DHMO Dental

Good news about dental benefits for employees of

Joseph F. McWherter MD DBA Fem Centre

A Dental Plan Means Healthy Smiles

Because you are a valued employee, we are pleased to offer you the opportunity to enroll in a dental benefit plan provided by United Dental Care of Texas, Inc. and administered by Union Security Insurance Company. This DHMO 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
- No copayments for most Preventive services
- Coverage for Pre-existing Conditions
- Includes Orthodontic copayments
- No Claim Forms for Members to File (except Non-Plan Specialty Dentist Services and Emergency Services provided by a Non-Plan Dentist)
- No Referrals Required for Specialty Dentist Services
- No Annual Maximum for Plan Dentist and Plan Specialty Dentist 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 specialty dentist 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 DHMO Dental Series Provider Network by visiting our web site at www.assurantemployeebenefits.com, and clicking on the “Find a dentist” link found under “Tools for Members”. Next, click “DHMO or Prepaid Dental Plan?”, select your state from the drop down list, and then select “DHMO Dental Series”. Availability of Plan Dentists and Plan Specialty Dentists varies depending on location.

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

Benefits are provided by United Dental Care of Texas, Inc. and administered by Union Security Insurance Company. United Dental Care of Texas, Inc. is a Dental HMO (Health Maintenance Organization) or DHMO.

Savings You Can See

Bi-Weekly Payroll Deduction†

Employee $6.69

Employee + Spouse $11.17

Employee + Child(ren) $14.88

Employee + Family $19.77

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

DHMO Dental Plan 189

1. Plan Provider Services

The dental services listed in the following schedule are covered when provided by the Member's selected Plan Dentist. If Member requires dental specialty services that cannot be provided by selected Plan Dentist, Member may obtain from a Plan Specialty Dentist the services marked as dental specialty services (S) in this Section 1. No referral from Member's selected Plan Dentist is needed to receive services from a Plan Specialty 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 Plan Provider's billing procedures.

Dental services obtained from a Plan Specialty Dentist that are not listed and marked as dental specialty services (S) in this Section 1 or listed in Section 2 below will be provided to Member at reduced charges. A 15% reduction from that Plan Specialty Dentist's normal retail charges applies to services obtained from a Plan Specialty Dentist whose practice is limited to endodontics. A 25% reduction from that Plan Specialty Dentist's normal retail charges applies to services obtained from any other Plan Specialty Dentist (including, but not limited to, a Plan Specialty Dentist whose practice is orthodontics). Member is responsible for paying the entire reduced charge either at the time the service is received or in accordance with Plan Specialty Dentist's billing procedures.

To fully understand the benefits, exclusions and limitations of this plan, the Member should consult the Evidence of Coverage. The Plan Provider is permitted to charge the member for any missed appointments if the Member fails to give at least 24 hours notice. The charge may not exceed $20.00.

Services marked with a single asterisk (*) below also require separate payment of laboratory charges. The laboratory charges must be paid to the Plan Provider 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 Plan Benefits for covered dental Emergency Services.

ADA Code**	Service Description**	Member Copayment
	Appointments	
None	Office visit - during regularly scheduled hours***	No Charge
D0120	Periodic oral evaluation - established patient	No Charge
	(ADA Code D0120 may only be obtained once in any six calendar months, except for medically necessary more frequent evaluations as determined by Member's Plan Dentist.)	
D0140	Limited oral evaluation - problem focused	No Charge
D0150	Comprehensive oral evaluation - new or established patient	No Charge
	(ADA Code D0150 may only be obtained once in any six calendar months, except for medically necessary more frequent evaluations as determined by Member's Plan Dentist.)	
D0160	Detailed and extensive oral evaluation - problem focused, by report	No Charge
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	No Charge
D0180	Comprehensive periodontal evaluation - new or established patient	No Charge
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	55.00
D9440	Office visit - after regularly scheduled hours	30.00

