Smile

Good news about dental benefits for employees of

A Dental Plan Means Healthy Smiles

Because you are a valued employee, we are pleased to offer you the opportunity to enroll in an excellent dental benefit plan from United Dental Care of Michigan, Inc. This dental program is a "managed care" plan, offering comprehensive benefits through a network of Plan dentists. For your convenience, a partial list of some of the most frequently used dental treatments is included.

Managed Care Features:

- No Deductibles
- No Waiting Periods for Covered Members
- Coverage for Pre-Existing Conditions
- Worldwide Emergency Coverage
- Wide Range of Covered Procedures

Vision Care Program

Your dental plan includes an excellent vision care program. This vision plan includes discounts on eye exams (including contact lens exams), eyeglasses, and other prescription eyewear when provided by participating providers.

Important Enrollment Information

To enroll, just follow three simple steps:

1. Select a dentist from the Directory of Dentists for yourself and every eligible member of your family. Each family member may choose a different Plan dentist. You may change your dentist(s) throughout the plan year*, however, all services must be performed by a Plan provider.
2. Complete the enclosed enrollment form, being sure to include the Dental Facility Number of each dentist you have selected.
3. Return your completed enrollment form to your Personnel Department or Benefits Manager authorizing payroll deductions for your coverage.

*Changes must be made in accordance with group plan provisions.

Products are marketed by Assurant Employee Benefits, administered by Union Security Insurance Company, and underwritten and/or provided by United Dental Care of Michigan, Inc.

Savings You Can See

Monthly Payroll Deduction

Employee $11.61

Employee + 1 Dependent $19.12

Employee + Family $29.59

The following is a sample of some of the most frequently used dental treatments. When you enroll for coverage, treatments you receive from your Plan Dentist will be provided at reduced fees called copayments. (After you enroll, a complete list of copayments will be provided to you along with your Evidence of Coverage.)

Summit Plan

Underwritten by United Dental Care of Michigan, Inc.

1. Plan Dentist Services

The dental services listed on this sample Copayment Schedule are covered only when provided by the Member's selected Plan Dentist. Members will be responsible for paying the amount listed in the "Member Copayment" column at the time the service is received, or in accordance with the 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 the Member.

2. Plan Specialist Services

See enclosed Copayment Schedule for Specialty Benefit Amendment.

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)	35.00
D9440	Office visit - after regularly scheduled hours	40.00
	Diagnostic Dentistry	
D0210	Intraoral - complete series (including bitewings)	5.00
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

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ADA Code**	Service Description**	Member Copayment
	Preventive Dentistry	
D1110	Prophylaxis - adult	10.00
	(once every 6 calendar months)	
D1120	Prophylaxis - child	9.00
	(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	13.00
D1510	Space maintainer - fixed - unilateral*	70.00
D1515	Space maintainer - fixed - bilateral*	70.00
D1520	Space maintainer - removable - unilateral*	85.00
D1525	Space maintainer - removable - bilateral*	110.00
D1550	Re-cementation of space maintainer	18.00
None	Additional prophylaxis (D1110 or D1120 service does not apply to patients with periodontal disease)***	35.00
	Restorative Dentistry	
D2140	Amalgam - one surface, primary or permanent	17.00
D2150	Amalgam - two surfaces, primary or permanent	21.00
D2160	Amalgam - three surfaces, primary or permanent	25.00
D2161	Amalgam - four or more surfaces, primary or permanent	29.00
D2330	Resin-based composite - one surface, anterior	25.00
D2331	Resin-based composite - two surfaces, anterior	29.00
D2332	Resin-based composite - three surfaces, anterior	33.00
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	37.00
D2391	Resin-based composite - one surface, posterior	35.00
D2392	Resin-based composite - two surfaces, posterior	39.00
D2393	Resin-based composite - three surfaces, posterior	43.00
D2394	Resin-based composite - four or more surfaces, posterior	43.00
D2510	Inlay - metallic - one surface*	220.00
D2520	Inlay - metallic - two surfaces*	225.00
D2530	Inlay - metallic - three or more surfaces*	250.00
D2543	Onlay - metallic - three surfaces*	290.00
D2544	Onlay - metallic - four or more surfaces*	290.00
D2610	Inlay - porcelain/ceramic one surface*	250.00
D2620	Inlay - porcelain/ceramic two surfaces*	260.00
D2630	Inlay - porcelain/ceramic three or more surfaces*	270.00
D2740	Crown - porcelain/ceramic substrate*	270.00
D2750	Crown - porcelain fused to high noble metal*	270.00
D2751	Crown - porcelain fused to predominantly base metal*	270.00
D2752	Crown - porcelain fused to noble metal*	270.00
D2790	Crown - full cast high noble metal*	270.00
D2791	Crown - full cast predominantly base metal*	270.00
D2792	Crown - full cast noble metal*	270.00
D2910	Recement inlay, onlay, or partial coverage restoration	16.00
D2920	Recement crown	16.00
D2930	Prefabricated stainless steel crown - primary tooth	70.00
D2940	Sedative filling	28.00
D2950	Core buildup, including any pins	80.00
D2951	Pin retention - per tooth, in addition to restoration	17.00
D2952	Cast post and core in addition to crown*	105.00
D2954	Prefabricated post and core in addition to crown	88.00
D2960	Labial veneer (resin laminate) - chairside*	260.00
D2962	Labial veneer (porcelain laminate) - laboratory*	315.00
D2980	Crown repair, by report*	22.00
None	Temporary filling***	18.00

