A City of Houston Payroll Deduction Authorization and Cancellation Form

I, _____ hereby authorize the City of Houston to
Print Employee Name
deduct/stop _____ from my pay each scheduled cycle and remit to
(circle one) *Amount*

Texas Police Trust 1600 State Street Houston, Texas 77007
Company Name and Address

Veronica Mc Donough 832-200-3410 in payment of goods and services purchased by me.
Agent/Representative *Agent's Phone*

I understand the City of Houston neither sponsors nor endorses the product or services purchased from the above company, nor does it attest to the worth or value of the product or service. I understand, except when restrictions by federal laws apply, that I may cancel this authorization at any time, in writing, by executing a Form 6 (revised 10/91). In consideration of the City providing this service, I agree not to hold the City liable for any loss resulting from failure to deduct and/or remit the payment specified. I will pay directly to the company any monies not withheld during a payroll cycle. I further authorize increases or reductions in such deductions. I will request directly from the company any change to my address; however, if I fail to do so, I authorize the City to release my address of record to the company. I certify that no portion of this deduction is for a Political Action Contribution (PAC) or any other purpose prohibited by City of Houston Legislation. I further agree to notify the company or agent, listed above, in writing of any changes or cancellations to my coverage 30 days prior to the effective date of change. Additionally I will not hold the company or agent responsible for changes made by parties other than the company or agent or incorrect deductions over 30 days old.

Employee Signature _____ Date Signed _____

--To be completed by payroll clerk—

Employee Number _____

Employee SS# _____ Dept._____ Dept. Name _____

Check appropriate box(es)		Amount	Type/Plan	Date	Name
(X)	Start Amount	_____	HPOAD / HPOAD	_____	_____
( )	Change if new amt.	_____	_____/_____	_____	_____
( )	Stop Amount	_____	_____/_____	_____	_____
( )	One-time Deduction	_____	_____/_____	_____	_____
( )	One-time Refund	_____	_____/_____	_____	_____

_____ _____ _____
Payroll Clerk *Date Prepared* *Department Head*

DUAL CHOICE ENROLLMENT APPLICATION

☐ CHOICE ONE- PREPAID

ENROLLMENT INSTRUCTIONS:

1. Complete the application. (Be sure to list all Family Members to be included.)
2. **Select a dental office from the Provider List and Insert the dental facility number on the application.**
3. Complete the authorization for deduction with full information and sign in the lower portion.
4. Return the completed application and authorization for deduction to your payroll department for processing.

Completed applications, with correct premiums, received by Home Office by the 15th of the month will become effective on the 1st of the following month.

SOCIAL SECURITY #	LAST NAME	FIRST	MI	DATE OF BIRTH

HOME ADDRESS	AREA CODE	HOME PHONE	SEX
			☐ M ☐ F

CITY	STATE	ZIP CODE	AREA CODE	BUSINESS PHONE	DENTAL FACILITY #

NAME AND ADDRESS OF EMPLOYER OR ORGANIZATION

LIST ALL YOUR ELIGIBLE DEPENDENTS IF THEY ARE TO BE COVERED

	FIRST	M.I.	LAST	S.S.N. #	SEX	BIRTHDATE
SPOUSE:					☐M ☐F	/ /
CHILD:					☐M ☐F	/ /
CHILD:					☐M ☐F	/ /
CHILD:					☐M ☐F	/ /

EFFECTIVE DATE

PLAN CODE	GROUP CODE #	PREMIUM AMOUNT	AMOUNT PAID	AGENT CODE
		$	$	

I wish to enroll in the Prepaid Plan. I understand that this is a minimum one (1) year contract and that all necessary dental services will be provided in the description of benefits and surcharges. I have received and understand the outline of coverage.

Applicant's Signature: _____ **Date:** _____

Agent's Signature: _____

☐ CHOICE TWO

Insured by CompDent Insurance Company, Roswell, Georgia

ENROLLMENT INSTRUCTIONS:

1. Complete the application. (Be sure to list all Family Members to be included.)
2. Complete the authorization for deduction with full information and sign in the lower portion.
3. Return the completed application and authorization for deduction to your payroll department for processing.

Completed applications, with correct premiums, received by Home Office by the 15th of the month will become effective on the 1st of the following month.