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ADA Code**	Service Description**	Member Copayment
	Diagnostic Dentistry	
D0210	Intraoral-complete series of radiographic images	No Charge
	(ADA Code D0210 may only be obtained once in any three calendar years, except for medically necessary more frequent x-rays as determined by Member's Plan Dentist.)	
D0220	Intraoral-periapical first radiographic image	No Charge
D0230	Intraoral-periapical each additional radiographic image	No Charge
D0240	Intraoral-occlusal radiographic image	No Charge
D0250	Extraoral-2D projection radiographic image created using a stationary radiation source, and detector	No Charge
D0260	Extraoral-each additional radiographic image	No Charge
D0270	Bitewing-single radiographic image	No Charge
D0272	Bitewing-two radiographic images	No Charge
	(ADA Code D0272 may only be obtained once in any six calendar months, except for medically necessary more frequent x-rays as determined by Member's Plan Dentist.)	
D0274	Bitewing-four radiographic images	No Charge
	(ADA Code D0274 may only be obtained once in any six calendar months, except for medically necessary more frequent x-rays as determined by Member's Plan Dentist.)	
D0277	Vertical bitewings-7 to 8 radiographic images	No Charge
D0330	Panoramic radiographic image	No Charge
	(ADA Code D0330 may only be obtained once in any three calendar years, except for medically necessary more frequent x-rays as determined by Member's Plan Dentist.)	
D0415	Collection of microorganisms for culture and sensitivity	No Charge
D0425	Caries susceptibility tests	No Charge
D0431	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	40.00
D0460	Pulp vitality tests	No Charge
	Preventive Dentistry	
D1110	Prophylaxis - adult	No Charge
	(ADA Code D1110 may only be obtained once in any six calendar months, except for medically necessary more frequent prophylaxis as determined by Member's Plan Dentist.)	
D1120	Prophylaxis - child	No Charge
	(ADA Code D1120 may only be obtained once in any six calendar months, except for medically necessary more frequent prophylaxis as determined by Member's Plan Dentist.)	
D1203	Topical application of fluoride - child	No Charge
D1204	Topical application of fluoride - adult	No Charge
D1206	Topical application of fluoride varnish	No Charge
D1310	Nutritional counseling for control of dental disease	No Charge
D1320	Tobacco counseling for the control and prevention of oral disease	No Charge
D1330	Oral hygiene instructions	No Charge
D1351	Sealant - per tooth	No Charge
D1510	Space maintainer - fixed - unilateral*	50.00
D1515	Space maintainer - fixed - bilateral*	50.00
D1520	Space maintainer - removable - unilateral*	65.00
D1525	Space maintainer - removable - bilateral*	90.00
D1550	Re-cement or re-bond space maintainer	10.00
None	Additional prophylaxis***	40.00
D9940	Occlusal guard, by report*	85.00
D9951	Occlusal adjustment - limited	15.00
D9952	Occlusal adjustment - complete	55.00
	Restorative Dentistry	
D2140	Amalgam - one surface, primary or permanent	5.00
D2150	Amalgam - two surfaces, primary or permanent	10.00
D2160	Amalgam - three surfaces, primary or permanent	15.00
D2161	Amalgam - four or more surfaces, primary or permanent	15.00
D2330	Resin-based composite - one surface, anterior	20.00
D2331	Resin-based composite - two surfaces, anterior	30.00
D2332	Resin-based composite - three surfaces, anterior	45.00
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	65.00
D2391	Resin-based composite - one surface, posterior	50.00

