



ASSURANT  
Employee  
Benefits

# Dental HMO Option

for employees and retirees of  
The University of Texas System



2005 / 2006

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 Assurant Employee Benefits. 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 from the Directory of Participating General Dentists for yourself and every eligible member of your family. 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 in on the back of this booklet, being sure to include the Dental I.D. number of each dentist you have selected.

3. Mail your completed Dentist Selection Form to:

Attn: Customer Relations / GV-6  
3595 Grandview Pkwy, Suite 150  
Birmingham, AL 35243

Select in UT Touch also.

\*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	\$10.73
Employee and Spouse	\$17.97
Employee and Child(ren)	\$24.50
Employee and Family	\$28.78

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 Texas, 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, unless otherwise authorized by Plan in writing.*

### 2. Specialty Dentist Services

See enclosed Copayment Schedule for Specialty Benefit Rider.

ADA Code	Plan Dentist Treatment	Member Copayment
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#### Appointments

None	Office Visit - During Regularly Scheduled Hours***	5.00
120	Periodic Oral Evaluation	No Charge
150	Comprehensive Oral Evaluation - New or Established Patient	No Charge
140	Limited Oral Evaluation - Problem Focused (emergency office visit, normal hours)	20.00
180	Comprehensive Periodontal Evaluation - New or Established Patient	No Charge
9440	Office Visit - After Regularly Scheduled Hours***	40.00

#### Diagnostic Dentistry

##### X-Ray - Intraoral

210	Complete Series (including bitewings)	No Charge
220	Periapical, First Film	No Charge
230	Periapical, Each Additional Film	No Charge
240	Occlusal Film	No Charge

ADA Code	Plan Dentist Treatment	Member Copayment
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<b>X-Ray - Extraoral</b>		
250	First Film	No Charge
260	Each Additional Film	No Charge
<b>X-Ray - Bitewing</b>		
270	Single Film	No Charge
272	Two Films	No Charge
274	Four Films	No Charge
330	X-Ray - Panoramic Film	5.00
415	Collection of micro-organisms for culture and sensitivity	No Charge
425	Caries Susceptibility Tests	No Charge
460	Pulp Vitality Tests	No Charge

#### Preventive Dentistry

<b>Prophylaxis</b>		
1110	Adult (once every 6 months)	No Charge
1120	Child up to age 18 (once every 6 months)	No Charge
1203	Topical Application of Fluoride (prophylaxis not included) - Child up to age 18	No Charge
1310	Nutritional Counseling for Control of Dental Disease	No Charge
1330	Oral Hygiene Instructions	No Charge
1351	Sealant - Per Tooth	7.00
<b>Space Maintainer</b>		
1510	Fixed - Unilateral*	60.00
1515	Fixed - Bilateral*	60.00
1520	Removable - Unilateral*	65.00
1525	Removable - Bilateral*	70.00
1550	Recementation of Space Maintainer	15.00
None	Additional Prophylaxis (1110 or 1120 service does not apply to patients with periodontal disease)***	25.00

#### Restorative Dentistry (Fillings/Crowns)

<b>Amalgam</b>		
2140	One Surface, Primary or Permanent	9.00
2150	Two Surfaces, Primary or Permanent	12.00
2160	Three Surfaces, Primary or Permanent	14.00
2161	Four or More Surfaces, Primary or Permanent	18.00
<b>Resin-based Composite</b>		
2330	One Surface, Anterior	15.00
2331	Two Surfaces, Anterior	20.00
2332	Three Surfaces, Anterior	25.00
2335	Four or More Surfaces or Involving Incisal Angle, Anterior	40.00
2391	One Surface, Posterior	30.00
2392	Two Surfaces, Posterior	45.00
2393	Three Surfaces, Posterior	65.00
2394	Four or More Surfaces, Posterior	65.00
<b>Inlay - Metallic</b>		
2510	One Surface*	80.00
2520	Two Surfaces*	90.00
2530	Three or More Surfaces*	115.00
2543	Three Surfaces*	185.00
2544	Four or More Surfaces*	185.00
<b>Inlay - Porcelain/Ceramic</b>		
2610	One Surface*	190.00
2620	Two Surfaces*	195.00
2630	Three or More Surfaces*	195.00
<b>Crown - Porcelain</b>		
2740	Ertamic Substrate*	235.00
2750	Fused to High Noble Metal*	235.00
2751	Fused to Predominantly Base Metal*	235.00

