

EMPLOYEE PLAN OPTIONS

(Employee may select one of the three plans)

Office Visit Copay
Type I: Diagnostic and Preventive ¹
Type II: Basic ¹
Type III: Major ¹
Endodontic & Periodontic Services ¹
Deductible
Calendar Year Maximum
Type I Waiting Period ⁴
Type II Waiting Period ⁴
Type III Waiting Period ⁴
Discount Orthodontic Fee Program

THE COPAY PLAN

Network	Non-Network ²
\$10	
See Schedule AZ500	See Schedule AZ500
See Schedule AZ500	
\$50 per person; \$150 per family; Calendar year (Type II, & III Services)	
None	
None	None
None	None
None	12 months
Included	Not Included

THE PPO MAC PLAN

Network	Non-Network ²
None	
100%	80%
80%	60%
50%	40%
Type II: Basic	
\$50 per person; \$150 per family; Calendar year (Type II, & III Services)	
\$ 1,000 per person	
None	None
None	None
None	None
Included	Not Included

THE PPO UCR PLAN

Network	Non-Network ²
None	
100%	100%
80%	80%
50%	50%
Type II: Basic	
\$50 per person; \$150 per family; Calendar year (Type II, & III Services)	
\$ 1,000 per person	
None	None
None	None
None	None
Included	Not Included

Monthly Premium Rates	Employee
	Employee + Spouse
	Employee + Child(ren)
	Employee + Family
Plan Code	

\$ 17.94
\$ 34.53
\$ 40.03
\$ 51.82
A5A9

\$ 33.89
\$ 64.41
\$ 81.32
\$105.34
2MCO

\$ 47.73
\$ 89.07
\$105.01
\$136.33
2201

¹ SUMMARY OF COVERED SERVICES (The Certificate of Coverage will include a complete list of Covered Services)	
Type I: Diagnostic & Preventive	Oral Examinations (2 per calendar year) * Routine Cleanings (2 per calendar year) * Topical fluoride up to age 16 (1 per calendar year) * Diagnostic x-rays, full or panoramic (1 in any 3-year period) * Bitewing x-rays (2 per calendar year) * Emergency palliative treatment to relieve pain * Space maintainers (for premature loss of primary tooth).
Type II: Basic	Fillings using amalgam, silicate, acrylic, synthetic porcelain and composite filling materials * Simple extractions * Antibiotic injections administered by Dentist * Oral Surgery, including customary postoperative treatment. * Endodontics - root canal therapy, pulpotomy * Periodontics - treatment of gum disease.
Type III: Major	Restorative - inlays, onlays, crowns (5-year waiting period for replacement) * Prosthodontics - full or partial dentures or bridges (5-year waiting period for replacement) * Endodontics - root canal therapy, pulpotomy * Periodontics - treatment of gum disease.

NOTES: Pre Treatment Review recommended for services or supplies over \$300. **ELIGIBILITY:** Full-time Employees working at least 30 hours per week, and their dependents. See page 2 for details.
 2-For PPO MAC plans, non-network benefits are paid on a Maximum Allowable Charge (MAC) basis. For PPO, Indemnity & SecureFlex UCR plans, non-network benefits are paid on a Usual, Customary, and Reasonable (UCR) basis. The employee is responsible for non-network balance billing that may result.
 4-Replacement Benefits: Time periods satisfied under the employer's prior qualifying group dental plan (without coverage gap) will reduce Type I, II, III Waiting Periods.

Insured benefits under the SecureCare Dental Insurance Plan are provided under the Master Policy. This brochure is a summary of the SecureCare Dental benefits. It is not a contract and not part of the policy, but simply an outline of benefits provided under the Master Group Policy. For complete details consult the Certificate of Coverage.

SecureCare Dental Plan Information

Eligibility for Enrollment

You may enroll yourself for coverage if you (1) are an active employee; (2) meet your employer's eligibility criteria (e.g., number of work hours, job classification); and (3) have completed any applicable waiting period for coverage.

An employee may also enroll (1) his/her lawful spouse; (2) his/her child (natural, legally-adopted, step, or foster) who is under age 26; (3) his/her grandchild who is under age 19, and whom the employee can claim as an exemption on his/her federal income tax return; and (4) his/her handicapped child or grandchild older than the maximum age limit, who receives at least 50% support and care from the employee.

Effective Date of Coverage

Your coverage will begin on the first day of the month following your completed enrollment, provided (1) you are Actively At Work on such date; and (2) your first premium has been paid by you, or on your behalf. (Actively At Work means you are performing all customary job duties of your occupation, at your usual place of employment [or would be able to do so if it is a regular paid vacation day, or a regular non-working day, provided you are at work on the last preceding regular work day].)

If you enroll for dependent coverage, such coverage will begin the same day your coverage begins. If you enroll for dependent coverage at a later date, coverage on such eligible dependent(s) will begin on the first day of the month following completed enrollment, and payment of premium. If a dependent is Disabled (hospital confined; or unable to perform the regular and customary activities of a person in good health, and of the same age) on the date their coverage is to begin, coverage on that dependent will be delayed until the first of the month coincident with, or next following, the date Disability no longer exists.

End of Coverage

Your coverage will end on the earliest of (1) the date the policy ends; (2) the date you enter the Armed Forces of any country; (3) the end of the month during which you cease eligibility; or (4) the end of the last period for which premium payment has been made by you or on your behalf. Coverage on your dependents will end on the earliest of (1) the date your coverage ends; (2) the date your dependent no longer meets eligibility requirements; (3) the date

your dependent enters the Armed Forces of any country; or (4) the end of the last period for which premium payment has been for dependent coverage.