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ADA Code**	Service Description**	Member Copayment
D2392	Resin-based composite - two surfaces, posterior	60.00
D2393	Resin-based composite - three surfaces, posterior	70.00
D2394	Resin-based composite - four or more surfaces, posterior	95.00
D2510	Inlay - metallic - one surface*	75.00
D2520	Inlay - metallic - two surfaces*	85.00
D2530	Inlay - metallic - three or more surfaces*	110.00
D2542	Onlay - metallic - two surfaces*	100.00
D2543	Onlay - metallic - three surfaces*	120.00
D2544	Onlay - metallic - four or more surfaces*	130.00
D2610	Inlay - porcelain/ceramic one surface*	200.00
D2620	Inlay - porcelain/ceramic two surfaces*	210.00
D2630	Inlay - porcelain/ceramic three or more surfaces*	220.00
D2740	Crown - porcelain/ceramic substrate*	189.00
D2750	Crown - porcelain fused to high noble metal*	189.00
D2751	Crown - porcelain fused to predominantly base metal*	189.00
D2752	Crown - porcelain fused to noble metal*	189.00
D2790	Crown - full cast high noble metal*	189.00
D2791	Crown - full cast predominantly base metal*	189.00
D2792	Crown - full cast noble metal*	189.00
D2910	Re-cement or re-bond inlay, onlay, veneer, or partial coverage restoration	15.00
D2920	Re-cement or re-bond crown	15.00
D2930	Prefabricated stainless steel crown - primary tooth	80.00
D2932	Prefabricated resin crown	35.00
D2933	Prefabricated stainless steel crown with resin window	45.00
D2940	Protective restoration	15.00
D2950	Core buildup, including any pins	75.00
D2951	Pin retention - per tooth, in addition to restoration	15.00
D2952	Post and core in addition to crown, indirectly fabricated*	90.00
D2953	Each additional indirectly fabricated post - same tooth*	45.00
D2954	Prefabricated post and core in addition to crown	80.00
D2955	Post removal	25.00
D2957	Each additional prefabricated post - same tooth	30.00
D2971	Additional procedures to construct new crown under existing partial denture framework*	55.00
D2980	Crown repair necessitated by restorative material failure*	25.00
None	Temporary filling***	15.00
	Endodontics	
D3110	Pulp cap - direct (excluding final restoration)	15.00
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	40.00
D3221	Pulpal debridement, primary and permanent teeth	50.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	50.00
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	95.00
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)(S)	200.00
D3330	Endodontic therapy, molar (excluding final restoration)(S)	225.00
D3331	Treatment of root canal obstruction, non-surgical access	70.00
D3332	Incomplete endodontic therapy, inoperable, unrestorable or fractured tooth	150.00
D3333	Internal root repair of perforation defects	100.00
D3346	Retreatment of previous root canal therapy - anterior(S)	300.00
D3347	Retreatment of previous root canal therapy - bicuspid(S)	390.00
D3348	Retreatment of previous root canal therapy - molar(S)	460.00
D3351	Apexification / recalcification - initial visit (apical closure / calcific repair of perforations, root resorption, etc.)	175.00
D3352	Apexification/Recalcification-Interim Medication Replacement	175.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	175.00
D3410	Apicoectomy-Anterior(S)	125.00
D3421	Apicoectomy-Bicuspid (first root)(S)	165.00
D3425	Apicoectomy-Molar (first root)(S)	240.00
D3426	Apicoectomy-Each additional root	100.00

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ADA Code**	Service Description**	Member Copayment
D3430	Retrograde filling - per root(S)	75.00
D3450	Root amputation - per root	70.00
D3910	Surgical procedure for isolation of tooth with rubber dam	10.00
D3920	Hemisection (including any root removal), not including root canal therapy	80.00
D3950	Canal preparation and fitting of performed dowel or post	65.00
	Periodontics	
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant(S)	135.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant(S)	75.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	140.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	100.00
D4245	Apically positioned flap	145.00
D4249	Clinical crown lengthening - hard tissue	120.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant(S)	70.00
D4261	Osseous surgery (including elevation of full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant(S)	50.00
D4263	Bone replacement graft - first site in quadrant*	160.00
D4264	Bone replacement graft - each additional site in quadrant*	145.00
D4265	Biologic materials to aid in soft and osseous tissue regeneration*	80.00
D4266	Guided tissue regeneration-resorbable barrier, per site*	230.00
D4267	Guided tissue regeneration-nonresorbable barrier, per site (includes membrane removal)	240.00
D4270	Pedicle soft tissue graft procedure	265.00
D4271	Free soft tissue graft procedure (including donor site surgery)	260.00
D4273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft	75.00
D4320	Provisional splinting - intracoronal	80.00
D4275	Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft	320.00
D4321	Provisional splinting - extracoronal	75.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant(S)	75.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant(S)	35.00
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis(S)	50.00
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth*	40.00
D4910	Periodontal maintenance	45.00
None	Additional periodontal maintenance procedures (limit 2 additional years)***	30.00
None	Periodontal hygiene instructions***	No Charge
	Removable Prosthodontics (Removable Dentures)	
D5110	Complete denture - maxillary*	295.00
D5120	Complete denture - mandibular*	295.00
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)*	355.00
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)*	335.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)*	365.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)*	365.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)*	700.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)*	700.00
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth)*	400.00
D5410	Adjust complete denture - maxillary	15.00
D5411	Adjust complete denture - mandibular	15.00
D5421	Adjust partial denture - maxillary	15.00
D5422	Adjust partial denture - mandibular	15.00
D5510	Repair broken complete denture base*	30.00
D5610	Repair resin denture base*	35.00
D5620	Repair cast framework*	35.00
D5630	Repair or replace broken clasp - per tooth*	35.00
D5640	Replace broken teeth - per tooth*	35.00

