ASSURANT
Employee
Benefits

Prepaid Dental

Good news about dental benefits for employees of City of Clearwater

A Dental Plan Means Healthy Smiles

Because you are a valued employee, Assurant Employee Benefits* is pleased to offer you the opportunity to enroll in a dental benefit plan provided by DentiCare, Inc. (A Florida Corporation) A Prepaid Limited Health Service Organization Licensed Under Chapter 636 of the Florida Statutes and administered by Union Security Insurance Company. This prepaid dental plan offers benefits through a network of Plan Dentists. When you enroll for benefits, treatments you receive from your selected Plan Dentist will be provided at reduced fees called copayments. For your information, a partial list of frequently used dental treatments is included.

Plan Features

- No Deductibles
- No Waiting Periods
- Coverage for Pre-existing Conditions
- No Claim Forms to File for Plan Dentist and Plan Specialist Services
- No Referrals Required for Specialist Services
- No Annual Maximum for Plan Dentist and Plan Specialist Services

Important Enrollment Information

To enroll, just follow three simple steps:

1. Select a general 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 must select a Plan Dentist to receive services. Except for certain specialist services, all services must be performed by this selected Plan Dentist. You may change your Plan Dentist(s) throughout the Plan Year in accordance with the provisions of the group agreement. 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 Plan Dentist selected.

3. Return your completed enrollment form to your Personnel Department or Benefits Manager authorizing payroll deductions for your coverage.

Finding a Provider

You can find a dental provider in the Heritage Series Provider Network by visiting the Assurant Employee Benefits web site at www.assurantemployeebenefits.com, clicking on the "Provider Search" link, and then selecting Heritage Series. Availability of Plan Dentists and Plan Specialists varies depending on location.

If you have any questions, call Customer Service at 800.443.2995.

***Products are marketed by Assurant Employee Benefits, administered by Union Security Insurance Company, and underwritten and/or provided by DentiCare, Inc. (A Florida Corporation) A Prepaid Limited Health Service Organization Licensed Under Chapter 636 of the Florida Statutes.**

Savings You Can See

Monthly Payroll Deduction†

Employee **$8.49**

Employee + 1 Dependent **$14.37**

Employee + Family **$22.66**

†May be changed according to the terms of the Group Dental Service Agreement.

The following is a list of commonly used dental treatments. It is not the Evidence of Coverage. After you enroll, a complete list of copayments will be provided to you along with your Evidence of Coverage.

Secure Plan

1. Plan Dentist Services

The dental services listed in the following schedule are covered only when provided by the Member's selected Plan Dentist. The Member will be responsible for paying the amount listed in the "Member Copayment" column (plus any applicable lab fees*) at the time the service is received, or in accordance with the selected Plan Dentist's billing procedures. To fully understand the benefits, exclusions and limitations of this plan, the Member should consult the Evidence of Coverage.

Services marked with a single asterisk (*) below also require separate payment of laboratory charges. The laboratory charges must be paid to the Plan Dentist in addition to any applicable copayment for the service.

Payment for each service of a Non-Plan Dentist (at that dentist's normal retail charge) is the responsibility of the Member, except for limited Plan Benefits for covered dental Emergency Services for temporary pain relief.

2. Plan Specialist Services

Should the Member require dental services that his or her selected Plan Dentist is unable to provide, he or she may obtain those services from a Plan Specialist at a reduced rate. No referral is needed from the selected Plan Dentist in order for the Member to obtain services from a Plan Specialist.

There is no applicable copayment schedule for Plan Specialist services. Instead, the following reductions in that Plan Specialist's normal retail charges apply to all services received from a Plan Specialist. A 15% reduction applies if the Plan Specialist is an endodontist. A 25% reduction applies if the Plan Specialist is any other type of specialist, including but not limited to an orthodontist. The Member is responsible for paying the entire reduced charge at the time the service is received, or in accordance with the Plan Specialist's billing procedures.

Payment for each service of a Non-Plan Specialist (at that specialist's normal retail charge) is the responsibility of the Member, except for limited Plan Benefits for covered dental Emergency Services for temporary pain relief.