Continued On Next Page

ADA Code**	Service Description**	Member Copayment
	Endodontics	
D3110	Pulp cap - direct (excluding final restoration)	10.00
D3120	Pulp cap - indirect (excluding final restoration)	10.00
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	30.00
D3310	Anterior (excluding final restoration)	120.00
D3320	Bicuspid (excluding final restoration)	150.00
D3330	Molar (excluding final restoration)	190.00
D3346	Retreatment of previous root canal therapy - anterior	320.00
D3347	Retreatment of previous root canal therapy - bicuspid	380.00
D3348	Retreatment of previous root canal therapy - molar	455.00
D3410	Apicoectomy/periradicular surgery - anterior	140.00
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	150.00
D3425	Apicoectomy/periradicular surgery - molar (first root)	170.00
D3426	Apicoectomy/periradicular surgery - (each additional root)	60.00
D3430	Retrograde filling - per root	40.00
D3450	Root amputation - per root	85.00
D3920	Hemisection (including any root removal), not including root canal therapy	85.00
	Periodontics	
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant	115.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant	69.00
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant	220.00
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or bounded teeth spaces per quadrant	132.00
D4320	Provisional splinting - intracoronal	90.00
D4321	Provisional splinting - extracoronal	75.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	50.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	30.00
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	30.00
D4910	Periodontal maintenance	30.00
None	Periodontal hygiene instructions***	No Charge
None	Periodontal charting for planning (specialty)***	12.00
	Removable Prosthodontics (Removable Dentures)	
D5110	Complete denture - maxillary*	350.00
D5120	Complete denture - mandibular*	350.00
D5130	Immediate denture - maxillary*	400.00
D5140	Immediate denture - mandibular*	400.00
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)*	380.00
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)*	380.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)*	380.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)*	380.00
D5410	Adjust complete denture - maxillary	30.00
D5411	Adjust complete denture - mandibular	30.00
D5421	Adjust partial denture - maxillary	30.00
D5422	Adjust partial denture - mandibular	30.00
D5510	Repair broken complete denture base*	42.00
D5610	Repair resin denture base*	45.00
D5620	Repair cast framework*	60.00
D5630	Repair or replace broken clasp*	70.00
D5640	Replace broken teeth - per tooth*	45.00
D5650	Add tooth to existing partial denture*	50.00
D5730	Reline complete maxillary denture (chairside)	85.00
D5731	Reline complete mandibular denture (chairside)	85.00
D5740	Reline maxillary partial denture (chairside)	85.00