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ADA Code**	Service Description**	Member Copayment
D5650	Add tooth to existing partial denture*	35.00
D5660	Add clasp to existing partial denture - per tooth*	55.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)*	165.00
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)*	165.00
D5710	Rebase complete maxillary denture*	195.00
D5711	Rebase complete mandibular denture*	180.00
D5720	Rebase maxillary partial denture*	150.00
D5721	Rebase mandibular partial denture*	155.00
D5730	Reline complete maxillary denture (chairside)	60.00
D5731	Reline complete mandibular denture (chairside)	60.00
D5740	Reline maxillary partial denture (chairside)	60.00
D5741	Reline mandibular partial denture (chairside)	60.00
D5750	Reline complete maxillary denture (laboratory)*	95.00
D5751	Reline complete mandibular denture (laboratory)*	95.00
D5760	Reline maxillary partial denture (laboratory)*	95.00
D5761	Reline mandibular partial denture (laboratory)*	95.00
D5810	Interim complete denture (maxillary)*	240.00
D5811	Interim complete denture (mandibular)*	240.00
D5820	Interim partial denture (maxillary)*	300.00
D5821	Interim partial denture (mandibular)*	300.00
D5850	Tissue conditioning, maxillary	25.00
D5851	Tissue conditioning, mandibular	25.00
D5862	Precision attachment, by report*	145.00
	Fixed Prosthodontics (Bridges or Fixed Partial Dentures)	
D6210	Pontic - cast high noble metal*	189.00
D6211	Pontic - cast predominantly base metal*	189.00
D6212	Pontic - cast noble metal*	189.00
D6240	Pontic - porcelain fused to high noble metal*	189.00
D6241	Pontic - porcelain fused to predominantly base metal*	189.00
D6242	Pontic - porcelain fused to noble metal*	189.00
D6250	Pontic - resin with high noble metal*	189.00
D6251	Pontic - resin with predominantly base metal*	189.00
D6252	Pontic - resin with noble metal*	189.00
D6253	Provisional pontic-further treatment or completion of diagnosis necessary prior to final impression*	189.00
D6545	Retainer - cast metal for resin bonded fixed prosthesis*	140.00
D6600	Retainer inlay - porcelain/ceramic, two surfaces*	165.00
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces*	175.00
D6602	Retainer inlay - cast high noble metal, two surfaces*	165.00
D6603	Retainer inlay - cast high noble metal, three or more surfaces*	175.00
D6604	Retainer inlay - cast predominantly base metal, two surfaces*	165.00
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces*	175.00
D6606	Retainer inlay - cast noble metal, two surfaces*	165.00
D6607	Retainer inlay - cast noble metal, three or more surfaces*	175.00
D6608	Retainer onlay - porcelain/ceramic, two surfaces*	165.00
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces*	175.00
D6610	Retainer onlay - cast high noble metal, two surfaces*	165.00
D6611	Retainer onlay - cast high noble metal, three or more surfaces*	175.00
D6612	Retainer onlay - cast predominantly base metal, two surfaces*	165.00
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces*	175.00
D6614	Retainer onlay - cast noble metal, two surfaces*	165.00
D6615	Retainer onlay - cast noble metal, three or more surfaces*	175.00
D6710	Retainer crown - indirect resin based composite*	100.00
D6720	Retainer crown - resin with high noble metal*	189.00
D6721	Retainer crown - resin with predominantly base metal*	189.00
D6722	Retainer crown - resin with noble metal*	189.00
D6740	Retainer crown - porcelain/ceramic*	189.00
D6750	Retainer crown - porcelain fused to high noble metal*	189.00
D6751	Retainer crown - porcelain fused to predominantly base metal*	189.00
D6752	Retainer crown - porcelain fused to noble metal*	189.00

