this program with your benefits under any other group pre-paid program or benefit plan. (This does not apply to a blanket school accident policy). Benefits under one of the programs may be reduced so that combined coverage does not exceed the Dentist's fees for covered services. If this is the "primary" program, AmFirst shall not reduce Benefits. But if the other program is the primary one, AmFirst shall reduce Benefits otherwise payable under this program. The reduction shall be the amount paid for or provided under the terms of the primary program for covered services under this program (see BENEFITS, LIMITATIONS & EXCLUSIONS).

How does AmFirst determine which is the "primary" program?:

a) If the other program is not primarily a dental program, this program is primary.

b) If the other program is a dental program, the following rules are applied:
   (1) The program covering the patient as an employee or group member is primary over a program covering the patient as a dependent.
   (2) The plan covering the patient as a dependent child of a person whose date of birth occurs earlier in the calendar year shall be primary over the plan covering the patient as a dependent of a person whose date of birth occurs later in the calendar year provided. However, in the case of a dependent child of legally separated or divorced parents, the plan covering the patient as a dependent of the parent with legal custody, or as a dependent of the custodial parent's spouse (i.e. step-parent) shall be primary over the plan covering the patient as a dependent of the parent without legal custody. If there is a court decree which would otherwise establish financial responsibility for the health care expenses with respect to the child, the benefits of a plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other policy which covers the child as a dependent child.

c) If neither (a) nor (b) applies, the program that has covered the patient longer is primary, except that a plan covering the patient as a laid-off or retired employee or the dependent of a laid-off or retired employee shall be determined after those of a plan covering the patient as an employee or the dependent of an employee. However, if the other plan does not have a provision similar to this provision, then this exception shall not apply.

Benefits and Cost to Insured Using Non-Network Providers

The network of providers under contract with AmFirst shall be sufficient to meet the adequacy and accessibility requirements set forth in the California law, however, an Enrollee may choose to seek services from Non-Participating Dentists. Non-Participating Dentists may charge more than the Contract Allowance. In most cases, the Primary Enrollee will be responsible for the cost of services that exceeds the Contract Allowance. Exceptions to this are detailed below.

If dental services deemed necessary under generally accepted dental practice standards cannot be provided within the network, AmFirst shall arrange for a Non-Participating Dentist to perform those services. The financial responsibility of

the Member to that provider shall be no greater than for the same services rendered by a Participating Provider in the same geographic area.

Dependent Enrollees who do not reside with the Primary Enrollee and who do not reside within the service area may receive benefits for services performed by a Non-Participating Dentist. However, the financial responsibility for cost of services that exceeds the Contract allowance will remain with the Member. The exception to this is for services deemed an emergency under generally accepted dental practice standards. In the case of such an emergency, the financial responsibility of the Member to that provider shall be no greater than for the same services rendered by a Participating Provider in the same geographic area.

Enrollees who are traveling outside the service area may receive benefits for services performed by a Non-Participating Dentist. However, the financial responsibility for cost of services that exceeds the Contract allowance will remain with the Member. The exception to this is for services deemed an emergency under generally accepted dental practice standards. In the case of such an emergency, the financial responsibility of the Member to that provider shall be no greater than for the same services rendered by a Participating Provider in the same geographic area.

When receiving services from a Non-Participating Dentist, the out-of-pocket cost to the member may be greater than when services are provided by a Participating Dentist. The Member is responsible for the cost of services that exceeds the Contract Allowance.

If medically necessary dental services cannot be provided by a Participating Provider, AmFirst will arrange for a Non-Participating Provider to provide those services at the same cost to the Member as those same services provided by a Participating Provider.

Timely Access to Care

Information regarding "Timely Access to Care," at least annually, in or with newsletters, outreach, or other materials that are routinely disseminated to the Policy's insureds, shall be provided.

In a separate section of the provider directory published and maintained by the insurer, a section entitled "Timely Access to Care" shall be included.