SOCIAL SECURITY #	LAST NAME	FIRST	MI	DATE OF BIRTH

HOME ADDRESS	AREA CODE	HOME PHONE	SEX
			☐ M ☐ F

CITY	STATE	ZIP CODE	AREA CODE	BUSINESS PHONE

NAME AND ADDRESS OF EMPLOYER OR ORGANIZATION	OCCUPATION (TITLE)	DATE HIRED FULL TIME

LIST ALL YOUR ELIGIBLE DEPENDENTS IF THEY ARE TO BE COVERED

	FIRST	M.I.	LAST	S.S.N. #	SEX	BIRTHDATE
SPOUSE:					☐M ☐F	/ /
CHILD:					☐M ☐F	/ /
CHILD:					☐M ☐F	/ /
CHILD:					☐M ☐F	/ /

BENEFICIARY
NAME AND RELATIONSHIP (i.e., Mary Jones, Wife)

EFFECTIVE DATE	PLAN CODE	GROUP CODE #	PREMIUM AMOUNT	AMOUNT PAID	AGENT CODE
			$	$	

I wish to enroll in the Choice Two dental plan. I have received and understand the outline of coverage.

Applicant's Signature: _____ **Date:** _____

Agent's Signature: _____

Please Note:
Any person who, 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. I hereby consent, personally and on behalf of any family members enrolled, to the unrestricted release of my/our dental records maintained by participating dentists to CompDent for, but not limited to, claims verification and quality assessment review, and to any other participating dentist who may be or become involved in my/our dental care.

AUTHORIZATION FOR DEDUCTION – Signature Required – Employer

Name _____ Social Security No. _____ I authorize _____
(Employer, Financial, or other organization)

To make ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly (Check correct payment method) Deductions of $ _____ From: My salary or other compensation

and to remit the amount deducted to **CompDent (CD)**, upon instruction from **CD**. The amount of deduction indicated above is approximate and may be corrected as instructed by **CD**. This authorization shall cease (a) upon my giving written cancellation notice to you; or (b) automatically upon my termination as a member or depositor, as the case may be, of the above named organization. I understand this authorization does not waive or change any of the payment provisions of any policy issued to me by **CD** and if this authorization terminates for any reason, any further payments required under said policy (ies) shall be made as provided in the policy (ies). I agree that the above-named organization is acting gratuitously and for my sole accommodation and not as an agent for **CD**.