Expenses Not Covered

No benefits are payable for, and any applicable Deductible amount may not be reduced by, any of the following:

- any service or supply (a) not listed as a Covered Service within the Schedule of Benefits, (b) payable under any medical expense plan, or (c) rendered by someone who is related to the covered person by blood, marriage, or adoption; or is normally a member of the covered person's household;
- any procedure (a) begun, but not completed; (b) begun before insurance begins; or (c) begun after insurance ends;
- any prosthetic appliance (a) for which the impression (for new or modified device) was made before insurance begins; (b) installed before insurance begins; or (c) finally installed or delivered more than 30 days after insurance ends;
- any treatment which is elective, or primarily cosmetic in nature, and/or not recognized as a generally accepted dental practice by the American Dental Association, as well as any replacement of prior cosmetic restorations;
- any procedure that (a) is determined to be not Medically Necessary, (b) does not offer a favorable prognosis, (c) does not have uniform professional endorsement, or (d) is experimental in nature;
- the correction of congenital malformations, including anodontia and cleft palate;
- the replacement of lost, discarded, or stolen appliances; or any duplicate device or appliance;
- cast restorations, inlays, onlays, and crowns for teeth that are not broken down by extensive decay or accidental injury, or for teeth that can be restored by other means (such as an amalgam or composite filling);
- restoration of third molars, except fillings;
- crowns, inlays and onlays used to restore teeth with micro fractures or fracture lines, undermined cusps, or existing large restorations without overt pathology;
- replacement of (a) bridges, (b) full or partial dentures, (c) crowns, inlays or onlays, or (d) occlusal guards (night guards, except for bruxism); unless such item is more than five years old and cannot be made serviceable;
- appliances, services, or procedures relating to: (a) the change or maintenance of vertical dimension; (b) correction of attrition, abrasion, erosion, or abfraction; (c) biteregistration; (d) bite analysis; or (e) splints, other than provisional splints;
- Procedures related to implants (other than what is listed as covered in COVERED DENTAL SERVICES, CLASS/TYPE III Major Services, item 11.), and any complications as of the result of implants; removal of implants; precision or semi-

precision attachments; denture duplication; overdentures and surgery; or other customized services or attachments

- services provided for any type of (a) temporomandibular joint (TMJ) dysfunction; (b) muscular or skeletal deficiencies involving TMJ or related structures; or (c) myofascial pain;
- orthognathic surgery;
- orthodontic treatment, unless stated otherwise;
- treatment of malignancies;
- general anesthesia and intravenous sedation (regardless of the age of the patient), except in conjunction with covered oral surgery procedures;
- hospital services, or services of anesthetists or anesthesiologists;
- prescribed drugs;
- any instruction for diet, plaque control, or oral hygiene;
- dental disease, defect, or injury caused by a declared or undeclared war, or any act of war;
- charges for failure to keep a scheduled visit, or for the completion of any claim forms;
- expenses compensable under Workers' Compensation or Employers' Liability Laws or by any coverage provided or required by law (including, but not limited to, group, group-type and individual automobile "No Fault" coverage);
- expenses provided, or paid for, by any governmental program or law, except as to charges which the person is legally required to pay;
- services for which there would be no charge in the absence of insurance, or for any service or treatment provided without charge;
- Interpretation of a diagnostic image by a practitioner not associated with the capture.

Coordination of Benefits

Other coverage you have may affect benefits payable under the policy, to ensure that the total benefits from all plans will not exceed 100% of eligible expenses.

Administered by:

Southwest Preferred Dental Organization

Underwritten by:

**American National Life Insurance Company of Texas
Galveston, TX**

SECURECARE DENTAL

COPAY SCHEDULE AZ500 - SCHEDULE OF COPAYMENTS

GENERAL INFORMATION

Lab fees are included in “**Network General Dentist Copay**” unless indicated by specific code. Services not listed are not covered. Services listed in the Limitations and Exclusions section of the Certificate of Coverage, as well as, services determined to be unnecessary by the member’s general dentists or specialist are not covered.

You can search for a General or Specialist dentist on our website at www.securecaredental.com. Click the Look For a Dentist link and follow the instructions. Please note the contracted dentist needs to be seen at the address listed to receive In Network Benefits.

For **SECURECARE DENTAL** customer service call (602)241-0914 or toll free (888)429-0914.

GENERAL DENTIST

Copays in the column entitled “**Network General Dentist Copay**” apply to services performed by **SECURECARE DENTAL** contracted general dentists. Along with any applicable Office Visit Copay and/or Deductible listed on your Schedule of Dental Benefits, the “**Network General Dentist Copay**” is all that you will pay when you visit a contracted general dentist.

Visiting a non-contracted dentist is not recommended. The plan is designed for use with a contracted dentist in order to limit your out-of-pocket cost beyond the listed copayment.

SPECIALIST DENTIST

SECURECARE DENTAL has contracted specialists of oral surgery, endodontics, periodontics, pediatric dentists and prosthodontics. Referrals and Prior Authorization are not required to see a specialist. You may call directly and make an appointment. Please note Pediatric Dentists are Specialists and “**Network Specialist Copays**” apply when seeking treatment from a Pediatric Dentist.

Along with any applicable Office Visit Copay and/or Deductible shown on your Schedule of Dental Benefits, as a **SECURECARE DENTAL** member, all you will pay when you visit a network specialist, is the copay listed in the “**Network Specialist Copay**” column.

Visiting a non-contracted specialist is not recommended. The plan is designed for use with a contracted specialist in order to limit your out-of-pocket cost beyond the listed copayment.

ORTHODONTICS

For a description of the Orthodontic Services available to you, see your Certificate of Coverage.

