

Smile



FORTIS

Solid partners, flexible solutionsSM

Good news about dental benefits for members of

AFGE Local Colorado

A Dental Plan Means Healthy Smiles

Because you are a valued member, we are pleased to offer you the opportunity to enroll in an excellent dental benefit plan provided by United Dental Care of Colorado, 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 Claims to File
- No Annual Dollar Maximum
- No Waiting Periods for Covered Members
- Coverage for Pre-Existing Conditions
- Worldwide Emergency Coverage
- Wide Range of Covered Procedures

Vision Care Program

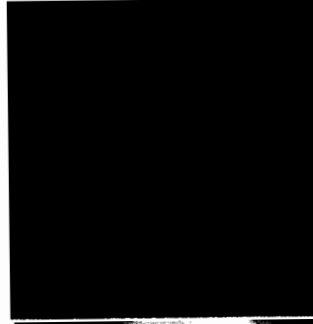
Your dental plan includes an excellent vision care program. The vision plan includes discounts on eye exams, eyeglasses, contact lenses and other prescription eyewear when provided by participating providers.

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. You can find our Legend Series Provider Network by visiting our website at www.fortisbenefitsdental.com and clicking on "Provider Search." 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 policy provisions.



Savings You Can See

Bi-Weekly Payroll Deduction

Employee	\$6.73
Employee and One Dependent	\$11.11
Employee and Family	17.23

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.)

Pinnacle Plan

Underwritten by United Dental Care of Colorado, 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	Plan Dentist Treatment	Member Copayment
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Appointments

999	Routine Office Visit	5.00
120	Periodic Oral Evaluation	No Charge
150	Comprehensive Oral Evaluation	No Charge
9999	Missed Appointment without 24-Hour Notice	20.00

Diagnostic Dentistry

210	X-Ray - Intraoral, Comp. Series, Incl. Bitewings	No Charge
415	Bacterial Studies	No Charge

Preventive Dentistry

1110	Routine Prophylaxis/Cleaning - Adult (once every 6 mos.)	No Charge
1120	Routine Prophylaxis/Cleaning - Child (once every 6 mos.)	No Charge
1203	Topical Application of Fluoride - (Child)	No Charge
1330	Oral Hygiene Instruction	No Charge

ADA Code	Plan Dentist Treatment	Member Copayment
1351	Application of Sealant, Per Tooth	5.00
1510	Space Maintainer (Fixed) - Unilateral*	60.00
1515	Space Maintainer (Fixed) - Bilateral*	60.00
1520	Space Maintainer (Removable) - Unilateral*	60.00
1525	Space Maintainer (Removable) - Bilateral*	60.00

Restorative Dentistry (Fillings/Crowns)

2110	Amalgam - One Surface, Primary	8.00
2120	Amalgam - Two Surfaces, Primary	9.00
2130	Amalgam - Three Surfaces, Primary	10.00
2131	Amalgam - Four or More Surfaces, Primary	15.00
2140	Amalgam - One Surface, Permanent	10.00
2150	Amalgam - Two Surfaces, Permanent	15.00
2160	Amalgam - Three Surfaces, Permanent	20.00
2161	Amalgam - Four or More Surfaces, Permanent	25.00
2330	Resin Filling - One Surface, Anterior	15.00
2331	Resin Filling - Two Surfaces, Anterior	20.00
2332	Resin Filling - Three Surfaces, Anterior	25.00
2335	Resin Filling - Four or More Surfaces, Anterior	40.00
2385	Resin Filling - One Surface, Posterior, Permanent	25.00
2386	Resin Filling - Two Surfaces, Posterior, Permanent	35.00
2387	Resin Filling - Three or More Surfaces, Post., Perm.	45.00
2750	Crown - Porcelain Fused to High Noble Metal*	225.00
2962	Labial Veneer (Porcelain Laminate) - Lab*	315.00

Endodontics (Root Canals)

3310	Root Canal - Anterior (excluding final restoration)	110.00
3320	Root Canal - Bicuspid (excluding final restoration)	130.00
3330	Root Canal - Molar (excluding final restoration)	190.00

Periodontics

4341	Periodontal Scaling and Root Planing, Per Quadrant	40.00
4355	Full Mouth Debridement (Complicated Cleaning)	30.00

Removable Prosthodontics (Dentures)

5110	Complete Upper Denture*	300.00
5120	Complete Lower Denture*	300.00
5211	Partial Denture - Upper Resin Base*	310.00
5212	Partial Denture - Lower Resin Base*	310.00

Fixed Prosthodontics

6750	Crown - Porcelain Fused to High Noble Metal, Per Unit*	225.00
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Oral Surgery

7110	Single Tooth Extraction	10.00
7120	Each Additional Tooth Extraction, Per Visit	10.00
7220	Removal of Impacted Tooth - Soft Tissue	50.00
7230	Removal of Impacted Tooth - Partial Bony	70.00
7240	Removal of Impacted Tooth - Complete Bony	90.00
7241	Removal of Impacted Tooth - Complete Bony, with Complications	75.00

*Members are responsible for additional lab 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 (PDC-CO-0105), Evidence of Coverage (PDC-CO-0107) and Copayment Schedule (PDC-CO-0109), which determine all rights, benefits, and applicable Limitations and Exclusions.