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ADA Code**	Service Description**	Member Copayment
D6780	Retainer crown - 3/4 cast high noble metal*	189.00
D6781	Retainer crown - 3/4 cast predominantly base metal	170.00
D6782	Retainer crown - 3/4 cast noble metal	170.00
D6783	Retainer crown - 3/4 porcelain/ceramic*	170.00
D6790	Retainer crown - full cast high noble metal*	189.00
D6791	Retainer crown - full cast predominantly base metal*	189.00
D6792	Retainer crown - full cast noble metal*	189.00
D6794	Retainer crown - titanium*	225.00
D6930	Re-cement or re-bond fixed partial denture	15.00
D6940	Stress breaker	150.00
D6950	Precision attachment	195.00
D6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated*	150.00
D6972	Prefabricated post and core in addition to fixed partial denture retainer	150.00
D6973	Core build up for retainer, including any pins	100.00
D6976	Each additional indirectly fabricated post - same tooth*	75.00
D6977	Each additional prefabricated post - same tooth	60.00
D6980	Fixed partial denture repair, by report*	45.00
D9120	Fixed partial denture sectioning	65.00
None	Resin bonded bridge pontic, per unit*(***)	235.00
	Oral Surgery	
D7111	Extraction, coronal remnants - deciduous tooth	15.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	15.00
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth(S)	60.00
D7220	Removal of impacted tooth - soft tissue(S)	70.00
D7230	Removal of impacted tooth - partially bony(S)	85.00
D7240	Removal of impacted tooth - completely bony(S)	125.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications(S)	150.00
D7250	Surgical removal of residual tooth roots (cutting procedure)(S)	40.00
D7280	Surgical access of an unerupted tooth	165.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	90.00
D7283	Placement of device to facilitate eruption of impacted tooth*	70.00
D7285	Biopsy of oral tissue - hard (bone, tooth)	70.00
D7286	Biopsy of oral tissue - soft	20.00
D7288	Brush biopsy - transepithelial sample collection	45.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant(S)	70.00
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	80.00
D7287	Exfoliative cytological sample collection	45.00
D7320	Alveoloplasty not in conjunction with extractions -four or more teeth or tooth spaces, per quadrant(S)	90.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	100.00
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	20.00
D7471	Removal of lateral exostosis (maxilla or mandible)	75.00
D7472	Removal of torus palatinus	55.00
D7473	Removal of torus mandibularis	55.00
D7485	Surgical reduction of osseous tuberosity	55.00
D7510	Incision and drainage of abscess - intraoral soft tissue(S)	35.00
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	40.00
D7520	Incision and drainage of abscess - extraoral soft tissue	40.00
D7521	Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	40.00
D7910	Suture of recent small wounds up to 5 cm	35.00
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure(S)	40.00
D7963	Frenuloplasty	50.00
D7970	Excision of hyperplastic tissue - per arch	60.00
D7971	Excision of pericoronal gingiva	60.00
	Emergency Treatment of Pain	
D9110	Palliative (emergency) treatment of dental pain - minor procedure	25.00
None	Palliative (emergency) service - treatment to evaluate, stabalize, and control pain including local anesthesia when necessary	
	Anesthesia, Analgesia, and Sedation	
D9212	Trigeminal division block anesthesia	No Charge