COVERED SERVICES	ADA CODE	NETWORK GENERAL DENTIST COPAY	NETWORK SPECIALIST DENTIST COPAY	COVERED SERVICES	ADA CODE	NETWORK GENERAL DENTIST COPAY	NETWORK SPECIALIST DENTIST COPAY
Type I - Diagnostic/Evaluation Services							
Periodic Oral Evaluation	D0120	\$0	\$19	Panoramic Image - Image Capture Only	D0701	\$11	\$114
Limited Oral Evaluation - Problem Focused	D0140	\$0	\$44	Intraoral - Occlusal Image - Image Capture Only	D0706	\$6	\$36
Oral Evaluation - under 3 years old	D0145	\$0	\$50	Intraoral - Periapical image - Image Capture Only	D0707	\$6	\$21
Comprehensive Oral Evaluation	D0150	\$0	\$38	Intraoral - Bitewing Image - Image Capture Only	D0708	\$6	\$21
Detailed and Extensive Oral Eval - Problem Focused	D0160	\$0	\$117	Intraoral - Complete Series - Image Capture Only	D0709	\$11	\$93
Re-evaluation - Limited - Problem Focused	D0170	\$0	\$29	Type I - Preventive Services			
Re-evaluation Post-Operative Office Visit	D0171	\$0	\$0	Prophylaxis Cleaning - Adult	D1110	\$0	\$20
Comprehensive Periodontal Evaluation	D0180	\$0	\$53	Prophylaxis Cleaning - Child	D1120	\$0	\$22
Intraoral - Complete Series of Images	D0210	\$11	\$68	Fluoride - Topical Application of Fluoride Varnish	D1206	\$0	\$42
Intraoral - Periapical - 1st Image	D0220	\$6	\$19	Fluoride - Topical Application Fluoride excl Varnish	D1208	\$0	\$15
Intraoral - Periapical - Each Additional Image	D0230	\$6	\$20	Sealant - Per Tooth	D1351	\$17	\$37
Intraoral - Occlusal Image	D0240	\$6	\$33	Preventive Resin Restoration (Including Sealant)	D1352	\$19	\$51
Extraoral - 2D Image	D0250	\$6	\$30	Sealant Repair - Per Tooth	D1353	\$18	\$52
Extraoral - Posterior Image	D0251	\$13	\$38	Space Maintainer; Fixed Unilateral - per quad	D1510	\$111	\$250
Bitewing - 1 Image	D0270	\$6	\$18	Upper Space Maintainer; Fixed Bilateral	D1516	\$117	\$311
Bitewing - 2 Images	D0272	\$6	\$28	Lower Space Maintainer; Fixed Bilateral	D1517	\$117	\$311
Bitewing - 3 Images	D0273	\$6	\$33	Space Maintainer; Removable Unilateral - per quad	D1520	\$84	\$224
Bitewing - 4 Images	D0274	\$6	\$36	Upper Space Maintainer; Removable Bilateral	D1526	\$84	\$326
Vertical Bitewings - 7 to 8 Images	D0277	\$6	\$49	Lower Space Maintainer; Removable Bilateral	D1527	\$84	\$326
Panoramic Image	D0330	\$11	\$67	Re-cement or Re-bond Bilateral Upper Space Maintainer	D1551	\$26	\$42
Pulp Vitality Tests	D0460	\$0	\$0	Re-cement or Re-bond Bilateral Lower Space Maintainer	D1552	\$26	\$42
Diagnostic Casts	D0470	\$11	\$86	Re-cement or Re-bond Unilateral Space Maintainer - per quad	D1553	\$26	\$42

COPAY SCHEDULE AZ500 - SCHEDULE OF COPAYMENTS

COVERED SERVICES	ADA CODE	NETWORK GENERAL DENTIST COPAY	NETWORK SPECIALIST DENTIST COPAY	COVERED SERVICES	ADA CODE	NETWORK GENERAL DENTIST COPAY	NETWORK SPECIALIST DENTIST COPAY
Distal Shoe Space Maintainer - Fixed - Unilateral - per quad	D1575	\$107	\$141	Crown - Porcelain with Predominantly Base Metal	D2751	\$389	\$652
Type II - Restorative Dentistry				Crown - Porcelain With Noble Metal	D2752	\$400	\$669
Amalgam - 1 Surface - Primary or Permanent	D2140	\$39	\$118	Crown - Porcelain with Titanium	D2753	\$389	\$716
Amalgam - 2 Surfaces - Primary or Permanent	D2150	\$39	\$146	Crown - ¾ Cast High Noble Metal	D2780	\$411	\$709
Amalgam - 3 Surfaces - Primary or Permanent	D2160	\$39	\$176	Crown - ¾ Cast Predominantly Base Metal	D2781	\$375	\$628
Amalgam - 4+ Surfaces - Primary or Permanent	D2161	\$44	\$202	Crown - ¾ Cast Noble Metal	D2782	\$389	\$665
Resin Composite - 1 Surface - Anterior	D2330	\$50	\$131	Crown - ¾ Porcelain/Ceramic	D2783	\$404	\$727
Resin Composite - 2 Surfaces - Anterior	D2331	\$53	\$142	Crown - Full Cast High Noble Metal	D2790	\$400	\$701