ADA Code**	Service Description**	Member Copayment
	Appointments	
None	Office visit - during regularly scheduled hours***	10.00
D0120	Periodic oral evaluation	No Charge
D0150	Comprehensive oral evaluation - new or established patient	No Charge
None	Missed appointment without 24 hour notice***	25.00
	Diagnostic Dentistry	
D0210	Intraoral - complete series (including bitewings)	5.00
D0415	Collection of microorganisms for culture and sensitivity	No Charge
	Preventive Dentistry	
D1110	Prophylaxis - adult	5.00
D1120	Prophylaxis - child	5.00
D1203	Topical application of fluoride (prophylaxis not included) - child	No Charge

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ADA Code**	Service Description**	Member Copayment
D1330	Oral hygiene instructions	No Charge
D1351	Sealant - per tooth	15.00
D1510	Space maintainer - fixed - unilateral*	70.00
D1515	Space maintainer - fixed - bilateral*	70.00
D1520	Space maintainer - removable - unilateral*	95.00
D1525	Space maintainer - removable - bilateral*	115.00
	Restorative Dentistry	
D2140	Amalgam - one surface, primary or permanent	20.00
D2150	Amalgam - two surfaces, primary or permanent	25.00
D2160	Amalgam - three surfaces, primary or permanent	50.00
D2161	Amalgam - four or more surfaces, primary or permanent	60.00
D2330	Resin-based composite - one surface, anterior	45.00
D2331	Resin-based composite - two surfaces, anterior	55.00
D2332	Resin-based composite - three surfaces, anterior	75.00
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	90.00
D2750	Crown - porcelain fused to high noble metal*	280.00
D2751	Crown - porcelain fused to predominantly base metal*	280.00
D2962	Labial veneer (porcelain laminate) - laboratory*	325.00
	Endodontics	
D3310	Anterior (excluding final restoration)	155.00
D3320	Bicuspid (excluding final restoration)	225.00
D3330	Molar (excluding final restoration)	275.00
	Periodontics	
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	55.00
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	85.00
	Removable Prosthodontics (Removable Dentures)	
D5110	Complete denture - maxillary*	325.00
D5120	Complete denture - mandibular*	410.00
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)*	390.00
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)*	390.00
	Fixed Prosthodontics (Bridges or Fixed Partial Dentures)	
D6750	Crown - porcelain fused to high noble metal*	280.00
	Oral Surgery	
D7111	Extraction, coronal remnants - deciduous tooth	30.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	20.00
D7220	Removal of impacted tooth - soft tissue	75.00
D7230	Removal of impacted tooth - partially bony	100.00
D7240	Removal of impacted tooth - completely bony	140.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	170.00

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.

Listed copayments apply only to Plan Dentists who perform the corresponding listed services. The Plan Dentist selected by the Member may not perform all listed services. Availability of Plan Dentists is subject to change.

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. © 2004 American Dental Association. All rights reserved.

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

Learn more about the prepaid dental plan being offered to you!

Your employer is offering you an attractive prepaid dental plan. This Q&A will help provide you more information about the plan being offered to you.

What is a prepaid plan?

With a prepaid plan you pay a monthly prepayment fee plus you pay reduced fees called "copayments" for dental services provided. To receive the reduced fees you must use a Plan Dentist selected at the time of enrollment.

What are copayments and where can I locate the copayment schedule?

A copayment is the set fee that you pay to the Plan Dentist at the time of treatment for covered services that are being performed.

The copayment schedule is a listing of covered services and copayments for your plan. The schedule is included in the Evidence of Coverage. It is helpful to bring your copayment schedule to your dental appointment.

How do I select a Plan Dentist?

You should select your Plan Dentist when you enroll. You can visit www.assurantemployeebenefits.com and go to Provider Search or refer to your plan network directory for a listing of Plan Dentists. On the web site please choose the Heritage Series network listed on the Provider Search page for provider look-up. Note that your Plan Dentist must be a general dentist, not a specialist.

How long does it take to appear on the patient list/roster of my Plan Dentist that I select at time of enrollment?

If Assurant Employee Benefits receives your Plan Dentist selection by the 10th of the month, you will appear on the roster the 1st of the next month. If we receive the selection after the 10th, you will appear on the roster the 1st day of the second following month. If you are not listed on the roster, please contact us at 800.443.2995.

How will the Plan Dentist know I am a patient?

The Plan Dentist receives a patient listing, called a roster, from Assurant Employee Benefits each month that includes all members who have chosen that individual as their dentist.

Please confirm at the time of making your appointment with the Plan Dentist that you are on the provider's roster.

