SECURECARE GROUP INSURANCE

BEST PLACES TO WORK BPtW PHOENIX BUSINESS JOURNAL 2017 2018 2019

Quote For: **VALUED CLIENT**
Presented by: **WORD AND BROWN**
Quote Effective Date: **7-21 - 9-21** Quote ID: **NV-003 - 03012021**
Quote Date: **03/01/2021** **Quote effective for 60 days**

Ask about our individual Dental and Vision Plan.

Group Quote Summary

Dental, Vision, Healthiest You and PrivacyArmor Plus Plans may be bundled for convenience. One contact number. One bill. One Payment. One easy choice.

Dental

5 or more enrolled — EMP SPONSORED

Copay & PPO Plans use same state/national dentist network.

		THE COPAY PLAN (MAC)	THE PPO PLAN (MAC)			THE PPO PLAN (UCR)		
Type I, II, III Coinsurance		Schedule NV500	100% 80% 50%			100% 80% 50%		
Endodontic & Periodontics		Schedule NV500	Type II			Type II		
Deductible		None	$50 per person; $150 per family			$50 per person; $150 per family		
Insured Orthodontia		Not Included	Not Included			Not Included		
Calendar Year Maximum		**None**	**$1,000**	**$1,500**	**$2,000**	**$1,000**	**$1,500**	**$2,000**
Monthly Premium Rates	Employee	$ 16.75	$ 29.26	$ 32.19	$ 34.77	$ 39.05	$ 42.95	$ 46.39
	Employee + Spouse	$ 31.82	$ 55.60	$ 61.16	$ 66.05	$ 74.19	$ 81.61	$ 88.13
	Employee + Child(ren)	$ 36.86	$ 71.44	$ 77.88	$ 83.54	$ 92.57	$ 101.16	$ 108.72
	Employee + Family	$ 47.73	$ 92.53	$ 100.87	$ 108.20	$ 119.91	$ 131.04	$ 140.84
Dental Plan Code		**A5D4**	**2MCF**	**2MCG**	**2MCH**	**2354**	**2355**	**2356**

Dental Implants
Covered Standard

Vision

5 or more enrolled — EMP SPONSORED

		FASHION PLAN		DESIGNER PLAN		PREMIER PLAN	
Copayments: Eye Health Exam; Spectacle Lenses		10 / 25		10 / 25		10 / 10	
Eyeglass Frame Allowance (Retail)		Up to $100 plus 20% off balance		Up to $130 plus 20% off balance		Up to $150 plus 20% off balance	
Frequencies: Eye Exam/Spectacle or Contact Lenses/Frame (months)		**12/12/12**	**12/12/24**	**12/12/12**	**12/12/24**	**12/12/12**	**12/12/24**
Monthly Premium Rates	Employee	$ 6.41	$ 5.73	$ 6.80	$ 6.08	$ 7.42	$ 6.63
	Employee + Spouse	$ 11.69	$ 10.44	$ 12.43	$ 11.10	$ 13.61	$ 12.16
	Employee + Child(ren)	$ 10.82	$ 9.66	$ 11.50	$ 10.27	$ 12.58	$ 11.24
	Employee + Family	$ 16.68	$ 14.89	$ 17.75	$ 15.85	$ 19.45	$ 17.37
Vision Plan Code		**V151**	**V101**	**V152**	**V102**	**V153**	**V103**

Included
One year eyeglass breakage warranty

Group may select ONE Vision Plan.

InfoArmor

VOLUNTARY — Bundled Billing — Monthly Plan Rates

$1,000,000 Identity Theft Insurance Policy
Social Media Reputation Monitoring
Financial Wellness
Wallet Protection
Privacy Advocate Remediation
Digital Identity Report

Employee: $ 9.95
Employee + Family: $ 17.95

Healthiest You

Employer Sponsored or Voluntary — Bundled Billing — Includes Employee and Family

$0 Copay - 24 x 7 Telemedicine
Prescription Savings
Shop and price procedures
Sync with your medical benefits
Locate Providers
$9 per month

For groups enrolling more than 100 eligibile employees on Healthiest You, please ask for a custom Healthiest You quote. ***Healthiest You is not an insurance product.***

Info Armor and **Healthiest You** require 2 or more enrolled.

SECURECARE GROUP INSURANCE
Dental ▪ Vision

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Dental Quote For: **VALUED CLIENT**
Presented by: **WORD AND BROWN**

Quote Date: **03/01/2021**
Quote Effective Date: **7-21 - 9-21**
Quote ID: **003 - 012621**

Rate Guarantee: **12 months**
Quote effective for 60 days

Group Dental Quote: Employer Sponsored

Copay & PPO Plans use same state/national dentist network.