Resin Composite - 3 Surfaces - Anterior	D2332	\$64	\$175	Crown - Full Cast Predominantly Base Metal	D2791	\$386	\$669
Resin Composite - 4+ Surfaces - Anterior	D2335	\$81	\$223	Crown - Full Cast Noble Metal	D2792	\$393	\$678
Resin Composite Crown - Anterior	D2390	\$56	\$183	Crown - Titanium	D2794	\$400	\$755
Resin Composite - 1 Surface - Posterior	D2391	\$54	\$132	Re-cement/Re-bond Inlay/Onlay/Partial Restoration	D2910	\$20	\$32
Resin Composite - 2 Surfaces - Posterior	D2392	\$71	\$175	Re-cement/Re-bond Crown	D2920	\$52	\$63
Resin Composite - 3 Surfaces - Posterior	D2393	\$79	\$212	Prefabricated Porcelain/Ceramic Crown - Permanent	D2928	\$158	\$280
Resin Composite - 4+ Surfaces - Posterior	D2394	\$79	\$253	Prefabricated Porcelain/Ceramic Crown - Primary	D2929	\$158	\$250
Type III - Onlays Crowns and Bridges				Prefabricated Stainless Steel Crown - Primary	D2930	\$109	\$227
Inlay - Metallic - 1 Surface	D2510	\$219	\$563	Prefabricated Stainless Steel Crown - Permanent	D2931	\$70	\$197
Inlay - Metallic - 2 Surfaces	D2520	\$278	\$647	Prefabricated Resin Crown	D2932	\$97	\$280
Inlay - Metallic - 3+ Surfaces	D2530	\$354	\$739	Protective Restoration	D2940	\$9	\$40
Onlay - Metallic - 2 Surfaces	D2542	\$346	\$784	Core Build Up - Including any Pins when required	D2950	\$103	\$197
Onlay - Metallic - 3 Surfaces	D2543	\$363	\$718	Pin Retention - Per Tooth - in Addition to Restoration	D2951	\$17	\$22
Onlay - Metallic - 4+ Surfaces	D2544	\$363	\$573	Cast Post and Core - in Addition to Crown	D2952	\$143	\$304
Inlay - Porcelain/Ceramic - 1 Surface	D2610	\$245	\$711	Cast Post and Core - Each Additional - same tooth	D2953	\$97	\$126
Inlay - Porcelain/Ceramic - 2 Surfaces	D2620	\$354	\$752	Prefabricated Post and Core - in Addition to Crown	D2954	\$113	\$235
Inlay - Porcelain/Ceramic - 3+ Surfaces	D2630	\$327	\$702	Post Removal	D2955	\$0	\$0
Onlay - Porcelain/Ceramic - 2 Surfaces	D2642	\$300	\$726	Each Additional Prefabricated Post - same tooth	D2957	\$43	\$46
Onlay - Porcelain/Ceramic - 3 Surfaces	D2643	\$311	\$709	Labial Veneer (resin laminate) - Chairside	D2960	\$219	\$598
Onlay - Porcelain/Ceramic - 4+ Surfaces	D2644	\$422	\$680	Labial Veneer (resin laminate) - Laboratory	D2961	\$380	\$687
Inlay - Resin Composite - 1 Surface	D2650	\$128	\$354	Labial Veneer (porcelain laminate) - Laboratory	D2962	\$344	\$638
Inlay - Resin Composite - 2 Surfaces	D2651	\$178	\$442	Crown Repair	D2980	\$68	\$138
Inlay - Resin Composite - 3+ Surfaces	D2652	\$235	\$475	Inlay Repair	D2981	\$68	\$137
Onlay - Resin Composite - 2 Surfaces	D2662	\$229	\$388	Onlay Repair	D2982	\$68	\$137
Onlay - Resin Composite - 3 Surfaces	D2663	\$295	\$521	Veneer Repair	D2983	\$68	\$137
Onlay - Resin Composite - 4+ Surfaces	D2664	\$362	\$597	Type III - Endodontics			
Crown - Resin Based Composite - Indirect	D2710	\$161	\$188	Pulp Cap - Direct (Excluding Final Restoration)	D3110	\$21	\$66
Crown - ¾ Resin Based Composite - Indirect	D2712	\$150	\$298	Pulp Cap - Indirect (Excluding Final Restoration)	D3120	\$17	\$49
Crown - Resin with High Noble Metal	D2720	\$447	\$724	Therapeutic Pulpotomy (Excluding Final Restoration)	D3220	\$49	\$142
Crown - Resin with Base Metal	D2721	\$432	\$718	Pulpal Debridement - Primary/Permanent	D3221	\$51	\$185
Crown - Resin with Noble Metal	D2722	\$438	\$734	Partial Pulpotomy for Apexogenesis	D3222	\$51	\$150
Crown - Porcelain/Ceramic	D2740	\$422	\$723	Pulpal Therapy Anterior - Primary	D3230	\$68	\$153
Crown - Porcelain with High Noble Metal	D2750	\$422	\$695	Pulpal Therapy Posterior - Primary	D3240	\$60	\$167
				Root Canal - Anterior (Excluding Final Restoration)	D3310	\$194	\$427

