Assurant Dental Care
Individual Enrollment

Thank you for your interest in the Assurant Dental Program. Assurant Dental Care is a managed dental plan that arranges for comprehensive dental services through their contracted panel of dentists conveniently located throughout Colorado. The enclosed package should provide you with everything necessary to fully review the program and become a plan member.

Sample Benefits of Assurant Dental Care Plan

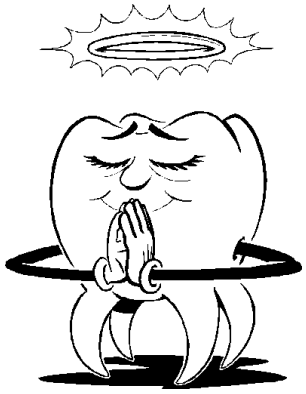
Routine Office Visit	Low Co-payment
Comprehensive Oral Evaluation	No Charge
X-Ray- Intraoral, Comp., Series, Incl. Bitewing	No Charge
Topical Application of Fluoride (Child)	No Charge
Fillings	Low Co-payment
Crowns and Bridges	Low Co-payment

Special features include No Deductibles, No Claim Forms, No Maximum Limits on Benefits, No Pre-Existing Dental Problems Excluded, Orthodontia Included. No Referral required for specialists, World Wide Emergency Coverage.

Vision Benefit Included

Low Monthly Cost

Member Only	$14.15
Member + 1	$22.75
Member + 2	$30.68
Member & Family	$35.88



How to Enroll

Step 1: Complete all sections of the enclosed enrollment form.

Step 2: Select a dentist from the Assurant website www.assurantemployeebenefits.com (go to "Provider Search", then "Legend Series") or call Assurant at 1-800-456-9194 for a list of dentists in your area. Record the dentist name and ID number on the enrollment form in the space provide. Application cannot be processed if you do not select a dentist.

Step 3: After completing and signing the enrollment form, **mail the form and a check for the first and last months' premium** payable to:

National Benefits Consultants
P.O. Box 370528
Denver, CO 80237-0528

Enrollment form and payment must be received by the 7th of the month in order to begin coverage on the 1st day of the following month. When your enrollment is processed, membership confirmation will be sent to your home. You may make an appointment with your selected dentist at anytime after your effective date of coverage.

Questions:

Assurant Dental Care:	1-800-456-9194
National Benefits- billing administration:	1-720-488-9892

Copayment Schedule with Specialty Benefits

Benefits provided by:

1. PLAN DENTIST SERVICES (subject to Limitations and Exclusions listed in the Evidence of Coverage):

The dental services listed on the Copayment Schedule below are covered only when provided by Member's selected Plan Dentist. Dental services that do not appear on this list are not covered by Plan. Member will be responsible for paying the amount listed in "Member Copayment" column at the time the service is received, or in accordance with Plan Dentist's billing procedures.

Except in the case of covered dental emergency services, payment for all services received from a non-Plan Dentist will be the responsibility of Member.

ADA Code**	Service Description**	Member Copayment
	Appointments	
None	Office visit - during regularly scheduled hours***	5.00
D0120	Periodic oral evaluation	No Charge
D0140	Limited oral evaluation - problem focused	20.00
D0150	Comprehensive oral evaluation - new or established patient	No Charge
D0180	Comprehensive periodontal evaluation - new or established patient	No Charge
None	Missed appointment without 24 hour notice***	20.00
D9310	Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)	25.00
D9440	Office visit - after regularly scheduled hours	40.00
	Diagnostic Dentistry	
D0210	Intraoral - complete series (including bitewings)	No Charge
D0220	Intraoral - periapical first film	No Charge
D0230	Intraoral - periapical each additional film	No Charge
D0240	Intraoral - occlusal film	No Charge
D0250	Extraoral - first film	No Charge
D0260	Extraoral - each additional film	No Charge
D0270	Bitewing - single film	No Charge
D0272	Bitewings - two films	No Charge
D0274	Bitewings - four films	No Charge
D0330	Panoramic film	No Charge
D0415	Collection of microorganisms for culture and sensitivity	No Charge
D0425	Caries susceptibility tests	No Charge
D0460	Pulp vitality tests	No Charge
	Preventive Dentistry	
D1110	Prophylaxis - adult	No Charge