DENTAL PLAN CHOICES	THE COPAY PLAN (MAC)		THE PPO PLAN (MAC)			THE PPO PLAN (UCR)		
	Network	Non-Network[2]	Network		Non-Network[2]	Network		Non-Network[2]
Office Visit Copay	$10		None			None		
Type I: Diagnostic and Preventive [1]			100%		80%	100%		100%
Type II: Basic [1]	Schedule NV500	Schedule NV500	80%		60%	80%		80%
Type III: Major [1]			50%		40%	50%		50%
Endodontic & Periodontic Services [1]	Schedule NV500		Type II			Type II		
Deductible	None		$50 per person; $150 per family; Calendar Yr (Type II & III Services)			$50 per person; $150 per family; Calendar Yr (Type II & III Services)		
Calendar Year Maximum (per person)	None		$1,000	$1,500	$2,000	$1,000	$1,500	$2,000
Type I Waiting Period [4]	None	None	None		None	None		None
Type II Waiting Period [4]	None	None	None		None	None		None
Type III Waiting Period [4]	None	12 months	None		None	None		None
Discount Orthodontic Fee Program	Included	Not Included	Included		Not Included	Included		Not Included
Non-Network UCR/MAC	MAC		MAC			90th		
Calendar Year Maximum	**None**		**$1,000**	**$1,500**	**$2,000**	**$1,000**	**$1,500**	**$2,000**
Monthly Premium Rates Employee	$ 16.75		$ 29.26	$ 32.19	$ 34.77	$ 39.05	$ 42.95	$ 46.39
Employee + Spouse	$ 31.82		$ 55.60	$ 61.16	$ 66.05	$ 74.19	$ 81.61	$ 88.13
Employee + Child(ren)	$ 36.86		$ 71.44	$ 77.88	$ 83.54	$ 92.57	$ 101.16	$ 108.72
Employee + Family	$ 47.73		$ 92.53	$ 100.87	$ 108.20	$ 119.91	$ 131.04	$ 140.84
SecureCare Dental Plan Code	A5D4		2MCF	2MCG	2MCH	2354	2355	2356

Triple Choice Plans: **Employers enrolling 5 or more eligible employees may offer a Dual or Triple Choice.**

Minimum Employees: 5 **Participation Requirement:** 75% **Employer Contribution:** 50%

Monthly Group Admin Fee: (By Total Enrollees)	2-24	25-49	50+	PEO's
	$15/month	$20/month	$30/month	$50/month

TRIPLE CHOICE PLANS™ (PPO · COPAY · INDEMNITY)
by SecureCare Dental

Dental Quote For: **VALUED CLIENT** Presented by: **WORD AND BROWN**

[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.
PLAN INFORMATION	
GROUPS NOT ELIGIBLE FOR DENTAL COVERAGE:	Dental offices or dental related businesses. Businesses in existence less than 12 months. 2 person husband and wife businesses. Groups not paying social security (1099).
PRE TREATMENT:	Pretreatment recommended for services or supplies over $300.
ELIGIBILITY:	Full-time employees working at least 30 hours per week, and their dependents. See page 3 for details.
REPLACEMENT BENEFITS:	[4] Time periods satisfied under the employer's prior qualifying group dental plan (without coverage gap) will reduce Type I, II, & III Waiting Periods.
ORTHODONTIC REPLACEMENT BENEFITS:	[5] Time periods satisfied under the employer's prior qualifying group orthodontic coverage (without coverage gap) will reduce Orthodontic Waiting Period.
PLAN BENEFITS:	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.
NON-NETWORK BENEFITS:	[2] For PPO MAC plans, non-network benefits are paid on a Maximum Allowable Charge (MAC) basis. For PPO & Indemnity UCR plans, non-network benefits are paid on a Usual, Customary, and Usual (UCR) basis. The employee is responsible for non-network balance billing that may result.

Dental 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) bite registration; (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
- 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.

Dental 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.

SECURECARE
GROUP INSURANCE
Dental ▪ Vision

2017 BEST PLACES TO WORK
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Vision Quote For: **VALUED CLIENT**
Presented by: **WORD AND BROWN**

Quote Date: **03/01/2021**
Rate Guarantee: **24 months**
Quote Effective Date: **7-21 - 9-21**
Quote effective for 60 days
Quote ID: **003 - 012621**