COPAY SCHEDULE AZ500 - SCHEDULE OF COPAYMENTS

COVERED SERVICES	ADA CODE	NETWORK GENERAL DENTIST COPAY	NETWORK SPECIALIST DENTIST COPAY	COVERED SERVICES	ADA CODE	NETWORK GENERAL DENTIST COPAY	NETWORK SPECIALIST DENTIST COPAY
Root Canal - Premolar (Excluding Final Restoration)	D3320	\$266	\$564	Perio. Scaling & Root Planing - 4+ teeth/quad	D4341	\$95	\$193
Root Canal - Molar (Excluding Final Restoration)	D3330	\$422	\$820	Perio. Scaling & Root Planing - 1 to 3 teeth/quad	D4342	\$52	\$117
Treatment of Root Canal Obstruction - non surgical	D3331	\$152	\$237	Scaling - Full Mouth - After Oral Evaluation	D4346	\$49	\$43
Incomplete Endodontic Therapy - Inoperable/Fractured	D3332	\$202	\$473	Full Mouth Debridement	D4355	\$56	\$150
Internal Root Repair of Perforation Defects	D3333	\$194	\$220	Periodontal Maintenance Procedures	D4910	\$60	\$115
Retreatment of Previous RCT - Anterior	D3346	\$340	\$760				
Retreatment of Previous RCT - Premolar	D3347	\$345	\$808	Type III - Removable Prosthetics			
Retreatment of Previous RCT - Molar	D3348	\$355	\$1,042	Complete Denture - Upper	D5110	\$416	\$1,112
Apexification/Recalcification - Initial Visit	D3351	\$51	\$282	Complete Denture - Lower	D5120	\$400	\$1,096
Apexification/Recalcification - Interim Visit	D3352	\$51	\$132	Immediate Denture - Upper	D5130	\$416	\$1,280
Apexification/Recalcification - Final Visit	D3353	\$51	\$395	Immediate Denture - Lower	D5140	\$416	\$1,280
Apicoectomy - Anterior	D3410	\$225	\$625	Upper Partial Denture - Resin Base	D5211	\$354	\$1,076
Apicoectomy - Premolar - 1st Root	D3421	\$245	\$725	Lower Partial Denture - Resin Base	D5212	\$354	\$1,296
Apicoectomy - Molar - 1st Root	D3425	\$383	\$973	Upper Partial Denture - Cast Metal Frame - Resin Base	D5213	\$461	\$1,347
Apicoectomy - Each Additional Root	D3426	\$51	\$154	Lower Partial Denture - Cast Metal Frame - Resin Base	D5214	\$461	\$1,347
Retrograde Filling - Per Root	D3430	\$51	\$175	Upper Immediate Partial Denture - Resin Base	D5221	\$553	\$1,181
Root Amputation - Per Root	D3450	\$113	\$416	Lower Immediate Partial Denture - Resin Base	D5222	\$553	\$1,421
Hemisection (Including any Root Removal)	D3920	\$113	\$364	Upper Immediate Partial Denture - Cast Metal with Resin	D5223	\$725	\$1,519
Canal Preparation/Post Fitting	D3950	\$0	\$0	Lower Immediate Partial Denture - Cast Metal with Resin	D5224	\$725	\$1,519
				Upper Partial Denture - Flexible Base	D5225	\$461	\$1,544
Type III - Periodontics				Lower Partial Denture - Flexible Base	D5226	\$461	\$1,544
Gingivectomy/Gingivoplasty - 4+ teeth/quad	D4210	\$245	\$701	Upper Removable Unilateral Partial Denture - Cast Metal	D5282	\$286	\$769
Gingivectomy/Gingivoplasty - 1 to 3 teeth/quad	D4211	\$68	\$281	Lower Removable Unilateral Partial Denture - Cast Metal	D5283	\$286	\$769
Gingivectomy/Gingivoplasty for restorative procedure	D4212	\$39	\$212	Removable Flexible Unilateral Partial Denture - per quad	D5284	\$286	\$861
Gingival Flap-Incl. Root Planing - 4+ teeth/quad	D4240	\$312	\$817	Removable Resin Unilateral Partial Denture - per quad	D5286	\$286	\$861
Gingival Flap-Incl. Root Planing - 1 to 3 teeth/quad	D4241	\$202	\$514	Adjust Complete Denture - Upper	D5410	\$26	\$59
Crown Lengthening - Hard Tissue	D4249	\$344	\$882	Adjust Complete Denture - Lower	D5411	\$26	\$59
Osseous Surgery - 4+ teeth/quad	D4260	\$422	\$1,486	Adjust Partial Denture - Upper	D5421	\$26	\$20
Osseous Surgery - 1-3 teeth/quad	D4261	\$233	\$656	Adjust Partial Denture - Lower	D5422	\$26	\$20
Pedicle Soft Tissue Graft Procedure	D4270	\$110	\$1,069	Repair Broken Complete Denture Base - Mandibular	D5511	\$61	\$124
Autogenous Connective Tissue Graft - 1st Tooth (excl implants)	D4273	\$375	\$1,159	Repair Broken Complete Denture Base - Maxillary	D5512	\$61	\$124
Mesial/Distal Wedge Procedure - Single Tooth	D4274	\$303	\$707	Replace Missing or Broken Teeth - Complete Denture - Per Tooth	D5520	\$51	\$104
Non-Autogenous Connective Tissue Graft - 1st Tooth (excl implants)	D4275	\$360	\$894	Repair Resin Partial Denture Base - Mandibular	D5611	\$51	\$117
Combined Connective Tissue/Double Pedicle Graft	D4276	\$565	\$1,389	Repair Resin Partial Denture Base - Maxillary	D5612	\$51	\$117
Free Soft Tissue Graft Procedure - 1st Tooth (excl implants)	D4277	\$220	\$1,039	Repair Cast Partial Framework - Mandibular	D5621	\$60	\$113
Free Soft Tissue Graft Procedure - Each Addl Tooth (excl implants)	D4278	\$220	\$260	Repair Cast Partial Framework - Maxillary	D5622	\$60	\$113
Autogenous Connective Tissue Graft - Each Addl Tooth (excl implants)	D4283	\$375	\$957	Repair or Replace Broken Clasp - per tooth	D5630	\$60	\$169
Non-Autogenous Connective Tissue Graft - Each Addl Tooth (excl implants)	D4285	\$360	\$743	Replace Broken Teeth - Per Tooth	D5640	\$60	\$120
Provisional Intracoronal Splint	D4320	\$120	\$364	Add Tooth to Existing Partial Denture	D5650	\$60	\$150
Provisional Extracoronal Splint	D4321	\$118	\$339	Add Clasp to Existing Partial Denture - per tooth	D5660	\$60	\$166
				Replace Teeth/Acrylic on Cast Metal Framework (Upper)	D5670	\$211	\$404
				Replace Teeth/Acrylic on Cast Metal Framework (Lower)	D5671	\$211	\$404