On the Internet Web site published and maintained by the insurer, in a manner that allows insureds and prospective insureds to easily locate the information shall be provided.

The insurer shall provide the information required by this section to contracting providers on no less than an annual basis.

The insurer shall also inform a contracting provider of all of the following:

(A) Information about a health insurer's obligation under California law to provide or arrange for timely access to care.

(B) How a contracting provider or insured can contact the health insurer to obtain assistance if a patient is unable to obtain a timely referral to an appropriate provider.

(C) The toll-free telephone number for the Department of Insurance where providers and insureds can file a complaint if they are unable to obtain a timely referral to an appropriate provider.

The insurer may comply with this subdivision by including the information with an existing communication with a contracting provider.

ACCESS STANDARDS: AmFirst must assure that there are adequate full-time equivalents of network providers accepting new patients covered by the policy to accommodate anticipated enrollment growth.

(a) In addition to ensuring compliance with the clinical appropriateness standard set forth above, AmFirst shall ensure that contracted oral provider networks have adequate capacity and availability of licensed health care providers, including generalist and specialist dentists, to offer insureds appointments for covered oral services in accordance with the following requirements:

(1) Urgent appointments shall be offered within 72 hours of the time of request for appointment, when consistent with the covered person's individual needs and as required by professionally recognized standards of practice;

(2) Non-urgent appointments shall be offered within 36 business days of the request for appointment; and

(3) Preventive appointments shall be offered within 40 business days of the request for appointment.

(b) The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of the provider's practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the covered person.

INTERPRETER SERVICES shall be provided and coordinated with scheduled appointments for health care services in a manner that ensures the provision of interpreter services at the time of the appointment consistent with California Code of Regulations, section 2538.6 without imposing delay on the scheduling of the appointment.

AmFirst shall also include with the documents a written notice of the availability of interpretation services in the top 15 languages spoken by limited-English-proficient (LEP) individuals in California as determined by the State Department of Health Care Services.

Upon request, the insured shall receive a written translation of those documents. AmFirst shall have up to, but not to exceed, 21 days to comply with the insured's request for a written translation. If an enrollee requests a translated document, all timeframes and deadline requirements related to the documents that apply to AmFirst and insureds under the provisions of this section and under any regulations adopted pursuant to California Code of Regulations shall begin to run upon AmFirst's issuance of the translated document.

Claims

Claims for Benefits must be filed on a standard Attending Dentist Statement that you or your Dentist may obtain from:

AmFirst Life Insurance Company
P.O. Box 16708
Jackson, Mississippi 39236
(800) 800-1397

Predeterminations

A Dentist may file an Attending Dentist's Statement before treatment, showing the services to be provided to an Enrollee. AmFirst will predetermine the amount of Benefits payable under this Contract for the listed services. Predeterminations are valid for 60 days from the date of the Predetermination but not longer than the Contract's term or beyond the date of the patient's coverage ends.

Claims Appeal

AmFirst will notify the Enrollee if any services submitted on a claim are denied coverage as Benefits, in whole or in part, stating the reason or reasons for the denial. Within 60 days after the receipt of a notice of denial the Enrollee may make a written request for a review of the denial by addressing a letter to AmFirst stating the reason(s) for review or reconsideration and providing any pertinent documents which the Enrollee wishes AmFirst to review.

AmFirst will make a full and fair review. AmFirst may ask for more documents if needed. Some appeals may be referred to a dental consultant or to a peer review committee of your local dental society. A decision will be sent to the Primary Enrollee within 30 days after your request for an appeal is received, unless it is referred to a peer review committee or other unusual circumstances arise. In no event will the decision take longer than 120 days.

Cancellation of Program

AmFirst may cancel the program only:

a) On an anniversary of the Effective Date; or

b) If your Policyholder does not pay the monthly premiums; or

c) If your Policyholder does not provide a list of who is eligible; or

d) If less than the minimum number of Primary Enrollees required under the Contract reported eligible for three months or more.