ADA Code**	Service Description**	Member Copayment
	(once every 6 calendar months)	
D1120	Prophylaxis - child	No Charge
	(once every 6 calendar months)	
D1203	Topical application of fluoride (prophylaxis not included) - child	No Charge
D1310	Nutritional counseling for control of dental disease	No Charge
D1330	Oral hygiene instructions	No Charge
D1351	Sealant - per tooth	5.00
D1510	Space maintainer - fixed - unilateral*	60.00
D1515	Space maintainer - fixed - bilateral*	60.00
D1520	Space maintainer - removable - unilateral*	60.00
D1525	Space maintainer - removable - bilateral*	60.00
D1550	Re-cementation of space maintainer	5.00
None	Additional prophylaxis (D1110 or D1120 service does not apply to patients with periodontal disease)***	20.00
	Restorative Dentistry	
D2140	Amalgam - one surface, primary or permanent	10.00
D2150	Amalgam - two surfaces, primary or permanent	15.00
D2160	Amalgam - three surfaces, primary or permanent	20.00
D2161	Amalgam - four or more surfaces, primary or permanent	25.00
D2330	Resin-based composite - one surface, anterior	15.00
D2331	Resin-based composite - two surfaces, anterior	20.00
D2332	Resin-based composite - three surfaces, anterior	25.00
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	40.00
D2391	Resin-based composite - one surface, posterior	25.00
D2392	Resin-based composite - two surfaces, posterior	35.00
D2393	Resin-based composite - three surfaces, posterior	45.00
D2394	Resin-based composite - four or more surfaces, posterior	45.00
D2510	Inlay - metallic - one surface*	115.00
D2520	Inlay - metallic - two surfaces*	140.00
D2530	Inlay - metallic - three or more surfaces*	210.00
D2543	Onlay - metallic - three surfaces*	175.00
D2544	Onlay - metallic - four or more surfaces*	185.00
D2610	Inlay - porcelain/ceramic one surface*	175.00
D2620	Inlay - porcelain/ceramic two surfaces*	185.00
D2630	Inlay - porcelain/ceramic three or more surfaces*	185.00
D2740	Crown - porcelain/ceramic substrate*	225.00
D2750	Crown - porcelain fused to high noble metal*	225.00
D2751	Crown - porcelain fused to predominantly base metal*	225.00
D2752	Crown - porcelain fused to noble metal*	225.00
D2790	Crown - full cast high noble metal*	225.00
D2791	Crown - full cast predominantly base metal*	225.00
D2792	Crown - full cast noble metal*	225.00
D2910	Recement inlay, onlay, or partial coverage restoration	5.00
D2920	Recement crown	5.00
D2930	Prefabricated stainless steel crown - primary tooth	55.00
D2940	Sedative filling	10.00
D2950	Core buildup, including any pins	20.00
D2951	Pin retention - per tooth, in addition to restoration	10.00
D2952	Cast post and core in addition to crown*	80.00
D2954	Prefabricated post and core in addition to crown	50.00
D2960	Labial veneer (resin laminate) - chairside*	260.00
D2962	Labial veneer (porcelain laminate) - laboratory*	315.00
D2980	Crown repair, by report*	15.00
None	Temporary filling***	10.00

ADA Code**	Service Description**	Member Copayment
	Endodontics	
D3110	Pulp cap - direct (excluding final restoration)	12.00
D3120	Pulp cap - indirect (excluding final restoration)	6.00
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	25.00
D3310	Anterior (excluding final restoration)	110.00
D3320	Bicuspid (excluding final restoration)	130.00
D3330	Molar (excluding final restoration)	190.00
D3346	Retreatment of previous root canal therapy - anterior	210.00
D3347	Retreatment of previous root canal therapy - bicuspid	300.00
D3348	Retreatment of previous root canal therapy - molar	350.00
D3410	Apicoectomy/periradicular surgery - anterior	100.00
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	100.00
D3425	Apicoectomy/periradicular surgery - molar (first root)	100.00
D3426	Apicoectomy/periradicular surgery - (each additional root)	75.00
D3430	Retrograde filling - per root	30.00
D3450	Root amputation - per root	50.00
D3920	Hemisection (including any root removal), not including root canal therapy	40.00
	Periodontics	
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant	150.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant	90.00
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant	275.00
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or bounded teeth spaces per quadrant	165.00
D4320	Provisional splinting - intracoronal	60.00
D4321	Provisional splinting - extracoronal	40.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	40.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	25.00
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	30.00
D4910	Periodontal maintenance	25.00
None	Periodontal hygiene instructions***	No Charge
None	Periodontal charting for planning (specialty)***	8.00
	Removable Prosthodontics (Removable Dentures)	
D5110	Complete denture - maxillary*	300.00
D5120	Complete denture - mandibular*	300.00
D5130	Immediate denture - maxillary*	300.00
D5140	Immediate denture - mandibular*	300.00
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)*	310.00
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)*	310.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)*	310.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)*	320.00
D5410	Adjust complete denture - maxillary	10.00
D5411	Adjust complete denture - mandibular	10.00
D5421	Adjust partial denture - maxillary	10.00
D5422	Adjust partial denture - mandibular	10.00
D5510	Repair broken complete denture base*	30.00
D5610	Repair resin denture base*	25.00
D5620	Repair cast framework*	30.00
D5630	Repair or replace broken clasp*	40.00
D5640	Replace broken teeth - per tooth*	35.00