COPAY SCHEDULE AZ500 - SCHEDULE OF COPAYMENTS

COVERED SERVICES	ADA CODE	NETWORK GENERAL DENTIST COPAY	NETWORK SPECIALIST DENTIST COPAY	COVERED SERVICES	ADA CODE	NETWORK GENERAL DENTIST COPAY	NETWORK SPECIALIST DENTIST COPAY
Rebase Complete Upper Denture	D5710	\$110	\$324	Pontic - Cast Predominantly Base Metal	D6211	\$404	\$750
Rebase Complete Lower Denture	D5711	\$110	\$294	Pontic - Cast Noble Metal	D6212	\$421	\$743
Rebase Upper Partial Denture	D5720	\$110	\$330	Pontic - Titanium	D6214	\$431	\$700
Rebase Lower Partial Denture	D5721	\$110	\$330	Pontic - Porcelain Fused to High Noble Metal	D6240	\$355	\$640
Reline Complete Upper Denture (Chairside)	D5730	\$110	\$200	Pontic - Porcelain Fused to Predominantly Base Metal	D6241	\$355	\$612
Reline Complete Lower Denture (Chairside)	D5731	\$110	\$200	Pontic - Porcelain Fused to Noble Metal	D6242	\$355	\$650
Reline Upper Partial Denture (Chairside)	D5740	\$110	\$172	Pontic - Porcelain Fused to Titanium	D6243	\$355	\$652
Reline Lower Partial Denture (Chairside)	D5741	\$110	\$172	Pontic - Porcelain/Ceramic	D6245	\$493	\$718
Reline Complete Upper Denture (Laboratory)	D5750	\$110	\$264	Pontic - Resin with High Noble Metal	D6250	\$391	\$788
Reline Complete Lower Denture (Laboratory)	D5751	\$110	\$264	Pontic - Resin with Predominantly Base Metal	D6251	\$334	\$707
Reline Upper Partial Denture (Laboratory)	D5760	\$110	\$270	Pontic - Resin with Noble Metal	D6252	\$350	\$728
Reline Lower Partial Denture (Laboratory)	D5761	\$110	\$270	Retainer - Cast Metal or Resin Bonded Fixed Prosthesis	D6545	\$270	\$163
Tissue Conditioning - Upper	D5850	\$28	\$51	Retainer - Porcelain/Ceramic/Resin Bonded Fixed Prosthesis	D6548	\$253	\$199
Tissue Conditioning - Lower	D5851	\$26	\$49	Retainer - Resin for Resin Bonded Fixed Prosthesis	D6549	\$265	\$220
Type III - Implants				Retainer Inlay - Porcelain/Ceramic - 2 Surfaces	D6600	\$371	\$549
Surgical Placement of Implant Body - Endosteal	D6010	\$941	\$2,149	Retainer Inlay - Porcelain/Ceramic - 3+ Surfaces	D6601	\$387	\$534
Surgical Placement of Mini Implant	D6013	\$941	\$2,139	Retainer Inlay - Cast High Noble Metal - 2 Surfaces	D6602	\$371	\$543
Prefabricated Abutment - includes modification & placement	D6056	\$253	\$442	Retainer Inlay - Cast High Noble Metal - 3+ Surfaces	D6603	\$431	\$609
Crown - Abutment Supp. Porcelain/Ceramic	D6058	\$601	\$1,203	Retainer Inlay - Cast Predom. Base Metal - 2 Surfaces	D6604	\$337	\$541
Crown - Abutment Supp. Porcelain Fused to High Noble Metal	D6059	\$593	\$1,187	Retainer Inlay - Cast Predom. Base Metal - 3+ Surfaces	D6605	\$387	\$587
Crown - Abutment Supp. Porcelain Fused to Predom. Base Metal	D6060	\$523	\$1,138	Retainer Inlay - Cast Noble Metal - 2 Surfaces	D6606	\$380	\$537
Crown - Abutment Supp. Porcelain Fused to Noble Metal	D6061	\$558	\$1,153	Retainer Inlay - Cast Noble Metal - 3+ Surfaces	D6607	\$421	\$596
Crown - Abutment Supp. Cast High Noble Metal	D6062	\$562	\$1,144	Retainer Onlay - Porcelain/Ceramic - 2 Surfaces	D6608	\$421	\$502
Crown - Abutment Supp. Cast Predominantly Base Metal	D6063	\$446	\$1,017	Retainer Onlay - Porcelain/Ceramic - 3+ Surfaces	D6609	\$438	\$539
Crown - Abutment Supp. Cast Noble Metal	D6064	\$480	\$1,062	Retainer Onlay - Cast High Noble Metal - 2 Surfaces	D6610	\$363	\$597
Crown - Implant Supp. Porcelain/Ceramic Crown	D6065	\$579	\$1,190	Retainer Onlay - Cast High Noble Metal - 3+ Surfaces	D6611	\$447	\$639
Crown - Implant Supp. Porcelain Fused to High Noble Alloy	D6066	\$564	\$1,159	Retainer Onlay - Cast Predom. Base Metal - 2 Surfaces	D6612	\$337	\$622
Crown - Implant Supp. High Noble Alloy	D6067	\$527	\$1,136	Retainer Onlay - Cast Predom. Base Metal - 3+ Surfaces	D6613	\$421	\$606
Crown - Implant Supp. - Porcelain Fused to Predom. Base Alloy	D6082	\$523	\$1,267	Retainer Onlay - Cast Noble Metal - 2 Surfaces	D6614	\$354	\$579
Crown - Implant Supp. - Porcelain Fused to Noble Alloy	D6083	\$558	\$1,284	Retainer Onlay - Cast Noble Metal - 3+ Surfaces	D6615	\$455	\$577
Crown - Implant Supp. - Porcelain Fused to Titanium	D6084	\$558	\$1,284	Retainer Inlay - Titanium	D6624	\$278	\$520
Crown - Implant Supp. - Predom. Base Alloy	D6086	\$446	\$1,398	Retainer Onlay - Titanium	D6634	\$294	\$542
Crown - Implant Supp. - Noble Alloy	D6087	\$480	\$1,181	Retainer Crown - Resin With High Noble Metal	D6720	\$421	\$719
Crown - Implant Supp. - Titanium	D6088	\$522	\$1,014	Retainer Crown - Resin With Base Metal	D6721	\$396	\$715
Re-cement or Re-bond Implant/Abutment Supported Crown	D6092	\$33	\$98	Retainer Crown - Resin With Noble Metal	D6722	\$404	\$710
Crown - Abutment Supp. Titanium	D6094	\$522	\$906	Retainer Crown - Porcelain/Ceramic Substrate	D6740	\$427	\$707
Repair Implant Abutment - By Report	D6095	\$175	\$250	Retainer Crown - Porcelain With High Noble Metal	D6750	\$353	\$606
Remove Broken Implant Retaining Screw	D6096	\$26	\$26	Retainer Crown - Porcelain With Predominantly Base Metal	D6751	\$331	\$577
Crown - Abutment Supp. Porcelain Fused to Titanium	D6097	\$564	\$1,291	Retainer Crown - Porcelain With Noble Metal	D6752	\$353	\$604
				Retainer Crown - Porcelain Fused to Titanium	D6753	\$331	\$605
				Retainer Crown - ¾ Cast High Noble Metal	D6780	\$450	\$661
Type III - Pontics and Retainers				Retainer Crown - ¾ Cast Predominantly Base Metal	D6781	\$396	\$641
Pontic - Cast High Noble Metal	D6210	\$431	\$724	Retainer Crown - ¾ Cast Noble Metal	D6782	\$404	\$567