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. Benefits under the Specialty Benefit Amendment are available only if you use a Specialist who is a part of our provider network.

No Annual Maximum!

There is no annual maximum for procedures performed by a Plan Specialist.

ADA Code	Plan Dentist Treatment	In Network Member Copayment
Appointments		
140	Limited Oral Evaluation – Problem Focused (emergency office visit, normal hours).....	25.00
150	Comprehensive Oral Evaluation	25.00
Endodontics (Root Canals)		
3320	Root Canal - Bicuspid (excluding final restoration).....	235.00
3330	Root Canal - Molar (excluding final restoration).....	320.00
3346	Retreatment of Previous Root Canal Therapy - Anterior ...	335.00
3347	Retreatment of Previous Root Canal Therapy - Bicuspid ..	430.00
3348	Retreatment of Previous Root Canal Therapy - Molar.....	475.00
3410	Apicoectomy - Anterior.....	200.00
3421	Apicoectomy - Bicuspid, First Root.....	230.00
3425	Apicoectomy - Molar, First Root.....	265.00
3430	Retrograde Filling - Per Root.....	65.00
Periodontics		
4210	Gingivectomy or Gingivoplasty, Per Quadrant.....	225.00
4220	Gingival Curettage, Per Quadrant.....	90.00
4260	Osseous Surgery, Per Quadrant.....	390.00
4341	Periodontal Scaling and Root Planing, Per Quadrant.....	80.00
4355	Full Mouth Debridement (Complicated Cleaning).....	55.00
4381	Local Delivery Chemo Per Tooth.....	60.00

ADA Code	Plan Dentist Treatment	In Network Member Copayment
Oral Surgery		
7210	Surgical Removal of Erupted Tooth	60.00
7220	Removal of Impacted Tooth - Soft Tissue	80.00
7230	Removal of Impacted Tooth - Partial Bony.....	105.00
7240	Removal of Impacted Tooth - Complete Bony	150.00
7241	Removal of Impacted Tooth - Complete Bony, with Complications	160.00
7250	Surgical Removal of Residual Roots (Cutting Procedure) ...	60.00
7281	Surgical Exposure, Per Tooth	150.00
7310	Alveoloplasty in Conjunction with Extractions, Per Quadrant.....	100.00
7320	Alveoloplasty Not in Conjunction with Extractions, Per Quadrant.....	85.00
7470	Removal of Exostosis.....	220.00
7510	Incision and Drainage of Abscess – Intraoral.....	70.00
7960	Frenectomy	145.00
Other Services		
9240	IV Sedation	130.00

This is a Sample Member Copayment Schedule only. It is not an Evidence of Coverage. Please see the Group Dental Service Agreement (PDC-CO-0105), Evidence of Coverage (PDC-CO-0107) and Copayment Schedule (PDC-CO-0109), which determine all rights, benefits, and applicable Limitations and Exclusions.

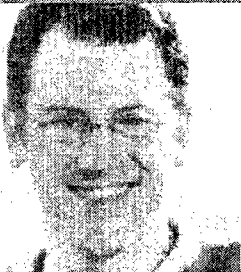
Benefits provided by or underwritten by United Dental Care of Colorado, Inc.



FORTIS

Solid partners, flexible solutions[®]

Access vision discount plan



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

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.

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 doctor's professional services when purchasing all prescription contact lenses (materials at doctor's usual and customary fees).^{2,3}
- **Laser VisionCareSM** - 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.

How to Use VSP

- 1 Locate a VSP doctor near you. You may either use the web-based doctor locator at www.vsp.com, or call VSP at **1-800-877-7195** to request a doctor listing.
- 2 Identify yourself as a VSP member and be prepared to provide the covered member's social security number when you make your appointment.
- 3 Fees are automatically reduced at the time of service - with no claim forms to fill out!

THIS VISION DISCOUNT PLAN IS NOT INSURANCE.