Group Vision Quote: Employer Sponsored

IN NETWORK BENEFITS	FASHION PLAN		DESIGNER PLAN		PREMIER PLAN	
Frequencies (once every):						
Eye Exam (months) [6]	12	12	12	12	12	12
Spectacle Lenses (months) [1] [3]	12	12	12	12	12	12
Frame (months) [3]	12	24	12	24	12	24
Contact Lens Evaluation, Fitting & Follow-up Care (months)	12	12	12	12	12	12
Contact Lens (in lieu of eyeglasses) (months)	12	12	12	12	12	12
Copayments: Eye Health Exam | Spectacle Lenses	10 / 25		10 / 25		10 / 10	
Non-Collection Frame Allowance [4]	**Up to $100 plus 20% off balance** **Up to $150 at Vision Works**		**Up to $130 plus 20% off balance** **Up to $180 at Vision Works**		**Up to $150 plus 20% off balance** **Up to $200 at Vision Works**	
Davis Vision Frame Collection (in lieu of Allowance)						
Fashion	Included		Included		Included	
Designer	$15 Copay		Included		Included	
Premier	$40 Copay		$25 Copay		Included	
Member Charges for optional lens types and coatings						
Clear plastic single vision, multifocal or lenticular lenses	Included		Included		Included	
Tinting of plastic lenses	$15		Included		Included	
Scratch resistant coating	Included		Included		Included	
Polycarbonate Lenses [2]	$0 / $35		$0 / $30		Included	
Ultraviolet Coating	$15		$12		Included	
Anti-Reflective Coating (Standard | Premium | Ultra)	$40 / $55 / $69		$35 / $48 / $60		$35 / $48 / $60	
Progressive Lenses (Standard | Premium | Ultra)	$65 / $105 / $140		$50 / $90 / $140		$0 / $40 / $90	
High Index Lenses	60		55		55	
Polarized Lenses	75		75		75	
Plastic Photosensitive Lenses	70		65		65	
Scratch Protetion Plan: Single Vision | Multifocal Lenses	$20 / $40		$20 / $40		$20 / $40	

		FASHION PLAN		DESIGNER PLAN		PREMIER PLAN	
		12 / 12 / 12	12 / 12 / 24	12 / 12 / 12	12 / 12 / 24	12 / 12 / 12	12 / 12 / 24
Monthly Premium Rates	Employee	$ 6.41	$ 5.73	$ 6.80	$ 6.08	$ 7.42	$ 6.63
	Employee + Spouse	$ 11.69	$ 10.44	$ 12.43	$ 11.10	$ 13.61	$ 12.16
	Employee + Child(ren)	$ 10.82	$ 9.66	$ 11.50	$ 10.27	$ 12.58	$ 11.24
	Employee + Family	$ 16.68	$ 14.89	$ 17.75	$ 15.85	$ 19.45	$ 17.37
	Vision Plan Code	**V151**	**V101**	**V152**	**V102**	**V153**	**V103**

One Year spectacle lens and frame breakage warranty included

See next page for Contact Lens and Out of Network Benefits

Group may select ONE Vision Plan

Vision Quote For: **VALUED CLIENT** Presented by: **WORD AND BROWN**

IN NETWORK BENEFITS	FASHION PLAN	DESIGNER PLAN	PREMIER PLAN
Contact Lens Benefit /1 /7			
Non Collection Contact Lenses: Materials Allowance /4	Up to $100 plus 15% off balance	Up to $130 plus 15% off balance	Up to $150 plus 15% off balance
Evaluation, Fitting & Follow up Care - Standard Lenses /4	15% Discount	15% Discount	Included
Evaluation, Fitting & Follow up Care - Specialty Lenses /4	15% Discount	15% Discount	Up to $60 plus 15% off balance
Collection Contact Lenses (in lieu of Allowance) /1 /7			
Disposable	Not Included	4 boxes/multi-packs	8 boxes/multi-packs
Planned Replacement	Not Included	2 boxes/multi-packs	4 boxes/multi-packs
Evaluation, Fitting & Follow up Care	Not Included	Included	Included
Medically Necessary Contact Lenses (w/ prior approval) /1 /5			
Materials, Evaluation, Fitting & Follow up Care	Included	Included	Included

OUT OF NETWORK REIMBURSEMENT SCHEDULE	FASHION PLAN	DESIGNER PLAN	PREMIER PLAN
Eye Exam	Up to $40	Up to $40	Up to $40
Frame	Up to $50	Up to $50	Up to $50
Single Vision Lenses	Up to $40	Up to $40	Up to $40
Bifocal/Progressive Lenses /8	Up to $60	Up to $60	Up to $60
Trifocal Lenses	Up to $80	Up to $80	Up to $80
Lenticular Lenses	Up to $100	Up to $100	Up to $100
Elective Contact Lenses	Up to $80	Up to $105	Up to $105
Medically Necessary Contact Lenses	Up to $225	Up to $225	Up to $225

Group may select ONE Vision Plan

/1 Including, but not limited to toric, multifocal and gas permeable contact lenses

/2 Covered in full for dependent children, monocular patients and patients with prescriptions of +/- 6.00 diopters or greater

/3 One year spectacle lens and frame breakage warranty – no charge

/4 Discounts not applicable at Walmart, Sam's Club or Costco locations

/5 Covered in full with prior Third Party Administrator approval

/6 Routine eye examinations do not include professional services for contact lens evaluations. Any applicable fees above the evaluation and fitting allowance are the responsibility of the member.