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ADA Code**	Service Description**	Member Copayment
D5741	Reline mandibular partial denture (chairside)	85.00
D5750	Reline complete maxillary denture (laboratory)*	120.00
D5751	Reline complete mandibular denture (laboratory)*	120.00
D5760	Reline maxillary partial denture (laboratory)*	120.00
D5761	Reline mandibular partial denture (laboratory)*	120.00
D5850	Tissue conditioning, maxillary	60.00
D5851	Tissue conditioning, mandibular	60.00
D5862	Precision attachment, by report*	100.00
	Fixed Prosthodontics	
D6210	Pontic - cast high noble metal*	270.00
D6211	Pontic - cast predominantly base metal*	270.00
D6212	Pontic - cast noble metal*	270.00
D6240	Pontic - porcelain fused to high noble metal*	270.00
D6241	Pontic - porcelain fused to predominantly base metal*	270.00
D6242	Pontic - porcelain fused to noble metal*	270.00
D6251	Pontic - resin with predominantly base metal*	270.00
D6545	Retainer - cast metal for resin bonded fixed prosthesis*	250.00
D6721	Crown - resin with predominantly base metal*	270.00
D6750	Crown - porcelain fused to high noble metal*	270.00
D6751	Crown - porcelain fused to predominantly base metal*	270.00
D6752	Crown - porcelain fused to noble metal*	270.00
D6780	Crown - 3/4 cast high noble metal*	270.00
D6790	Crown - full cast high noble metal*	270.00
D6791	Crown - full cast predominantly base metal*	270.00
D6792	Crown - full cast noble metal*	270.00
D6930	Recement fixed partial denture	30.00
D6940	Stress breaker	95.00
D6950	Precision attachment	185.00
D6980	Fixed partial denture repair, by report*	80.00
None	Resin bonded bridge pontic, per unit*	200.00
	Oral Surgery	
D7111	Extraction, coronal remnants - deciduous tooth	20.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	20.00
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	40.00
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	80.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	100.00
D7250	Surgical removal of residual tooth roots (cutting procedure)	45.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	90.00
D7280	Surgical access of an unerupted tooth	85.00
D7310	Alveoloplasty in conjunction with extractions - per quadrant	50.00
D7320	Alveoloplasty not in conjunction with extractions - per quadrant	85.00
D7471	Removal of lateral exostosis (maxilla or mandible)	185.00
D7510	Incision and drainage of abscess - intraoral soft tissue	35.00
D7910	Suture of recent small wounds up to 5 cm	70.00
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure	60.00
	Anesthesia, Analgesia, and Sedation	
D9220	Deep sedation/general anesthesia - first 30 minutes	180.00
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	20.00
D9241	Intravenous conscious sedation/analgesia - first 30 minutes	180.00
D9940	Occlusal guard, by report*	175.00
D9951	Occlusal adjustment - limited	90.00
D9952	Occlusal adjustment - complete	175.00

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ADA Code**	Service Description**	Member Copayment
	Bleaching	
D9972	External bleaching - per arch	150.00
None	External bleaching, both arches***	300.00

**Members are responsible for additional laboratory fees for these services.*

This is a sample Member Copayment Schedule which does not list all Member benefits and copayments. It is not an Evidence of Coverage. Please see the Group Dental Service Agreement, Evidence of Coverage and Copayment Schedule, which determine all rights, benefits, and applicable Limitations and Exclusions.

***Current and prior versions of the Current Dental Terminology (CDT) codes (in the ADA Code column) and descriptors (in the Service Description column) are copyrighted by the American Dental Association (ADA) and are used by permission. Current Dental Terminology © American Dental Association.*

****Service does not have an American Dental Association Current Dental Terminology code or descriptor.*

Legend Series

Sample Copayment Schedule

For Specialty Benefit Amendment

How Your Specialty Benefit Amendment Works

Should you need the services of a dental care Specialist, you may do so without a referral from your Plan dentist.

If you use a Specialist who is a part of our provider network for a procedure listed below on the Specialty Benefit Amendment (SBA), you will simply pay the Member Copayment amount at the time of service. However, if the procedure is not listed on the SBA, you will receive a 25% discount, including orthodontic services, (15% from Endodontists, includes root canal therapy) off of the Specialist's normal retail charges.

