



ASSURANT
Employee
Benefits®

Dental HMO Option

for employees and retirees of
The University of Texas System

2010/2011

Heritage Series - Plus Plan

Underwritten by:
United Dental Care of Texas, Inc.



Smile

Good news about dental benefits for employees and retirees of The University of Texas System

A Dental Plan Means Healthy Smiles

Because you are a valued employee or retiree, we are pleased to offer you the opportunity to enroll in a dental benefit plan underwritten by United Dental Care of Texas, Inc. and administered by Union Security Insurance Company. This dental program is an “HMO dental 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.

Dental HMO Plan Features

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

Primary Family Dentist (PFD) Designation

To enroll, just follow these three simple steps:

1. Select a primary family dentist by going to www.assurantemployeebenefits.com/UT and clicking Find a Dentist or you can call 800.443.2995. 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 Primary Family Dentist Selection Form located on the back of this booklet, being sure to include the Dental I.D. number of each dentist you have selected.
3. Select your Primary Family Dentist on UT TOUCH or you can mail your completed Dentist Selection Form to:

Attn: Customer Relations / GV-6
2323 Grand Blvd.
Kansas City, MO 64108

*Pre-Existing Conditions are defined as conditions that existed before the effective date of your HMO dental care plan.

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

THIS IS A DENTAL ONLY PLAN.

Savings You Can See

Monthly Payroll Deduction

Employee	\$10.05
Employee and Spouse	\$19.10
Employee and Child(ren)	\$21.11
Employee and Family	\$30.15

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.

Heritage Series - Plus 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. The Plan Dentist 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 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 Plan Benefits for covered dental Emergency Services.

2. Plan Specialty Dentist Services

See the enclosed Specialty Benefit Copayment Schedule.

ADA Code**	Service Description**	Member Copayment
Appointments		
None	Office visit - during regularly scheduled hours***	No Charge
D0120	Periodic oral evaluation† (once in any 6 calendar months)	No Charge
D0140	Limited oral evaluation - problem focused	20.00
D0150	Comprehensive oral evaluation - new or established patient† (once in any 6 calendar months)	No Charge
D0160	Detailed and extensive oral evaluation - problem focused, by report	15.00
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	15.00

ADA Code**	Service Description**	Member Copayment
Appointments - continued		
D0180	Comprehensive periodontal evaluation - new or established patient	15.00
D9310	Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)	55.00
D9440	Office visit - after regularly scheduled hours	40.00
Diagnostic Dentistry		
D0210	Intraoral - complete series (including bitewings)† (once in any 3 calendar years)	No Charge
D0220	Intraoral - periapical first film	No Charge
D0230	Intraoral - periapical each additional film	No Charge
D0240	Intraoral - occlusal film	No Charge
D0250	Extraoral - first film	No Charge
D0260	Extraoral - each additional film	No Charge
D0270	Bitewing - single film	No Charge
D0272	Bitewings - two films† (once in any 6 calendar months)	No Charge
D0274	Bitewings - four films† (once in any 6 calendar months)	No Charge
D0277	Vertical bitewings - 7 to 8 films	No Charge
D0330	Panoramic film† (once in any 3 calendar years)	5.00
D0415	Collection of microorganisms for culture and sensitivity	No Charge
D0425	Caries susceptibility tests	No Charge
D0460	Pulp vitality tests	No Charge
Preventive Dentistry		
D1110	Prophylaxis - adult (once in any 6 calendar months)	No Charge
D1120	Prophylaxis - child (once in any 6 calendar months)	No Charge
D1203	Topical application of fluoride (prophylaxis not included) - child	No Charge
D1310	Nutritional counseling for control of dental disease	No Charge
D1330	Oral hygiene instructions	No Charge
D1351	Sealant - per tooth	10.00
D1510	Space maintainer - fixed - unilateral*	60.00
D1515	Space maintainer - fixed - bilateral*	60.00
D1520	Space maintainer - removable - unilateral*	85.00
D1525	Space maintainer - removable - bilateral*	105.00
D1550	Re-cementation of space maintainer	15.00
None	Additional prophylaxis (D1110 or D1120 service does not apply to patients with periodontal disease)***	25.00
Restorative Dentistry		
D2140	Amalgam - one surface, primary or permanent	10.00
D2150	Amalgam - two surfaces, primary or permanent	15.00
D2160	Amalgam - three surfaces, primary or permanent	25.00
D2161	Amalgam - four or more surfaces, primary or permanent	35.00
D2330	Resin-based composite - one surface, anterior	30.00
D2331	Resin-based composite - two surfaces, anterior	40.00
D2332	Resin-based composite - three surfaces, anterior	50.00
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	65.00
D2391	Resin-based composite - one surface, posterior	60.00
D2392	Resin-based composite - two surfaces, posterior	70.00
D2393	Resin-based composite - three surfaces, posterior	80.00
D2394	Resin-based composite - four or more surfaces, posterior	110.00
D2510	Inlay - metallic - one surface*	102.00
D2520	Inlay - metallic - two surfaces*	125.00
D2530	Inlay - metallic - three or more surfaces*	150.00
D2542	Onlay - metallic - two surfaces*	215.00
D2543	Onlay - metallic - three surfaces*	220.00