/7 If contact lenses are selected and fitted, they may not be exchanged for eyeglasses.

/8 Progressive lenses: If you are unable to adapt to progressive addition lenses you have purchased, conventional bifocals will be supplied at no additional cost; however, your copayment is nonrefundable.

Value Added Features At No Extra Cost

More Covered Frames:	In lieu of the frame allowance, members may choose to select any frame from Davis Vision's exclusive Collection. The Collection is available at most participating independent provider offices and features three levels of frames: Fashion, Designer and Premier, with retail values of $125 - $225. By selecting a Collection frame, member eyewear is often completely covered. In fact, approximately 7 out of 10 members take advantage of the tremendous savings by selecting a Davis Vision Collection frame. /1
Free One-Year Breakage Warranty:	All eyeglasses come with a breakage warranty for repair or replacement of the frame and/or lenses for a period of one year from the date of delivery. The one-year breakage warranty applies to all plan-covered eyeglasses (i.e., all spectacle lenses, Davis Vision Collection frames and national retailer frames, where our exclusive frame Collection is not displayed).
Ancillary Product Discount:	Members will receive 50% off of additional pairs of eyeglasses at Visionworks retail locations nationally. At most other participating network offices, members will receive a 20% courtesy discount on items not covered by the benefit, e.g., second pairs, sunglasses, etc. Disposable contact lenses are available at a 10% discount. /2
Scratch Protection Plan:	Standard scratch-resistant coating is available for plastic lenses free of charge. Members may also purchase an optional scratch protection plan, which will replace scratched lenses with new lenses of the same material, style and prescription at no charge for one year from the original date of dispensing.
More Covered Contact Lenses:	In addition to the allowance, members may be fitted with contact lenses from our contact lens Collection /1, which includes torics and multifocals. All Collection contact lenses are covered in full up to the plan-specified amount and include evaluation, fitting and follow-up care. Davis Vision also covers the cost in full for contact lenses that are determined as medically necessary in the treatment of the following conditions: Keratoconus, Anisometropia, Corneal Disorders, Pathological Myopia, Aniseikonia, Post-Traumatic Disorders, Aphakia, Aniridia and Irregular Astigmatism. In general, medically necessary contact lenses may be prescribed in lieu of eyeglasses, when it will result in significantly better visual acuity and/or improved binocular function, including avoidance of diplopia or suppression.
Mail Order Contact Lenses:	Davis Vision's proprietary LENS123® mail order program offers the fastest, easiest and most convenient way to buy replacement contact lenses – and if you find a lower price, they will match it. Members simply call 1-800-LENS123 or visit lens123.com with their current prescription.
Laser Vision Correction Discounts:	Members are entitled to savings of up to 25% off participating provider's usual and customary fees, or a 5% discount on any advertised special through our network of physicians and refractive surgery centers (some centers provide a flat fee equating to these discount levels).
Low Vision Coverage:	Members who require low-vision services and optical devices are entitled to the following coverage, both in- and out-of-network, with prior approval from Third Party Administrator: **Low Vision Evaluation:** One comprehensive evaluation every five years, with a maximum charge of $300. This examination, sometimes called a functional vision assessment, can determine distance and clarity of vision, the size of readable print, the existence of blind spots or tunnel vision, depth perception, eye-hand coordination, problems perceiving contrast and lighting requirements for optimum vision. **Low-Vision Aid:** Maximum allowance of $600 with a lifetime maximum of $1,200 for items such as high- power spectacles, magnifiers and telescopes. These devices are utilized to maximize use of available vision, reduce problems of glare or increase contrast perception, based on the individual's visual goals and lifestyle needs. **Follow-up care:** Four visits in any five-year period, with a maximum charge of $100 for each visit.

1/Participating retail providers typically do not display the Collection, but are contractually required to maintain a comparable selection (in both quantity and quality) of frames that would be covered in full, with no additional member out-of-pocket expense. Collection is subject to change.

2/Additional discounts not applicable at Walmart, Sam's Club or Costco locations.

Vision Expenses Not Covered

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

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

SecureCare Dental & Vision 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.

Administered by:

Southwest Preferred Dental Organization

Underwritten by:

American National Life Insurance Company of Texas
Galveston, TX