If you choose to go to a Specialist who is **not** a part of our provider network, you may still receive benefits! For any procedure performed that is listed below on the SBA, the Plan will pay up to the total out-of-network scheduled amount. Your financial responsibility will be the difference, if any, between the out of network scheduled amount and the Specialist's normal retail charge.* If you have a procedure performed that is not listed on the SBA by a Non-Plan Specialist, you will receive no benefits.

No Annual Maximum!

There is no annual maximum for procedures performed by a Plan Specialist. For procedures performed by a Non-Plan Specialist, there is a $2,000 annual maximum benefit.

ADA Code**	Service Description**	SBA Plan Specialist Copayment	Maximum Reimbursement with A Non-Plan Specialist
	Appointments		
D0140	Limited oral evaluation - problem focused	25.00	15.00
D0150	Comprehensive oral evaluation - new or established patient	25.00	15.00
	Endodontics		
D3320	Bicuspid (excluding final restoration)	235.00	265.00
D3330	Molar (excluding final restoration)	320.00	330.00
D3346	Retreatment of previous root canal therapy - anterior	335.00	215.00
D3347	Retreatment of previous root canal therapy - bicuspid	430.00	220.00
D3348	Retreatment of previous root canal therapy - molar	475.00	300.00
D3410	Apicoectomy/periradicular surgery - anterior	200.00	250.00
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	230.00	350.00
D3425	Apicoectomy/periradicular surgery - molar (first root)	265.00	335.00
D3430	Retrograde filling - per root	65.00	60.00
	Periodontics		
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant	225.00	125.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant	135.00	75.00
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant	390.00	310.00
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or bounded teeth spaces per quadrant	234.00	186.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	80.00	70.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	48.00	42.00
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	55.00	35.00

ADA Code**	Service Description**	SBA Plan Specialist Copayment	Maximum Reimbursement with A Non-Plan Specialist
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report	60.00	40.00
	Oral Surgery		
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	60.00	90.00
D7220	Removal of impacted tooth - soft tissue	80.00	
D7230	Removal of impacted tooth - partially bony	105.00	
D7240	Removal of impacted tooth - completely bony	150.00	100.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	160.00	130.00
D7250	Surgical removal of residual tooth roots (cutting procedure)	60.00	100.00
D7280	Surgical access of an unerupted tooth	150.00	110.00
D7310	Alveoloplasty in conjunction with extractions - per quadrant	100.00	40.00
D7320	Alveoloplasty not in conjunction with extractions - per quadrant	85.00	100.00
D7471	Removal of lateral exostosis (maxilla or mandible)	220.00	140.00
D7510	Incision and drainage of abscess - intraoral soft tissue	70.00	35.00
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure	145.00	115.00
	Anesthesia, Analgesia, and Sedation		
D9241	Intravenous conscious sedation/analgesia - first 30 minutes	130.00	100.00

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This is a sample Member Copayment Schedule only. It is not an Evidence of Coverage. Please see the Group Dental Service Agreement, Evidence of Coverage and Copayment Schedule, which determine all rights, benefits, and applicable Limitations and Exclusions.

**If a Member chooses to receive a dental service listed on the schedule above from a non-Plan Specialist, he will be responsible for paying that specialist's entire normal retail charge for the service at the time the service is received or in accordance with specialist's billing procedures. Member may then submit a completed claim form, with an itemized bill attached, to the Plan. (Member may obtain claim forms by contacting the Plan.) The Plan will pay Member lesser of the amount shown in "Out of Network Plan Payment Schedule" column of the sample schedule above or the amount charged by specialist for the service.*

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GROUP ENROLLMENT FORM

PLEASE PRINT CLEARLY IN BLUE OR BLACK INK

Group Name	Group Number	Effective Date / /

❑ **I apply for the following coverage for myself and dependents, as listed.**

Managed Care Plan

❑ Summit

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 Michigan, Inc.

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. The authorization is not governed by HIPAA, however, when necessary, I may be asked to execute a HIPAA authorization form, allowing Union Security Insurance Company to use and disclose protected health information.

Signature:_____**Date:**_____

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℠** – 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