Can I change my Plan Dentist?

Yes, you can. To change your Plan Dentist, contact Customer Service at 800.443.2995.

What if I choose to see a dentist other than my selected Plan Dentist?

The costs will **not** be covered by your dental plan and you will be responsible for the full payment to the dentist. This is why it is important for you to seek treatment from your selected Plan Dentist.

If I have a dental emergency, do I need to see my Plan Dentist?

First, contact your Plan Dentist to make an appointment. If your Plan Dentist is unable to see you, you may seek treatment from any licensed dentist in the United States.

Please be informed that the emergency benefit in your plan is limited to the temporary relief of pain and has limited benefits.

If I need to see a specialist, how do I go about finding a Plan Specialist in my area?

You may find a list of Plan Specialists by looking in the plan network directory, visiting the web site at www.assurantemployeebenefits.com or calling 800.443.2995 for assistance. No referrals are necessary from your Plan Dentist to seek treatment from a Plan Specialist.

What if I lose my Dental ID card or have a question about my plan?

Contact Customer Service by calling 800.443.2995.

Pre-existing Conditions

Limitations and exclusions apply with respect to the Member's oral conditions without regard to whether or not such conditions existed before the effective date of the Member's enrollment.

Limitations and Exclusions

Plan Benefits are not available for:

1. Any services not specifically described in the Copayment Schedule (including but not limited to any hospital or outpatient care facility cost associated with any dental service).
2. Any dental service initiated (a) before the effective date of the Member's enrollment or (b) after the Member's enrollment ends.
3. Services provided by Non-Plan Providers unless for Emergency Services as specifically provided in the EMERGENCY PROCEDURES Article of the Evidence of Coverage.
4. Replacement of bridgework, dentures or other fixed or removable appliances unless (a) at least five years have elapsed since such appliance was provided as a Plan Benefit, or (b) during that five-year period, appliance becomes unusable and cannot be made usable due to the Member's illness or an accident involving damage to the appliance while it is in use.
5. Replacement of dentures or other removable appliances due to (a) damage while not in use or (b) loss or theft.
6. Oral reconstruction using fixed bridgework or other fixed appliances if the overall treatment plan to achieve complete oral reconstruction involves the replacement of six or more teeth (whether those teeth are missing before treatment begins or are extracted as part of the overall treatment plan).
7. Implants or any related implant appliances, or surgery for the insertion of implants or any related implant appliances, whether fixed or removable.
8. Surgical removal of implants or implant appliances, or any surgical or non-surgical services to adjust, repair, replace, or treat any problem related to an existing implant or implant appliance, whether fixed or removable.
9. Restorations or splints used to increase vertical dimension, restore occlusion, or replace or stabilize tooth structure lost by attrition.
10. Orthodontic treatment involving therapy for myofunctional problems, TMJ (temporomandibular joint) dysfunctions, micrognathia, macroglossia, cleft palate or other growth and developmental abnormalities.
11. Orthodontic treatment associated with orthognathic surgery, whether the treatment precedes or follows the surgery.
12. Extractions of third molars (wisdom teeth) that are not symptomatic, whether or not the extractions follow the completion of orthodontic treatment. Examples of symptomatic conditions include decay, odontogenic cysts, chronic pericoronitis and infection.
13. Treatment of malignancies, neoplasms or cysts, including but not limited to biopsies.

Orthodontic Extractions

Extractions by a Plan Provider for solely orthodontic purposes are not subject to the fixed Copayments shown for extractions in the Copayment Schedule. Instead, such extractions are subject to charges reflecting a 25% reduction from that Plan Provider's normal retail charges for such extractions.

Termination

The Member's enrollment may be terminated as stated in the **TERMINATION** article of the Evidence of Coverage.

GROUP ENROLLMENT FORM
PLEASE PRINT CLEARLY IN BLUE OR BLACK INK

Group Name	Group Number	Effective Date
City of Clearwater	D071	/ /

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

Prepaid Plan

☐ **Secure**

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#
Spouse				☐ M ☐ F	/ /	
Child(ren)				☐ 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 HMO Plan is provided by DentiCare, Inc. (A Florida Corporation) A Prepaid Limited Health Service Organization Licensed Under Chapter 636 of the Florida Statutes and administered by Union Security 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 Union Security Insurance Company and its affiliated dental companies 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. **IMPORTANT WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.**

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