ADA Code**	Service Description**	Member Copayment
Restorative Dentistry - continued		
D2544	Onlay - metallic - four or more surfaces*	220.00
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*	275.00
D2750	Crown - porcelain fused to high noble metal*	275.00
D2751	Crown - porcelain fused to predominantly base metal*	275.00
D2752	Crown - porcelain fused to noble metal*	275.00
D2790	Crown - full cast high noble metal*	275.00
D2791	Crown - full cast predominantly base metal*	275.00
D2792	Crown - full cast noble metal*	275.00
D2910	Recent inlay, onlay, or partial coverage restoration	15.00
D2920	Recent crown	15.00
D2930	Prefabricated stainless steel crown - primary tooth	80.00
D2940	Sedative filling	15.00
D2950	Core buildup, including any pins	75.00
D2951	Pin retention - per tooth, in addition to restoration	15.00
D2952	Cast post and core in addition to crown*	90.00
D2954	Prefabricated post and core in addition to crown	80.00
D2962	Labial veneer (porcelain laminate) - laboratory*	290.00
D2980	Crown repair, by report*	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
D3310	Anterior (excluding final restoration)	95.00
D3320	Bicuspid (excluding final restoration)	165.00
D3330	Molar (excluding final restoration)	175.00
D3346	Retreatment of previous root canal therapy - anterior	320.00
D3347	Retreatment of previous root canal therapy - bicuspid	380.00
D3348	Retreatment of previous root canal therapy - molar	460.00
D3410	Apicoectomy/periradicular surgery - anterior	125.00
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	170.00
D3425	Apicoectomy/periradicular surgery - molar (first root)	220.00
D3426	Apicoectomy/periradicular surgery (each additional root)	100.00
D3430	Retrograde filling - per root	40.00
D3450	Root amputation - per root	70.00
D3920	Hemisection (including any root removal), not including root canal therapy	80.00
Periodontics		
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant	120.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant	65.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces per quadrant	140.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or bounded teeth spaces per quadrant	100.00
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant	350.00
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or bounded teeth spaces per quadrant	203.00
D4320	Provisional splinting - intracoronal	80.00
D4321	Provisional splinting - extracoronal	75.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	45.00

ADA Code**	Service Description**	Member Copayment
Periodontics - continued		
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	27.00
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	50.00
D4910	Periodontal maintenance	45.00
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
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*	35.00
D5640	Replace broken teeth - per tooth*	35.00
D5650	Add tooth to existing partial denture*	35.00
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
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*	275.00
D6211	Pontic - cast predominantly base metal*	275.00
D6212	Pontic - cast noble metal*	275.00
D6240	Pontic - porcelain fused to high noble metal*	275.00
D6241	Pontic - porcelain fused to predominantly base metal*	275.00
D6242	Pontic - porcelain fused to noble metal*	275.00
D6251	Pontic - resin with predominantly base metal*	275.00
D6545	Retainer - cast metal for resin bonded fixed prosthesis*	140.00
D6721	Crown - resin with predominantly base metal*	275.00
D6750	Crown - porcelain fused to high noble metal*	275.00
D6751	Crown - porcelain fused to predominantly base metal*	275.00
D6752	Crown - porcelain fused to noble metal*	275.00
D6780	Crown - 3/4 cast high noble metal*	275.00
D6790	Crown - full cast high noble metal*	275.00
D6791	Crown - full cast predominantly base metal*	275.00
D6792	Crown - full cast noble metal*	275.00
D6930	Recent fixed partial denture	15.00
D6940	Stress breaker	150.00
D6950	Precision attachment	195.00
D6980	Fixed partial denture repair, by report*	45.00
None	Resin bonded bridge pontic, per unit***(*)	235.00