COPAY SCHEDULE AZ500 - SCHEDULE OF COPAYMENTS

COVERED SERVICES	ADA CODE	NETWORK GENERAL DENTIST COPAY	NETWORK SPECIALIST DENTIST COPAY	COVERED SERVICES	ADA CODE	NETWORK GENERAL DENTIST COPAY	NETWORK SPECIALIST DENTIST COPAY
Retainer Crown - ¾ Porcelain/Ceramic	D6783	\$404	\$692	Removal of Reaction Producing Foreign Bodies - Musculoskeletal System	D7540	\$134	\$690
Retainer Crown ¾ -Titanium	D6784	\$404	\$670	Sequestrectomy for Osteomyelitis	D7550	\$63	\$387
Retainer Crown - Full Cast High Noble Metal	D6790	\$421	\$689	Maxillary Sinusotomy for Removal of Tooth Fragment or Foreign Body	D7560	\$586	\$3,391
Retainer Crown - Full Cast Predominantly Base Metal	D6791	\$414	\$747	Suture of Recent Small Wounds up to 5cm	D7910	\$63	\$602
Retainer Crown - Full Cast Noble Metal	D6792	\$438	\$743	Buccal/Labial Frenectomy (Frenulectomy)	D7961	\$118	\$531
Retainer Crown - Titanium	D6794	\$400	\$701	Lingual Frenectomy (Frenulectomy)	D7962	\$118	\$531
Re-cement or Re-bond Fixed Partial Denture	D6930	\$17	\$84	Excision of Hyperplastic Tissue - Per Arch	D7970	\$113	\$678
Stress Breaker	D6940	\$56	\$142	Excision of Pericoronal Gingiva	D7971	\$89	\$256
Fixed Partial Denture Repair - by Report	D6980	\$110	\$93	Surgical Reduction of Fibrous Tuberosity	D7972	\$337	\$969
				Non-Surgical Sialolithotomy	D7979	\$295	\$915
Type II - Oral Surgery				Surgical Sialolithotomy	D7980	\$295	\$915
Extraction - Coronal Remnants - Primary Tooth	D7111	\$43	\$99	Closure of Salivary Fistula	D7983	\$779	\$2,183
Extraction - Erupted Tooth or Exposed Root	D7140	\$63	\$127				
Extraction - Erupted Tooth	D7210	\$94	\$200	Type - Miscellaneous Services			
Removal of Impacted Tooth - Soft Tissue	D7220	\$102	\$253	I - Palliative (Emergency) Treatment of Pain	D9110	\$20	\$86
Removal of Impacted Tooth - Partially Bony	D7230	\$120	\$329	I - Evaluation for Deep Sedation/General Anesthesia	D9219	\$0	\$0
Removal of Impacted Tooth - Completely Bony	D7240	\$171	\$426	III - Deep Sedation/General Anesthesia - First 15 Min*	D9222	\$53	\$162
Removal of Residual Tooth Roots	D7250	\$81	\$208	III - Deep Sedation/General Anesthesia - Each Additional 15 Min*	D9223	\$53	\$162
Coronectomy - Intentional Partial Tooth Removal	D7251	\$101	\$434	III - Analgesia - Anxiolysis - Inhal Nitrous Oxide*	D9230	\$20	\$40
Oroantral Fistula Closure	D7260	\$123	\$1,538	III - Intravenous Moderate Sedation/Analgesia - First 15 Min*	D9239	\$44	\$138
Tooth Reimplantation and/or Stabilization of Accidentally Evulsed or Displaced Teeth/Alveolus	D7270	\$253	\$621	III - Intravenous Moderate Sedation/Analgesia - Each Additional 15 Min*	D9243	\$44	\$138
Tooth Transplantation	D7272	\$253	\$543	III - Non-Intravenous Conscious Sedation*	D9248	\$70	\$98
Exposure of an Unerrupted Tooth	D7280	\$194	\$430	I - Consultation	D9310	\$0	\$113
Incisional Biopsy of Oral Tissue - Hard (Bone - Tooth)	D7285	\$68	\$903	I - Office Visit for Observ During Regular Scheduled Hours	D9430	\$0	\$0
Incisional Biopsy of Oral Tissue - Soft (All Others)	D7286	\$68	\$366	II - Therapeutic Drug Injection (Antibiotics)	D9610	\$51	\$51
Alveoplasty in Conjunction w/Extract- 4+ Teeth/Per Quad	D7310	\$101	\$351	II - Treatment of Complications (Post Surgical)	D9930	\$17	\$17
Alveoplasty in Conjunction w/Extract- 1 to 3 Teeth/Per Quad	D7311	\$43	\$282	III - Occlusal Guard - Hard Appliance; Full Arch (for Bruxism)	D9944	\$100	\$399
Alveoplasty not in Conjunct w/Extract- 4+ Teeth/Per Quad	D7320	\$152	\$596	III - Occlusal Guard - Soft Appliance; Full Arch (for Bruxism)	D9945	\$100	\$399
Alveoplasty not in Conjunct w/Extract- 1 to 3 Teeth/Per Quad	D7321	\$60	\$457	III - Occlusal Guard - Hard Appliance; Partial Arch (for Bruxism)	D9946	\$100	\$399
Vestibuloplasty-Ridge Ext (2nd Epithelialization)	D7340	\$202	\$2,467	III - Occlusal Adjustment - Limited	D9951	\$53	\$133
Vestibuloplasty-Ridge Ext (Grafts - Hypertissue)	D7350	\$303	\$7,230	III - Occlusal Adjustment - Complete	D9952	\$128	\$712
Removal of Odontogenic Cyst/Tumor <=1.25cm	D7450	\$320	\$1,005				
Removal of Odontogenic Cyst/Tumor > 1.25cm	D7451	\$194	\$1,196	* Covered only when performed in conjunction with covered oral surgery.			
Removal of Nonodontogenic Cyst/Tumor<=1.25cm	D7460	\$346	\$1,043				
Removal of Nonodontogenic Cyst/Tumor> 1.25cm	D7461	\$404	\$1,395				
Removal of Lateral Exostosis - Per Site	D7471	\$105	\$1,333				
Removal of Torus Palantinus	D7472	\$270	\$1,599				
Removal of Torus Mandibularus	D7473	\$270	\$1,507				
Reduction of Osseous Tuberosity	D7485	\$270	\$1,341				
Incision/Drain of Abscess Intraoral Soft Tissue	D7510	\$63	\$341				
Incision/Drain of Abscess Extraoral Soft Tissue	D7520	\$134	\$1,823				
Removal of Foreign Body - Skin or Subc. Areolar Tissue	D7530	\$63	\$675				

ONLINE DENTIST DIRECTORY

Our dentist directory is printed only once a year. Therefore, it is quickly out of date. As a result, our website is the best place to find the most current list of participating dentists.

For an up-to-date list of dentists on your plan please visit our Find a Dentist page at www.securecaredental.com.

Website Advantages

- Updated daily
- New dentists added weekly
- Search online 24 hours a day
- Nominate your Dentist to participate in your plan

For questions or assistance, please contact us at (602) 241-0914. We will be happy to help you!



MORE
REASONS TO SMILE



ORTHODONTIC SERVICES

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

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

STANDARD ORTHODONTIC CARE PROGRAM

MEMBER PAYS

Services Included In Orthodontic Care

Under Age 19 Age 19 & Over

COMPLETE ORTHODONTIC SURVEY FOLLOWED BY BANDING

D9310 – Consultation	D0330 – Panoramic Image		
D0350 – Oral/Facial Images	D9310 – Cephalometric Image	\$450.00	\$450.00
D0201 – Intraoral Images	D0470 – Diagnostic Casts		

ACTIVE COMPREHENSIVE ORTHODONTIC TREATMENT (BANDING)

D8070/D8080/D8090 (Class I, II, or III) Treatment up to 24 months following Complete Orthodontic Survey	\$2,900.00*	\$3,150.00*
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ORTHODONTIC RETENTION

D8680 – Removal of appliances, construction and placement of retainer(s)	\$300.00	\$300.00
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TOTAL STANDARD CARE FEE

\$3,650.00	\$3,900.00
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MORE
REASONS TO SMILE