Proof of Loss

Before approving a claim, AmFirst will be entitled to receive, to such extent as may be lawful, from any attending or examining Dentist, or from hospitals in which a Dentist's care is provided, such information and records relating to attendance to or examination of, or treatment provided to, an Enrollee as may be required to administer the claim, or that an Enrollee be examined by a dental consultant retained by AmFirst, in or near his community or residence. AmFirst shall in every case hold such information and records confidential.

AmFirst will give any Dentist or Enrollee, on request, a standard Attending Dentist's Statement to make a claim for Benefits. To make a claim, the form must be completed and signed by the Dentist who performed the services and by the Enrollee (or the parent or guardian if the patient is a minor) and submitted to AmFirst. If the form is not furnished by AmFirst within 15 days after requested by a Dentist or Enrollee, the requirements for proof of loss set forth in the next paragraph will be deemed to have been complied with upon the submission to AmFirst, within the time established in said paragraph for filing proofs of loss, of written proof covering the occurrence, the character and the extent of the loss for which claim is made.

Written proof of loss must be furnished to the insurer, in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss, within 90 days after the termination of the period for which the insurer is liable, and in case of claim for any other loss, within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the member, later than one year from the time proof is otherwise required.

Time of Payment

Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss.

Subject to due written proof of loss, all accrued indemnities for loss which this policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

To Whom Benefits are Paid

Payment for services provided by a Participating Dentist shall be made directly to the Dentist. Any other payments provided by this Contract shall be made to the Primary Enrollee, unless the Primary Enrollee requests when filing proof of loss that the payment be made directly to the Dentist providing the services. All Benefits not paid to the Dentist shall be payable to the Primary Enrollee, or to his estate, except that if the person is a minor or otherwise not competent to give a valid release, Benefits may be payable to his parent, guardian or to their person actually supporting him. If any indemnity of this policy shall be payable to the estate of the insured member, or to an insured member or beneficiary who is a minor or otherwise not competent to give a valid release, the insurer may pay. such indemnity up to an amount not exceeding $1,000 to any relative by blood or connection by marriage of the insured member or beneficiary who is deemed by the insurer to be equitably entitled thereto. Any payment made by the insurer in good faith pursuant to this provision shall fully discharge the insurer to the extent of such payment.

Subject to any written direction of the insured member in an application or otherwise all or a portion of any indemnities provided by this policy on account of hospital, nursing, medical or surgical service may, at the insurer's option, and unless the insured member requests otherwise in writing not later than the time for filing proof of such loss, be paid directly to the hospital or person rendering such services, but it is not required that the service be rendered by a particular hospital or person.

Legal Actions

No action at law or in equity shall be brought to recover on the Contract prior to expiration of 60 days after proof of loss has been filed in accordance with requirements of the Contract, nor shall an action be brought at all unless brought within 3 years from expiration of the time within proof of loss is required by the Contract.

This Certificate of Insurance constitutes only a summary of the dental service insurance Contract. The complete Contract must be consulted to determine the exact terms and conditions of coverage.

APPENDIX A
AMFIRST UNIFORM PROCEDURE CODE AND NOMENCLATURE

The following is a Complete list of the dental procedures for which benefits are payable under this policy and each procedure's Schedule Maximum, if any. No benefits are payable for a procedure if it is not listed.

DIAGNOSTIC AND PREVENTIVE (TYPE I PROCEDURES)

Diagnostic

Clinical Oral Examinations

0120 Periodic oral examination.
0140 Limited oral evaluation.

Radiographs

0210 Intraoral - complete series (including bitewings).
0220 Intraoral periapical - first film.
0230 Intraoral periapical - each additional film up to 12.
0240 Intraoral - occlusal film.
0250 Extraoral - first film.
0260 Extraoral - each additional film.
0270 Bitewing - single films.
0272 Bitewings - two films.
0274 Bitewings - four films.
0330 Panographic film.