Applicant's Signature: _____ Date Signed: _____

Schedule of Benefits and Subscriber Copayments

CS 600-TX

ADA CODE	PROCEDURE	PATIENT PAYS
APPOINTMENTS		
D9310	Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)	$0
D9430	Office visit (during regularly scheduled hours)	$5
D9440	Office visit - after regularly scheduled hours	$35
DIAGNOSTIC		
D0120	Periodic oral evaluation	$0
D0140	Limited oral evaluation - problem focused	$0
D0150	Comprehensive oral evaluation.	$0
D0160	Detailed & external oral evaluation-problem focused, by report	$0
D0210	Intraoral - complete series (inc. bitewings)	$0
D0220	Intraoral - periapical - first film	$0
D0230	Intraoral- periapical each additional film	$0
D0240	Intraoral- occlusal film	$0
D0250	Extraoral - first film	$0
D0260	Extraoral - each additional film	$0
D0270	Bitewing - single film	$0
D0272	Bitewings - two films	$0
D0274	Bitewings - four films	$0
D0330	Panoramic film	$0
D0415	Bacteriologic studies for determination of path. agents	$0
D0425	Caries susceptibility test	$0
D0460	Pulp vitality test	$0
D0470	Diagnostic casts	$0
PREVENTIVE CARE		
D1110	Prophylaxis - adult	$0
D1120	Prophylaxis - child	$0
D1201	Topical application of fluoride (including prophylaxis) - child	$0
D1203	Topical application of fluoride (prophylaxis not included) - child	$0
D1330	Oral hygiene instructions	$0
D1351	Sealant - per tooth	$8
D1510	Space maintenance - fixed- unilateral	$50 + Lab**
D1515	Space maintenance - fixed-bilateral	$60 + Lab**
D1520	Space maintenance - removable- unilateral	$60 + Lab**
D1525	Space maintenance - removable- bilateral	$75 + Lab**
D1550	Recementation of space maintainer	$15
RESTORATIVE		
D2110	Amalgam - one surface, primary	$10
D2120	Amalgam - two surfaces, primary	$15
D2130	Amalgam - three surfaces, primary	$20
D2131	Amalgam - four or more surfaces, primary	$25
D2140	Amalgam - one surface, permanent	$10
D2150	Amalgam - two surfaces, permanent	$15
D2160	Amalgam - three surfaces, permanent	$20
D2161	Amalgam - four or more surfaces, permanent	$25
RESIN RESTORATION		
D2330	Resin-based composite - one surface, anterior	$20
D2331	Resin-based composite - two surfaces, anterior	$30
D2332	Resin-based composite - three surfaces, anterior	$40
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$45
D2336	Resin-based composite crown, anterior- primary	$55
D2385	Resin-based composite - one surface, posterior-permanent	$40
D2386	Resin-based composite - two surfaces, posterior-permanent	$55
D2387	Resin-based composite - three surfaces, posterior-permanent	$70
D2510	Inlay - metallic - one surface	$85
D2520	Inlay - metallic - two surfaces	$95
D2530	Inlay - metallic - three or more surfaces	$105
D2610	Inlay - porcelain/ceramic - one surface	$190 + Lab**
D2620	Inlay - porcelain/ceramic - two surfaces	$190 + Lab**
D2630	Inlay - porcelain/ceramic - three or more surfaces	$190+ Lab**
CROWN & BRIDGE		
D2740	Crown porcelain/ceramic substrate	$230 + Lab**
D2750*	Crown - porcelain fused to high noble metal	$230
D2751	Crown - porcelain fused to predominantly base metal	$230
D2752*	Crown - porcelain fused to noble metal	$230
D2790*	Crown - full cast high noble metal	$230
D2791	Crown - full cast predominantly base metal	$230
D2792*	Crown - full cast noble metal	$230
D2910	Recement inlay	$15

ADA CODE	PROCEDURE	PATIENT PAYS
D2920	Recement crown	$15
D2930	Prefabricated stainless steel crown - primary tooth	$55
D2931	Prefabricated stainless steel crown - permanent tooth	$35
D2940	Sedative filling	$5
D2950	Core buildup, including any pins	$50
D2951	Pin retention - per tooth, in addition to restoration	$15
D2952	Cast post & core, in addition to crown	$75 + Lab**
D2953	Each additional cast post - same tooth	$75 + Lab**
D2954	Prefabricated post & core, in add to crown	$75
D2960	Labial veneer (resin laminate) - chairside	$200
D2962	Labial veneer (porcelain laminate)	$315+ Lab**
D9972	External bleaching- per arch	$145
ENDODONTICS		
D3110	Pulp cap - direct (excluding final restoration)	$0
D3120	Pulp cap - indirect (excluding final restoration)	$0
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$20
D3221	Gross pulpal debridement, primary and permanent teeth	$50
D3310	Root canal therapy - anterior (excluding final restoration)	$100
D3320	Root canal therapy - bicuspid (excluding final restoration)	$145
D3330	Root canal therapy - molar (excluding final restoration)	$175
D3351	Apexification/recalcification - initial visit (apical closer/calcific repair of perforations, root resorption, etc.)	$30
D3352	Apexification/recalcification - interim medication replacement (apical closer/calcific repair of perforations, root resorption,etc)	$30
D3353	Apexification/recalcification - final visit (apical closer/calcific repair of perforations, root resorption, etc.)	$30
D3410	Apicoectomy/periradicular surgery - anterior	$125
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	$170
D3425	Apicoectomy/periradicular surgery - molar (first root)	$180
D3426	Apicoectomy/periradicular surgery (each additional root)	$125
D3430	Retrograde - filling per root	$40
D3450	Root amputation - per root	$70
D3920	Hemisection (including any root removal), not including root canal therapy	$75
D3950	Canal preparation and fitting of preformed dowel or post	$0
PERIODONTICS (Gum Treatment)		
D4210	Gingivectomy or gingivoplasty - per quadrant	$120
D4211	Gingivectomy or gingivoplasty - per tooth	$30
D4220	Gingival currettage, surgical - per quadrant, by report	$50
D4260	Osseous surgery (including flap entry and closure) - per quad.	$300
D4320	Provisional splinting - intracoronal	$60
D4321	Provisional splinting - extracoronal	$50
D4341	Periodontal scaling and root planing, per quadrant	$40
D4355	Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis	$30
D4910	Periodontal maintenance procedures (following active therapy)	$30
D5110	Complete denture - maxillary	$290 + Lab**
D5120	Complete denture - mandibular	$290 + Lab**
D5130	Immediate denture - maxillary	$325 + Lab**
D5140	Immediate denture - mandibular	$325 + Lab**
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$290 + Lab**
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	$290 + Lab**
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$325 + Lab**
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$325 + Lab**
D5410	Adjust complete denture - maxillary	$10
D5411	Adjust complete denture - mandibular	$10
D5421	Adjust partial denture - maxillary	$10
D5422	Adjust partial denture - mandibular	$10
REPAIRS TO PROSTHETICS		
D5510	Repair broken complete denture base	$30 + Lab**
D5610	Repair resin denture base	$30 + Lab**
D5620	Repair cast framework	$30 + Lab**
D5630	Repair or replace broken clasp	$30 + Lab**
D5640	Replace broken teeth - per tooth	$30 + Lab**