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ADA Code**	Service Description**	Member Copayment
D9220	Deep sedation/general anesthesia - first 30 minutes	130.00
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	20.00
D9241	Intravenous moderate (conscious) sedation/analgesia - first 30 minutes(S)	100.00
D9242	Intravenous moderate (conscious) sedation/analgesia - each additional 15 minutes(S)	30.00
D9248	Non-intravenous (conscious) sedation	15.00
D9610	Therapeutic parenteral drug, single administration*	20.00
D9612	Therapeutic parenteral drugs, two or more administrations, different medications*	35.00
D9630	Other drugs and/or medicaments, by report*	20.00
D9910	Application of desensitizing medicament	15.00

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 Providers who perform the corresponding listed services. The Plan Dentist selected by the Member may not perform all listed services. Plan Specialty Dentists may not perform or offer all services listed. Availability and participation of Plan Dentists and Plan Specialty Dentists are subject to change.

(S) – Plan Benefits are available for these services when they are provided by a Plan Specialty Dentist.

This notice only applies to employers with 50 or fewer employees. This coverage does not include and is not required to include the pediatric dental essential health benefit as required under the federal Patient Protection and Affordable Care Act.

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

‡More often if medically necessary as determined by attending Plan Dentist.

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2. Orthodontia Services

The dental services listed in the following schedule are covered when provided by a Plan Specialty Dentist. Member is responsible for paying the amount in the Member Copayment column either at the time the service is received or in accordance with Plan Specialty Dentist's billing procedures.

ADA Code**	Service Description**	Member Copayment
	Orthodontics	
None	Bracketing (for D8070, D8080 or D8090)***	300.00
D8070	Comprehensive orthodontic treatment of the transitional dentition	2000.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition (under 19 years)	2000.00
D8090	Comprehensive orthodontic treatment of the adult dentition (19 years or older)	2200.00
D8660	Pre-orthodontic treatment examination to monitor growth and development (consult/records/exam)	100.00
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	250.00

The Orthodontic Copayments listed above only apply during the first 24 months of active treatment and are only available once per lifetime. After 24 months of active treatment, the above Orthodontic Copayments are no longer applicable, and the listed services will be provided to the Member at a 25% reduction from the Plan Specialty Dentist's normal retail charge. Member is responsible for paying the entire reduced charge either at the time the service is received or in accordance with Plan Specialty Dentist's billing procedures.

This is a sample 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 Specialty Dentists who perform the corresponding listed services. Plan Specialty Dentists may not perform or offer all services listed. Availability and participation of Plan Specialty Dentists are subject to change.

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

3. Non-Plan Specialty Dentist Services

The dental services listed in the following schedule are covered when provided by a Non-Plan Specialty Dentist. Except for benefits for Medically Necessary Services and Emergency Services as specifically stated in the MEDICALLY NECESSARY AND EMERGENCY SERVICES Article of the Evidence of Coverage, Member is responsible for paying the Non-Plan Specialty Dentist's entire normal retail charge for the service at the time the service is received or in accordance with the Non-Plan Specialty Dentist's billing procedures. Member may then submit a completed claim form, with the itemized bill attached, to Company. (Member may obtain claim forms by contacting Company.) Company will pay Member the lesser of the amount shown in the Maximum Company Reimbursement column or the amount charged by the Non-Plan Specialty Dentist for the service. Plan Benefit payments for services by Non-Plan Specialty Dentists are limited to a total of $2,000.00 per calendar year.