Tests and Laboratory Examinations

0470 Diagnostic cast.

Preventive

Dental Prophylaxis

1110 Prophylaxis - adult.
1120 Prophylaxis - child.

Topical Fluoride Treatment (Office Procedure)

1201 Topical application of fluoride (including prophylaxis) - child.
1203 Topical application of fluoride (excluding prophylaxis) - child.

Other Preventive Services

1351 Sealant - per tooth.

BASIC BENEFITS (TYPE II PROCEDURES)

Preventive

Space Maintenance (Passive Appliances)

1510 Space Maintainer - fixed unilateral.
1515 Space Maintainer - fixed-bilateral.
1520 Space Maintainer - removable-unilateral.
1525 Space Maintainer - removable-bilateral.
1550 Re-cementation of space maintainer.

Restorative

Amalgam Restorations (including Polishing)

2110 Amalgam - one surface, primary.
2120 Amalgam - two surfaces, primary.
2130 Amalgam - three surfaces, primary.
2140 Amalgam - one surface, permanent.
2150 Amalgam - two surfaces, permanent.
2160 Amalgam - three surfaces, permanent.

Silicate Restorations

2210 Silicate cement - per restoration.

Filled or Unfilled Resin Restorations

2310 Acrylic or plastic.
2330 Resin - one surface.
2331 Resin - two surface.
2332 Resin - three surfaces.

Other Restorative Services.

2920 Re-cement Crowns
2940 Sedative filling.

Adjunctive General Services

Unclassified Treatment

9110 Palliative (emergency) treatment of dental pain - minor procedures.

MAJOR BENEFITS (TYPE III PROCEDURES)

Restorative

Inlay Restorations

2510 Inlay, metallic - one surface (excluding gold).
2520 Inlay, metallic - two surfaces (excluding gold).
2530 Inlay, metallic - three surfaces (excluding gold).

Crowns - Single Restorations Only

2710 Crown - Plastic (acrylic).
2721 Crown - resin with predominantly base metal.
2740 Crown - porcelain/ceramic substrate.
2752 Crown - porcelain fused with noble metal.
2810 Crown - 3/4 cast metallic.
2830 Crown - Stainless steel.
2950 Crown buildup - pin retained.
2951 Pin retention - per tooth, in addition to restoration.
2953 Cast post as part of crown.
2954 Prefabricated post and core in addition to crown.

Oral Surgery

Extractions - Includes Local Anesthesia and Routine Postoperative Care

7110 Single tooth.
7120 Each additional tooth.

Surgical Extractions - Includes Local Anesthesia and Routine Postoperative Care

7210 Surgical removal of erupted tooth requiring elevation of mucoperiosteal lap and removal of bone and/or section of tooth.
7220 Removal of impacted tooth - soft tissue.
7230 Removal of impacted tooth - partially bony.
7240 Removal of impacted tooth - completely bony.

Other Surgical Procedures

7280 Surgical exposure of impacted or unerupted tooth for orthodontic reasons (including orthodontic attachments).

Alveoloplasty - Surgical Preparation of Ridge for Dentures

7310 Alveoloplasty in conjunction with extractions - per quadrant.
7320 Alveoloplasty not in conjunction with extractions - per quadrant.

Vestibuloplasty

7340 Vestibuloplasty - ridge extension (secondary epithelialization).

Surgical Incision

7510 Incision and drainage of abscess - intraoral soft tissue.

Endodontics

Pulp Capping

3110 Pulp cap - direct (excluding final restoration).
3120 Pulp cap - indirect (excluding final restoration).

Pulpotomy

3220 Therapeutic pulpotomy (excluding final restoration).

Root Canal Therapy (Including Treatment Plan, Clinical Procedures, and Follow-up Care)

3310 One canal (excluding final restoration).
3320 Two canals (excluding final restoration).
3330 Three canals (excluding final restoration).
3340 Four or more canals (excluding final restoration).
3350 Apexification (treatment may extend over period of 6 to 18 months).