ADA Code**	Service Description**	Member Copayment
D5650	Add tooth to existing partial denture*	40.00
D5730	Reline complete maxillary denture (chairside)	50.00
D5731	Reline complete mandibular denture (chairside)	50.00
D5740	Reline maxillary partial denture (chairside)	50.00
D5741	Reline mandibular partial denture (chairside)	50.00
D5750	Reline complete maxillary denture (laboratory)*	75.00
D5751	Reline complete mandibular denture (laboratory)*	75.00
D5760	Reline maxillary partial denture (laboratory)*	75.00
D5761	Reline mandibular partial denture (laboratory)*	75.00
D5850	Tissue conditioning, maxillary	15.00
D5851	Tissue conditioning, mandibular	10.00
D5862	Precision attachment, by report*	80.00
	Fixed Prosthodontics	
D6210	Pontic - cast high noble metal*	225.00
D6211	Pontic - cast predominantly base metal*	225.00
D6212	Pontic - cast noble metal*	225.00
D6240	Pontic - porcelain fused to high noble metal*	225.00
D6241	Pontic - porcelain fused to predominantly base metal*	225.00
D6242	Pontic - porcelain fused to noble metal*	225.00
D6251	Pontic - resin with predominantly base metal*	225.00
D6545	Retainer - cast metal for resin bonded fixed prosthesis*	120.00
D6721	Crown - resin with predominantly base metal*	225.00
D6750	Crown - porcelain fused to high noble metal*	225.00
D6751	Crown - porcelain fused to predominantly base metal*	225.00
D6752	Crown - porcelain fused to noble metal*	225.00
D6780	Crown - 3/4 cast high noble metal*	225.00
D6790	Crown - full cast high noble metal*	225.00
D6791	Crown - full cast predominantly base metal*	225.00
D6792	Crown - full cast noble metal*	225.00
D6930	Recement fixed partial denture	10.00
D6940	Stress breaker	60.00
D6950	Precision attachment	130.00
D6980	Fixed partial denture repair, by report*	35.00
None	Resin bonded bridge pontic, per unit*	160.00
	Oral Surgery	
D7111	Extraction, coronal remnants - deciduous tooth	10.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	10.00
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	30.00
D7220	Removal of impacted tooth - soft tissue	50.00
D7230	Removal of impacted tooth - partially bony	70.00
D7240	Removal of impacted tooth - completely bony	90.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	75.00
D7250	Surgical removal of residual tooth roots (cutting procedure)	35.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	60.00
D7280	Surgical access of an unerupted tooth	55.00
D7310	Alveoloplasty in conjunction with extractions - per quadrant	50.00
D7320	Alveoloplasty not in conjunction with extractions - per quadrant	70.00
D7471	Removal of lateral exostosis (maxilla or mandible)	85.00
D7510	Incision and drainage of abscess - intraoral soft tissue	30.00
D7910	Suture of recent small wounds up to 5 cm	50.00
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure	70.00

ADA Code**	Service Description**	Member Copayment
	Anesthesia, Analgesia, and Sedation	
D9220	Deep sedation/general anesthesia - first 30 minutes	180.00
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	6.00
D9241	Intravenous conscious sedation/analgesia - first 30 minutes	180.00
D9940	Occlusal guard, by report*	115.00
D9951	Occlusal adjustment - limited	25.00
D9952	Occlusal adjustment - complete	75.00
	Bleaching	
D9972	External bleaching - per arch	150.00
None	External bleaching, both arches***	300.00

2. SPECIALIST SERVICES (subject to Limitations and Exclusions listed in the Evidence of Coverage):

Should Member require dental services that his selected Plan Dentist is unable to provide, he may obtain those services from a Plan Specialist. No referral is needed from the selected Plan Dentist in order for Member to obtain services from a Plan Specialist. Member responsibilities for obtaining services from a Plan Specialist are outlined below.

1. On Copayment Schedule (subject to Limitations and Exclusions listed in the Evidence of Coverage):

The following Copayment Schedule applies to covered services when they are provided by a Plan Specialist. If Member receives a service listed on the schedule, he will be responsible for paying the amount in "Member Copayment" column at the time the service is received, or in accordance with Plan Specialist's billing procedures.