ADA Code**	Service Description**	Maximum Company Reimbursement
	Endodontics	
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)	415.00
D3330	Endodontic therapy, molar (excluding final restoration)	630.00
D3346	Retreatment of previous root canal therapy - anterior	280.00
D3347	Retreatment of previous root canal therapy - bicuspid	420.00
D3348	Retreatment of previous root canal therapy - molar	445.00
D3410	Apicoectomy-Anterior	475.00
D3421	Apicoectomy-Bicuspid (first root)	530.00
D3425	Apicoectomy-Molar (first root)	495.00
D3430	Retrograde filling - per root	135.00
	Periodontics	
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	405.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	110.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	550.00
D4261	Osseous surgery (including elevation of full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	180.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	135.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	110.00
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	85.00
	Oral Surgery	
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	155.00
D7220	Removal of impacted tooth - soft tissue	175.00
D7230	Removal of impacted tooth - partially bony	220.00
D7240	Removal of impacted tooth - completely bony	240.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	280.00
D7250	Surgical removal of residual tooth roots (cutting procedure)	160.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	195.00
D7320	Alveoloplasty not in conjunction with extractions -four or more teeth or tooth spaces, per quadrant	195.00
D7510	Incision and drainage of abscess - intraoral soft tissue	130.00
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure	205.00
	Anesthesia, Analgesia, and Sedation	
D9241	Intravenous moderate (conscious) sedation/analgesia - first 30 minutes	175.00
D9242	Intravenous moderate (conscious) sedation/analgesia - each additional 15 minutes	30.00

Plan Benefits are not available for any service that is both (a) received from a Non-Plan Specialty Dentist and (b) not listed on the Plan Benefit Schedule above. (Note: Plan Benefits are not available for Orthodontic services provided by a Non-Plan Specialty Dentist.

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

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

What is a DHMO plan?

With a DHMO 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 can find a dentist in the DHMO Dental Series Provider Network by visiting the Assurant Employee Benefits web site at www.assurantemployeebenefits.com and clicking on the "Find a Dentist" link found under "Tools for Members". Next, click "DHMO or Prepaid Dental Plan?", select your state from the drop down list, and then select "DHMO Dental Series". Note that your Plan Dentist must be a general dentist, not a specialty dentist.

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 20th of the month, you will appear on the roster the 1st of the next month. If we receive the selection after the 20th, 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 only covers procedures administered in a dentist's office or comparable facility to evaluate and stabilize conditions that are Dental Emergencies, as specified (with a description of benefits payable) in the Evidence of Coverage.

If I need to see a specialty dentist, how do I go about finding a Plan Specialty Dentist in my area?

You may find a list of Plan Specialty Dentists 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 Specialty Dentist.

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 part of any dental service for which a charge is incurred before the effective date of the Member's enrollment.
3. Any dental service initiated (a) before the effective date of Member's enrollment for Plan Benefits except as provided in the **ORTHODONTIC TREATMENT** Article of the Evidence of Coverage or (b) after Member's enrollment for Plan Benefits ends.
4. Services provided by Non-Plan Providers unless (a) for services of Non-Plan Specialty Dentists as specifically provided in the SPECIALTY DENTIST SERVICES section of the Copayment Schedule or (b) for Medically Necessary Services and Emergency Services as specifically provided in the MEDICALLY NECESSARY AND EMERGENCY PROCEDURES Article of the Evidence of Coverage.
5. 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.
6. Replacement of dentures or other removable appliances due to (a) damage while not in use or (b) loss or theft.
7. 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).
8. Implants or any related implant appliances, or surgery for the insertion of implants or any related implant appliances, whether fixed or removable.
9. 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.
10. Restorations or splints used to increase vertical dimension, restore occlusion, or replace or stabilize tooth structure lost by attrition.
11. Orthodontic treatment involving therapy for myofunctional problems, TMJ (temporomandibular joint) dysfunctions, micrognathia, macroglossia, cleft palate or other growth and developmental abnormalities.
12. Orthodontic treatment associated with orthognathic surgery, whether the treatment precedes or follows the surgery.
13. 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.
14. 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 can 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 **Joseph F. McWherter MD DBA Fem Centre**	Group Number	Effective Date / /

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

HMO Plan

☐ **189**

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 25? **Furnish proof of incapacity within 31 days of the Effective Date.**

☐ Check this box if you have a disability affecting your ability to communicate or read.

Please indicate your primary language by placing a check in the appropriate box: ☐ English ☐ Spanish ☐ Other

☐ **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 United Dental Care of Texas, Inc. 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 United Dental Care of Texas, Inc., Union Security Insurance Company, and their 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 United Dental Care of Texas, Inc., Union Security Insurance Company, and their affiliated dental companies to use and disclose protected health information. **IMPORTANT WARNING: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of benefits.**

Signature: **Date:**