ORTHODONTIC SERVICES

COVERED SERVICES NOT INCLUDED IN STANDARD CARE PROGRAM FEE **	MEMBER PAYS
Screening Exam/Consultation – D9310	No Charge
Diagnostic Work-up and X-rays (if not done in conjunction with complete treatment – otherwise see “Complete Orthodontic Survey” on other side.)	
D0201 – Intraoral Images D9310 – Cephalometric Image	\$250.00
D0350 – Oral/Facial Images D0470 – Diagnostic Casts	
D0330 – Panoramic Image	
Retainer (each arch) - New, lost or replacement ****	\$240.00
Final Records (Includes Radiographs and Diagnostic Casts)	\$205.00
Space Maintainer – Unilateral – Fixed/Removable – D1520/D1525	\$126 / \$140
Space Maintainer – Bilateral – Fixed/Removable – D1515/D1525	\$187 / \$189
Reattach Brackets and Bands (Limit 3x)	No Charge
Replace Broken Ligature Wires (Limit 3x)	No Charge

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

*Patients assumed after treatment has begun by another dentist and requires shorter than 24 months of active banding may have a prorated decrease to the treatment fee based on the “Banding” charge. (e.g. An 18 month treatment period would be a 25% decrease in the “Banding”. “Diagnostic Work Up and X-rays”, “Orthodontic Retention” Fee may apply.)

** May be charged in addition to the “Standard Care Program.”

****If a only a retainer is needed and the dentist providing the new or replacement retainer did not provide a previous retainer or study models, then he/she may charge, the retainer fee plus no more than the “Complete Orthodontic Survey” fee above.

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

For SecureCare Dental Customer Service

Please call: (602) 241-0914 or toll-free at 1-888-429-0914.

SECURECARE DENTAL

777 East Missouri Ave., Suite 121

Phoenix, AZ 85014

1-888-429-0914

f: 800-275-4064

www.securecaredental.com

Group Name:	Group Number:	Requested Effective Date:
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EMPLOYEE INFORMATION (all fields required)

Reason for application: <input type="checkbox"/> New Hire <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Qualifying Event _____ Qualifying Event Date _____ <input type="checkbox"/> COBRA – Start Date _____		Change: Dependent <input type="checkbox"/> Add <input type="checkbox"/> Remove (select one) Only list dependent(s) to add or remove. If Removing Dependent select "Waive" below for product(s) to term for dependent(s) listed. Change <input type="checkbox"/> Plan <input type="checkbox"/> Address <input type="checkbox"/> Name <input type="checkbox"/> Other:			
<input type="checkbox"/> Termination (Last Day Worked required if leaving company)					
Last Name		First Name	MI	Social Security Number (required)	
Address 1		Apt/Suite #	City	State	Zip Code
Gender	Date of Birth	Best Contact Phone #	Date of Hire (REQUIRED):	Class	
<input type="checkbox"/> M <input type="checkbox"/> F					
Email Address:			Division:		

DEPENDENT INFORMATION

Relationship	SSN	Last Name, First Name, MI	Gender	Date of Birth (mm/dd/yyyy)
Spouse			<input type="checkbox"/> M <input type="checkbox"/> F	
			<input type="checkbox"/> M <input type="checkbox"/> F	
			<input type="checkbox"/> M <input type="checkbox"/> F	
			<input type="checkbox"/> M <input type="checkbox"/> F	
			<input type="checkbox"/> M <input type="checkbox"/> F	
			<input type="checkbox"/> M <input type="checkbox"/> F	

INSURED PRODUCT SELECTION

Select your Plan Type and Enrollees

Dental	<input type="checkbox"/> Copay <input type="checkbox"/> PPO MAC <input type="checkbox"/> PPO UCR/Indemnity <input type="checkbox"/> Prime <input type="checkbox"/> Waive	Plan Code:		Enroll: <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren)
Vision	<input type="checkbox"/> Fashion <input type="checkbox"/> Designer <input type="checkbox"/> Premier <input type="checkbox"/> Waive	Plan Code:		Enroll: <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren)

PREMIER PARTNER PRODUCT SELECTION

Select your plan(s)

Healthiest You Telemedicine <input type="checkbox"/> EMP <input type="checkbox"/> FAM <input type="checkbox"/> Waive	InfoArmor Identity Protection <input type="checkbox"/> EMP <input type="checkbox"/> FAM <input type="checkbox"/> Waive	LegalEase Legal Plans <input type="checkbox"/> EMP <input type="checkbox"/> FAM <input type="checkbox"/> Waive
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OTHER COVERAGE

If you will have other Dental coverage that SecureCare will NOT be replacing, please complete the following information.

Insurance Company	Policy Effective Date
Policyholder Name	Policyholder Date of Birth
Of those to be covered under SecureCare Dental, who is also covered under the other Group Dental Insurance?	
<input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren)	

Employee Name:	Group Name or ID:
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DECLARATION, AGREEMENT, ACKNOWLEDGEMENT

Declaration and Agreement – I hereby apply for coverage as indicated. I hereby authorize any physician, dentist, eye care professional, hospital or insurer having any records or information concerning health history or other insurance on me, or my minor dependents, to furnish such records, data or information as may be requested by the insurer or their duly authorized representative to determine benefits, if any, and/or process claims. I understand that this authorization is valid for a minimum of 12 consecutive months from the date signed. A photocopy of this authorization shall be considered as effective and valid as the original. I understand that I, or any authorized representative, may receive, upon request, a copy of this authorization. **It is the employee’s responsibility to notify the administrator, Southwest Preferred Dental Organization, of any changes of address or family status in writing by completing a new enrollment form.**

Payroll Deduction -- I hereby request, authorize and direct my Employer to deduct the appropriate premium amount from my salary or wages, and any required premium thereafter, and forward that amount to SecureCare. This authorization will remain in effect until revoked by me in writing.

Arizona Fraud Warning: For your protection Arizona law requires the following statement to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Colorado Fraud Warning: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Nevada Fraud 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.

Texas Fraud Warning: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

Utah Fraud Warning: Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits, or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison.

Employee signature
(Faxed signature bears the full authority of the original signature)

Date

Dental and Vision Underwritten by:
American National Life Insurance Company of Texas
Galveston, Texas

Administered by:
Southwest Preferred Dental Organization
777 E Missouri Ave Ste 121 * Phoenix, AZ 85014
Tel: (602) 241-0914 * Toll Free: (888) 429-0914
Email: group@securecaredental.com * Fax: (602) 285-0121
www.securecaredental.com