ADA Code**	Service Description**	Member Copayment
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	50.00
D7220	Removal of impacted tooth - soft tissue	60.00
D7230	Removal of impacted tooth - partially bony	75.00
D7240	Removal of impacted tooth - completely bony	100.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications.....	135.00
D7250	Surgical removal of residual tooth roots (cutting procedure).....	40.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.....	100.00
D7280	Surgical access of an unerupted tooth	85.00
D7310	Alveoloplasty in conjunction with extractions - per quadrant.....	60.00
D7320	Alveoloplasty not in conjunction with extractions - per quadrant.....	90.00
D7510	Incision and drainage of abscess - intraoral soft tissue.....	35.00
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure	125.00
Other Services		
D9110	Palliative (emergency) treatment of dental pain - minor procedure	25.00
D9220	Deep sedation/general anesthesia - first 30 minutes	180.00
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	15.00
D9241	Intravenous conscious sedation/analgesia - first 30 minutes.....	165.00
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes	35.00
D9940	Occlusal guard, by report*	85.00
D9951	Occlusal adjustment - limited.....	30.00
D9952	Occlusal adjustment - complete.....	145.00
D9972	External bleaching - per arch.....	155.00
Bleaching		
D9972	External bleaching - per arch.....	155.00

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. 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.

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

**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.

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

Specialty Benefit Copayment Schedule for the Heritage Series

How Your Specialty Benefit (SB) Works

Should you need the services of a specialty dentist, you may receive those services without a referral from your Plan Dentist.

To find a Plan Specialty Dentist (SB or Non-SB), refer to www.assurantemployeebenefits.com/UT. SB Plan Specialty Dentists are indicated with an "S". All other listed specialists are Non-SB Plan Specialty Dentists. For more information about the SB plan or for assistance in finding a Plan Specialty Dentist, call Customer Service at 800.443.2995.

If you use an SB Plan Specialty Dentist (a specialty dentist who is a part of the plan provider network and accepts SB copayments) for a service listed on the schedule below, you will pay the corresponding Member Copayment shown in the "SB Specialty Dentist Copayment" column at the time of service.

All other services obtained from an SB Plan Specialty Dentist, and all services obtained from a Non-SB Plan Specialty Dentist (a specialty dentist who is a part of the plan provider network but does not accept SB copayments), will be provided to you at a reduction in that Plan Specialty Dentist's normal retail charges. A 15% reduction applies if that dentist's specialty is endodontics. A 25% reduction applies if that dentist has any other type of specialty, including but not limited to orthodontics. You will be responsible for paying the entire reduced charge at the time of service or in accordance with that Plan Specialty Dentist's billing procedures.

ADA Code**	Service Description	SB Plan Specialty Dentist Copayment	Maximum Reimbursement with A Non-Plan Specialty Dentist
Appointments			
D0140	Limited oral evaluation - problem focused	35.00	20.00
D0150	Comprehensive oral evaluation - new or established patient† (once in any 6 calendar months)	45.00	25.00
D0160	Detailed and extensive oral evaluation - problem focused, by report	67.00	45.00
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	35.00	25.00
D0180	Comprehensive periodontal evaluation - new or established patient	80.00	50.00
Endodontics			
D3320	Bicuspid (excluding final restoration)	280.00	320.00
D3330	Molar (excluding final restoration)	395.00	405.00
D3346	Retreatment of previous root canal therapy - anterior	360.00	230.00
D3347	Retreatment of previous root canal therapy - bicuspid	525.00	265.00
D3348	Retreatment of previous root canal therapy - molar	545.00	345.00
D3410	Apicoectomy/periradicular surgery - anterior	265.00	335.00
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	280.00	420.00
D3425	Apicoectomy/periradicular surgery - molar (first root)	310.00	390.00
D3430	Retrograde filling - per root	90.00	85.00
Periodontics			
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant	355.00	195.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant	100.00	65.00
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant	495.00	395.00
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or bounded teeth spaces per quadrant	215.00	170.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	100.00	90.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	70.00	65.00

If you choose to go to a Non-Plan Specialty Dentist (a specialty dentist who is not part of the plan provider network), you may still receive benefits!