ADA Code**	Service Description**	Member Copayment
	Appointments	
D0140	Limited oral evaluation - problem focused	25.00
D0150	Comprehensive oral evaluation - new or established patient	25.00
	Endodontics	
D3320	Bicuspid (excluding final restoration)	235.00
D3330	Molar (excluding final restoration)	320.00
D3346	Retreatment of previous root canal therapy - anterior	335.00
D3347	Retreatment of previous root canal therapy - bicuspid	430.00
D3348	Retreatment of previous root canal therapy - molar	475.00
D3410	Apicoectomy/periradicular surgery - anterior	200.00
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	230.00
D3425	Apicoectomy/periradicular surgery - molar (first root)	265.00
D3430	Retrograde filling - per root	65.00
	Periodontics	
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant	225.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant	135.00
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant	390.00

VISION DISCOUNT SERVICES

ACCESS PLAN

Your dental plan includes a vision discount plan through Vision Service Plan (VSP). The vision plan includes discounts on exams (including contact lens exams) and the purchase of eyeglasses, sunglasses and other prescription eyewear when provided by VSP doctors. VSP is available for you and everyone covered on your dental plan!

Services Available from a VSP Doctor

- **Eye Exams** – 20% discount applied to VSP doctor's usual and customary fees for eye exams[1]
- **Glasses** – 20% discount applied to VSP doctor's usual and customary fees for complete pairs of prescription glasses and spectacle lens options[2]
- **Contact Lenses** – 15% discount on VSP network doctor's contact lens exam fee.
- **Laser VisionCare**[SM] – VSP has contracted with many of the nation's laser surgery facilities and doctors, offering you a discount off PRK and LASIK surgeries, available through contracted laser centers

Other Valuable Features for You

- Immediate savings when using a VSP doctor
- You may use the discounts as often as you wish
- No waiting periods
- No deductibles
- No claim forms to fill out

How to Use VSP

Locate a VSP doctor near you. You may either use our Web-based doctor locator at **www.vsp.com**, or call VSP at **800.877.7195** to request a doctor listing.

Identify yourself as a VSP member and be prepared to provide the *enrolled member's* social security number when you make your appointment. (The VSP doctor will verify your eligibility and vision plan coverage, and will obtain authorization for services and materials. If you are not currently eligible for services, the VSP doctor is responsible for communicating this to you.)

Your fees are automatically reduced at the time of service – with no claim forms to fill out!

THIS VISION DISCOUNT PLAN IS NOT INSURANCE.

[1]Note: Does not apply to contact lens services. See contact lens section for applicable discount.
[2]Discounts only offered through the VSP doctor who provided an eye exam within the last 12 months.

VSP Member Services Support: 800.877.7195
Visit our Web site at www.vsp.com

VSP

FORTIS℠

GROUP ENROLLMENT FORM
PLEASE PRINT CLEARLY IN BLUE OR BLACK INK

Group Name	Group Number	Effective Date
Pinnacle Plan	DU67	

❑ **I apply for the following coverage for myself and dependents, as listed.**
Managed Care Plan
❑ Insert DHMO Plan

Employee First Name / MI / Last Name	❑ M ❑ F	Date of Birth	Facility ID #
		/ /	

Employee Street Address / City / State / Zip	Employee Social Security Number

Home Phone	Work Phone	Division/Department/Class	Date of Hire
( )	( )		/ /

Dependents to be Included for coverage:

First Name	MI	Last Name (if different)	Relationship	Sex	Date of Birth	Facility ID#
				❑ M ❑ F	/ /	
				❑ M ❑ F	/ /	
				❑ M ❑ F	/ /	
				❑ M ❑ F	/ /	

Check any boxes that apply and follow instructions
- ❑ Are you covering more than three children? **Please continue listing on additional Enrollment Forms**.
- ❑ Is the address of any child different than the member's? **Show that child's name & address on the back of this form.**
- ❑ Are you requesting coverage for a dependent child other than a son or daughter? **Forward legal custody paper.**
- ❑ Are you requesting coverage for dependent child over age 19 that is NOT a full time student? **Furnish proof of incapacity within 31 days of the Effective Date.**

❑ **I elect not to have coverage for myself or my dependents and I hereby waive coverage under the above mentioned plans.**

Signature:_____**Date:**_____

To the best of my knowledge and belief, each of the statements and answers supplied in this form is complete and true, and they constitute the sole basis for, and are the inducement for, the issuance of any coverage. Please read the following and sign below.

The Managed Care Plan is underwritten by United Dental Care of Colorado, Inc. and administered by Fortis Benefits Insurance Company

I hereby apply for membership in this dental Plan for myself and for any eligible dependents listed above. I authorize the [Group] named above to make deductions, if any, required as my contribution. I agree, for myself and for any eligible dependents listed, to abide by the rules and regulations of the Plan and the terms and conditions of the Group Dental Service Agreement. I authorize any licensed dentist, physician, hospital or other health care provider to furnish the Plan with any required dental or medical information, as permitted by law about myself and any eligible dependents listed. I represent the information provided is true and correct to the best of my knowledge. I further understand that my coverage and benefits may be affected by failure to provide complete and accurate information. I will promptly advise the Plan and my [Group] of any changes in this information.

Signature: _____**Date:** _____