ADA CODE	PROCEDURE	PATIENT PAYS
D5650	Add tooth to existing partial denture	$30 + Lab**
D5660	Add clasp to existing partial denture	$30 + Lab**
D5710	Rebase complete maxillary denture	$90 + Lab**
D5711	Rebase complete mandibular denture	$90 + Lab**
D5720	Rebase maxillary partial denture	$90 + Lab**
D5721	Rebase mandibular partial denture	$90 + Lab**
D5730	Reline complete maxillary denture (chairside)	$60
D5731	Reline complete mandibular denture (chairside)	$60
D5740	Reline maxillary partial denture (chairside)	$60
D5741	Reline mandibular partial denture (chairside)	$60
D5750	Reline complete maxillary denture (laboratory)	$80 + Lab**
D5751	Reline complete mandibular denture (laboratory)	$80 + Lab**
D5760	Reline maxillary partial denture (laboratory)	$75 + Lab**
D5761	Reline mandibular partial denture (laboratory)	$75 + Lab**
D5850	Tissue conditioning, maxillary	$25
D5851	Tissue conditioning, mandibular	$25
PROSTHODONTICS (Fixed)		
D6210*	Pontic - cast high noble metal	$230
D6211	Pontic - cast predominantly base metal	$230
D6212*	Pontic - cast noble metal	$230
D6240*	Pontic - porcelain fused to high noble metal	$230
D6241	Pontic - porcelain fused to predominantly base metal	$230
D6242*	Pontic - porcelain fused to noble metal	$230
D6750*	Crown - porcelain fused to high noble metal	$230
D6751	Crown - porcelain fused to predominantly base metal	$230
D6752*	Crown - porcelain fused to noble metal	$230
D6930	Recement fixed partial denture	$15
D6940	Stress breaker	$125 + Lab**
D6950	Precision attachment	$150 + Lab**
EXTRACTIONS/ORAL AND MAXILLOFACIAL SURGERY		
D7110	Extraction, single tooth	$10
D7120	Extraction, each additional tooth	$10
D7130	Root removal - exposed roots	$30
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiostial flap and removal of bone and/or section of tooth	$30
D7220	Removal of impacted tooth - soft tissue	$40
D7230	Removal of impacted tooth - partially bony	$60
D7240	Removal of impacted tooth - completely bony	$70
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$80
D7250	Surgical removal of residual tooth roots (cutting procedures)	$30
D7281	Surgical exposure of impacted or unerupted tooth to aid eruption	$50
D7310	Alveoplasty in conjunction with extractions - per quadrant	$50
D7320	Alveoplasty not in conjunction with extractions - per quadrant	$60
D7510	Incision and drainage of abcess - intraoral soft tissue	$25
D7910	Suture of recent small wounds up to 5cm	$0
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure	$40
D7970	Excision of hyperplastic tissue- per arch	$45
ADJUNCTIVE GENERAL SERVICES		
D9110	Palliative (emergency) treatment of dental pain - minor procedure	$20
D9210	Local anesthesia not in conjunction with operative or surgical procedures	$0
D9215	Local anesthesia	$0
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	$25
D9941	Fabrication of athletic mouth guard	$100
D9951	Occlusal adjustment - limited	$35
D9952	Occlusal adjustment - complete	$175
ORTHODONTICS		
D8070	Comprehensive orthodontic treatment of the transitional dentition	
	Consultation	$0
	Evaluation	$35
	Records/treatment planning	$250
	Orthodontic treatment	$1,800
D8080	Comprehensive orthodontic treatment of adolescent dentition	
	Consultation	$0
	Evaluation	$35
	Records/treatment planning	$250
	Orthodontic treatment	$1,800
D8090	Comprehensive orthodontic treatment of adult dentition	
	Consultation	$0
	Evaluation	$35
	Records/treatment planning	$250
	Orthodontic treatment	$2,100
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	$450