If you obtain a service listed on the schedule below from a Non-Plan Specialty Dentist, you will be responsible for paying that specialty dentist's entire normal retail charge for the service at the time of service or in accordance with that specialty dentist's billing procedures. You may then submit a completed claim form, with an itemized bill attached to United Dental Care of Texas, Inc. (You may obtain claim forms by contacting Customer Service at 800.443.2995.) United Dental Care of Texas, Inc. will reimburse you the lesser of (a) the corresponding amount shown in the "Maximum Reimbursement with a Non-Plan Specialty Dentist" column of the schedule below or (b) the amount charged by that specialty dentist for service.

Payment for any other service of a Non-Plan Specialty Dentist, at that specialty dentist's normal retail charge, is your responsibility, except for Plan Benefits for covered dental Emergency Services.

Annual Maximum Benefit

There is no annual maximum benefit for services of an SB or Non-SB Plan Specialty Dentist. For services of a Non-Plan Specialty Dentist, there is a \$2,000 annual maximum benefit.

ADA Code**	Service Description	SB Plan Specialty Dentist Copayment	Maximum Reimbursement with A Non-Plan Specialty Dentist
Periodontics - continued			
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	80.00	50.00
Oral Surgery			
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	80.00	120.00
D7220	Removal of impacted tooth - soft tissue	105.00	125.00
D7230	Removal of impacted tooth - partially bony	135.00	155.00
D7240	Removal of impacted tooth - completely bony	200.00	130.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	220.00	180.00
D7250	Surgical removal of residual tooth roots (cutting procedure)	75.00	125.00
D7310	Alveoloplasty in conjunction with extractions - per quadrant	180.00	70.00
D7320	Alveoloplasty not in conjunction with extractions - per quadrant	130.00	150.00
D7510	Incision and drainage of abscess - intraoral soft tissue	105.00	55.00
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure	185.00	145.00
Other Services			
D9241	Intravenous conscious sedation/analgesia - first 30 minutes	170.00	115.00

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 SB Specialty Dentists who perform the corresponding listed services. Plan Specialty Dentists may not perform or offer all services listed. Availability and participation of SB and Non-SB Plan Specialty Dentists are 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.

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

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 the Assurant Employee benefits website for UT System Members at www.assurantemployeebenefits.com/UT and go to Find a Dentist. 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 we receive 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 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 visiting the web site at www.assurantemployeebenefits.com/UT 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.

Limitations & Exclusions Termination

Pre-existing Conditions

Limitations and exclusions apply with respect to the Member's oral conditions without regard to whether 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 a dental service for which a charge is incurred before the effective date of the Member's enrollment.
3. Any dental service initiated after the Member's enrollment 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 Emergency Services as specifically provided in the 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 may be terminated as stated in the TERMINATION article of the Evidence of Coverage.

Please complete this form by printing in ink or typing. Please select a Primary Family Dentist and note your selection on the appropriate line below.

Name _____
Last First Initial

Social Security # _____

Employee DDS Selection _____ DDS ID# _____

Spouse _____
Last First Initial

Spouse DDS Selection _____ DDS ID# _____

Child _____
Last First Initial

Child DDS Selection _____ DDS ID# _____

Child _____
Last First Initial

Child DDS Selection _____ DDS ID# _____

Circle your UT Institution location:


UT at Arlington
UT at Austin
UT at Dallas
UT at El Paso

UT Medical Branch - Galveston
UT at San Antonio
UT Southwestern Medical Center
UT Health Science Center at Houston

UT System Administration
UT Health Science Center at San Antonio
UT M.D. Anderson Cancer Center
Other _____

To change your Primary Family Dentist or to select a different Primary Family Dentist for a covered dependent(s), simply call Toll Free **800.443.2995**.

PDC-TX-0511

 Cut along dotted line

Complete, detach and mail to:
Attn: Customer Relations/GV-6
2323 Grand Blvd.
Kansas City, MO 64108



ASSURANT
Employee
Benefits®

2323 Grand Blvd.
Kansas City, MO 64108
www.assurantemployeebenefits.com