Periapical Services

3410 Apicoectomy (per tooth) - first root.

Periodontics

Surgical Services (Including Unusual Postoperative Services)

4210 Gingivectomy or gingivoplasty - per quadrant.
4211 Gingivectomy or gingivoplasty - per tooth.
4220 Gingival curettage, by report.
4240 Gingival flap curettage (including root planning).
4260 Osseus surgery (including flap entry and closure) - per quadrant.

Adjunctive Periodontal Services

4340 Root Planning - entire mouth.
4341 Root Planning - per quadrant.
4910 Periodontal Prophylaxis.

Prosthodontics (Removable)

Complete Dentures (Including Routine Post Delivery Care)

5110 Complete upper.
5120 Complete lower.
5130 Immediate upper.
5140 Immediate lower.

Partial Dentures (Including Routine Post Delivery Care)

5211 Upper partial - acrylic base (including any conventional clasps and rests).
5212 Lower partial - acrylic base (including any conventional clasps and rests).
5213 Upper partial - cast chrome base with acrylic saddles (including any Conventional clasps and rests).
5214 Lower partial - cast chrome base with acrylic saddles (including any conventional clasps and rests).
5216 Lower partial - cast gold base with acrylic saddles (including any conventional clasps and rests).
5281 Removable unilateral partial denture - one-piece chrome casting, clasp attachments - per unit (including pontics).

Adjustments to Dentures

5410 Adjust complete denture - upper (more than six months after installation).

5411 Adjust complete denture - lower (more than six months after installation).
5421 Adjust partial denture - upper (more than six months after installation).
5422 Adjust partial denture - lower (more than six months after installation).

Repairs to Dentures

5520 Replace missing or broken teeth - complete denture (each tooth)
5640 Replace broken teeth or denture, no other repairs.
5650 Add tooth to existing partial denture.
5660 Add clasp to existing partial denture.

Denture Reline Procedures

5730 Reline complete upper denture (chair side).
5731 Reline complete lower denture (chair side).
5740 Reline upper partial denture (chair side).
5741 Reline lower partial denture (chair side).
5750 Reline complete upper denture (laboratory).
5751 Reline complete lower denture (laboratory).
5760 Reline upper partial denture (laboratory).
5761 Reline lower partial denture (laboratory).

Other Removable Prosthetic Services

5820 Temporary partial - stayplate denture (upper).
5821 Temporary partial - stayplate denture (lower).

Prosthodontics, Fixed (Each Abutment and Each Pontic Constitutes a Unit in a Bridge)

Bridge Pontics

6211 Pontic - cast predominantly base metal.
6241 Pontic - porcelain fused to predominantly base metal.
6251 Pontic - resin with predominantly base metal.

Bridge Retainers - Crowns

6710 Crown - resin.
6721 Crown - resin with predominantly base metal.
6751 Crown - porcelain fused to predominantly base metal.
6791 Crown - full cast predominantly base metal.

Other Fixed Prosthetic Services

6930 Recement bridge.
6940 Stress breaker.

Orthodontics IV

Minor treatment for tooth guidance

8110 Upper retainer.
8112 Lower retainer.
8120 Fixed appliance therapy.

Minor treatment to control harmful habits

8210 Removable appliance therapy.
8220 Fixed appliance therapy.

Interceptive orthodontic treatment

8360 Removable appliance therapy.
8370 Fixed appliance therapy.

Comprehensive orthodontic treatment-transitional dentition

8460 Class I malocclusion.
8470 Class II malocclusion.
8480 Class III malocclusion.

Comprehensive orthodontic treatment-permanent dentition

8560 Class I malocclusion.
8570 Class II malocclusion.
8580 Class III malocclusion.

Other orthodontic procedures

8650 Treatment of the atypical or extended skeletal case.
8750 Post-treatment stabilization.

Adjunctive General Services

Anesthesia

9220 General anesthesia.