¹Note: Does not apply to contact lens services. See contact lens bullet for applicable discount.

²Discounts only offered through the VSP doctor who provided an eye exam within the last 12 months.

³VSP offers valuable savings on annual supplies of select brands of contact lenses.

VSP Member
Services Support
1-800-877-7195



COLORADO Limitations & Exclusions

This dental plan is underwritten by United Dental Care of Colorado, Inc.

RENEWABILITY

After the initial Plan Year, each Plan Year of Agreement shall have a twelve month term.

TERMINATION

The Agreement may be terminated by Plan as follows:

- 1) for failure to pay proper monthly Prepayment Fees;
- 2) for fraud or misrepresentation of fact in obtaining coverage under Plan;
- 3) for material breach of any provision of Agreement.

CANCELLATION

Cancellation may occur as follows:

- 1) At Anniversary date, upon prior written notice by Plan or Group.
- 2) After the initial Plan Year, without cause, upon prior written notice by Plan or Group.

LIMITATIONS & EXCLUSIONS

1. Medical costs associated with dental procedures are not covered.
2. The parent or guardian is responsible for affecting behavior of dependents so that provider may safely render proper dental care. Services rendered by a specialist because of behavior adjustment may affect Member's out of pocket expense. Such services needed may be physical restraint, sedation or other method of control.
3. Dentures or appliances will be replaced only after five years since dentures or appliances were provided by Plan. If denture or appliance becomes unserviceable due to illness or causes not controlled by ordinary means, the following will apply: Replacement will be made only if existing denture or appliance cannot be made serviceable.
4. Replacement of dentures, appliances or bridgework due to loss or theft is not covered.
5. Dental treatment provided or started prior to Member's eligibility to receive benefits is not covered. Dental treatment started after Member's termination is not covered.
6. Failure to follow prescribed treatment may result in additional charges. Accidents occurring during the course of any treatment may result in additional charges.
7. Restorations and endodontic posts and cores placed after root canal therapy are separate procedures from actual root canal treatment. Therefore, the specific co-payments listed for restorations or posts and cores will apply.
8. Orthodontic Treatment is limited as follows:
 - Minor treatment of tooth guidance/interceptive orthodontia is limited to eighteen (18) consecutive months.
 - Retention treatment is limited to eighteen (18) consecutive months. Ongoing treatment past eighteen (18) consecutive months is not covered. Also, ongoing treatment past eighteen (18) consecutive months may be subject to additional fees. This would be determined as outlined in the Copayment Schedule and determined by provider.
9. Orthodontic treatment involving therapy for myofunctional problems, T.M.J. dysfunctions, micrognathia, macroglossia or hormonal imbalances causing growth and developmental abnormalities, is not covered.
10. Extractions for Orthodontic purposes only are at a 25% discount off of Plan Provider's normal retail charge.
11. Orthodontic cases, involving orthognathic surgery, are not covered.
12. Treatment for malignancies, neoplasms or cysts, including biopsy, is not covered.
13. Services provided by non-Plan dentists are not covered unless preauthorized by Plan or unless specified otherwise elsewhere in the Evidence of Coverage.
14. Copayments listed for restorations do not include the cost of lab fees.
15. Restorations and splints used to increase vertical dimension, restore occlusion, or replace/stabilize tooth structure loss by attrition are not covered.
16. Fixed prosthetic restoration of six (6) or more existing teeth, when performed as a simple procedure as part of a complete oral rehabilitation or reconstruction is not covered.
17. Complete oral rehabilitation or reconstruction involving replacement of six (6) or more missing teeth using fixed prosthetic restorations and/or appliances is not covered.
18. Dental treatment is not covered if Member's general health or physical limitations prevent provider from rendering appropriate dental treatment.
19. Costs associated with prescriptions or over the counter medications are not covered.
20. Implants, surgery for the insertion of implants, all related implant appliances and restorations, removable or fixed, are not covered.
21. The surgical removal of implants, or any surgery required to adjust, replace, or treat any problem related to an existing implant, or implant appliance, is not covered.



Group Name AFGE Local Colorado	Group Number EE32	Effective Date
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I apply for the following coverage for myself and dependents, as listed.
Managed Care Plan
 Pinnacle

Employee First Name _____ MI _____ Last Name _____	<input type="checkbox"/> M <input type="checkbox"/> 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#
				<input type="checkbox"/> M <input type="checkbox"/> F	/ /	
				<input type="checkbox"/> M <input type="checkbox"/> F	/ /	
				<input type="checkbox"/> M <input type="checkbox"/> F	/ /	
				<input type="checkbox"/> M <input type="checkbox"/> 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: _____