IF YOU BREAK YOUR APPOINTMENT WITH YOUR DENTIST WITHOUT 24-HOUR ADVANCE NOTICE, YOU WILL BE SUBJECT TO YOUR DENTIST'S BROKEN APPOINTMENT FEE.

*** THE ABOVE COPAYMENTS DO NOT INCLUDE THE ADDITIONAL COST OF PRECIOUS (HIGH NOBLE) AND SEMI-PRECIOUS (NOBLE) METAL.**

THE ADDITIONAL COST OF PRECIOUS METAL SHALL NOT EXCEED $125 PER UNIT AND $75 PER UNIT FOR SEMI-PRECIOUS METAL.

**** PATIENT IS RESPONSIBLE FOR LAB FEES.**

NOTE: WHEN CROWN AND/OR BRIDGEWORK EXCEEDS SIX UNITS IN THE SAME TREATMENT PLAN, THE PATIENT MAY BE CHARGED AN ADDITIONAL $50.00 PER UNIT.

UNLISTED PROCEDURES ARE AT THE DENTIST'S USUAL FEE LESS 25%.

SPECIALTY CARE

Should you need specialty care, (i.e., endodontist, orthodontist, oral surgeon, periodontist, prosthodontist, pediatric dentist), you may be referred by your Participating General Dentist, or you may refer yourself to any Participating Specialty Dentist. Copayment amounts are applicable when treatment is performed by selected Participating General Dentist or by Participating Specialty Dentist. Benefits for procedures not listed on the schedule, that are performed by a Participating Specialty Dentist, are available at the Participating Specialty Dentist's usual and customary fee less 25%.

CompBenefits Family of Companies

CompDent • CompBenefits Insurance Company • American Dental Plan, Inc.

Oral Health Services, Inc.• DentiCare (Texas)• American Prepaid Dental Plan

American Dental Plan of North Carolina, Inc.• National Dental Plans, Inc.

Texas Dental Plans, Inc.• Vision Care, Inc.• Ultimate Optical, Inc.

Limitations and Exclusions

1. No service of any dentist other than a Participating General Dentist or Participating specialty dentist will be covered by Company, except out-of area emergency care as provided in the Member Handbook and Evidence of Coverage.

2. Whenever any Contributions or Copayments are delinquent, Member will not be entitled to receive Benefits, transfer Dental Facilities, or enjoy any of the other privileges of a Member in good standing.

3. Company does not provide coverage for the following services:

   a) Cost of hospitalization and pharmaceuticals, drugs or medications.

   b) Services which in the opinion of the Participating General Dentist or Participating specialty dentist are not Necessary Treatment to establish and/or maintain the Member's oral health.

   c) Any service that is not consistent with the normal and/or usual services provided by the Participating General Dentist or Participating specialty dentist or which in the opinion of the Participating General Dentist or Participating specialty dentist would endanger the health of the Member.

   d) Any service or procedure which the Participating General Dentist or Participating specialty dentist is unable to perform because of the general health or physical limitations of the Member.

   e) Any dental treatment started prior to the Member's effective date for eligibility of benefits.

   f) Services for injuries and conditions which are paid or payable under Workers' Compensation or Employers' Liability laws.

   g) Treatment for cysts, neoplasms and malignancies.

   h) General anesthesia.