ADA Code	Plan Dentist Treatment	Member Copayment
<b>Crown - Porcelain (Continued)</b>		
2752	Fused to Noble Metal*	235.00
2790	Full Cast High Noble Metal*	235.00
2791	Full Cast Predominantly Base Metal*	235.00
2792	Full Cast Noble Metal*	235.00
2910	Recement Inlay	15.00
2920	Recement Crown	15.00
2930	Prefabricated Stainless Steel Crown - Primary Tooth	60.00
2940	Sedative Filling	7.00
2950	Core Buildup, Including Any Pins	50.00
2951	Pin Retention - Per Tooth, in Addition to Restoration	15.00
2952	Cast Post and Core in Addition to Crown*	80.00
2954	Prefabricated Post and Core in Addition to Crown	75.00
<b>Labial Veneer</b>		
2960	Laminate - Chairside	200.00
2962	Porcelain laminate - Laboratory*	315.00
2980	Crown Repair, by Report*	25.00
None	Temporary Filling***	15.00
<b>Cosmetic Bleaching</b>		
None	Per Arch***	150.00
None	Both Arches***	250.00

### Endodontics (Root Canals)

<b>Pulp Cap</b>		
3110	Direct (excluding final restoration)	5.00
3120	Indirect (excluding final restoration)	5.00
3220	Therapeutic Pulpotomy (excluding final restoration) - Removal of Pulp Coronal to the Dentinocemrntal Junction an Application of Medicament	25.00
<b>Root Canal Therapy</b>		
3310	Anterior (excluding final restoration)	95.00
3320	Bicuspid (excluding final restoration)	165.00
3330	Molar (excluding final restoration)	175.00
<b>Retreatment of Previous Root Canal Therapy</b>		
3346	Anterior	320.00
3347	Bicuspid	380.00
3348	Molar	455.00
<b>Apicoectomy/Periradicular Surgery</b>		
3410	Anterior	100.00
3421	Bicuspid, (first root)	110.00
3425	Molar, (first root)	115.00
3426	Each additional root	85.00
3430	Retrograde Filling - Per Root	35.00
3450	Root Amputation - Per Root	65.00
3920	Hemisection (including any root removal), Not Including Root Canal Therapy	60.00

### Periodontics

<b>Gingivectomy or Gingivoplasty</b>		
4210	Four or More Contiguous Teeth or Bounded Teeth Spaces Per Quadrant	90.00
4211	One to Three Teeth, Per Quadrant	54.00
<b>Osseous Surgery (including flap entry and closure)</b>		
4260	Four or More Contiguous Teeth or Bounded Teeth Spaces Per Quadrant	200.00
4261	One to Three Teeth, Per Quadrant	120.00
<b>Provisional Splinting</b>		
4320	Intracoronal	65.00
4321	Extracoronal	55.00

ADA Code	Plan Dentist Treatment	Member Copayment
<b>Periodontal Scaling and Root Planing</b>		
4341	Four or More Teeth Per Quadrant	35.00
4342	One to Three Teeth, Per Quadrant	21.00
4355	Full Mouth Debridement to Enable Comprehensive Evaluation and Diagnosis	25.00
4910	Periodontal Maintenance	30.00
None	Periodontal Hygiene Instruction***	No Charge
None	Periodontal Charting for Planning Treatment of Periodontal Disease***	8.00

### Removable Prosthodontics (Dentures)

5110	Complete Maxillary*	295.00
5120	Complete Mandibular*	295.00
5130	Immediate Maxillary*	355.00
5140	Immediate Mandibular*	355.00
5211	Maxillary Partial Denture - Resin Base (including any conventional clasps, rests, and teeth)*	295.00
5212	Mandibular Partial Denture - Resin Base (including any conventional clasps, rests and teeth)*	295.00
5213	Maxillary - Partial Denture - Cast Metal Framework with Resin Denture Bases (including any conventional clasps, rests and teeth)*	350.00
5214	Mandibular Partial Denture - Cast Metal Framework with Resin Denture Bases (including any conventional clasps, rests and teeth)*	350.00
5410	Adjust Complete Denture - Maxillary	10.00
5411	Adjust Complete Denture - Mandibular	10.00
5421	Adjust Partial Denture - Maxillary	10.00
5422	Adjust Partial Denture - Mandibular	10.00
5510	Repair Broken Complete Denture Base*	25.00
5610	Repair Resin Denture Base*	35.00
5620	Repair Cast Framework*	35.00
5630	Repair or Replace Broken Clasps	35.00
5640	Repair Broken Teeth - Per Tooth	35.00
5650	Add Tooth to Existing Partial Denture	35.00
5730	Reline Complete Maxillary Denture (chairside)	60.00
5731	Reline Complete Mandibular Denture (chairside)	60.00
5740	Reline Maxillary Partial Denture (chairside)	60.00
5741	Reline Mandibular Partial Denture (chairside)	60.00
5750	Reline Complete Maxillary Denture (laboratory)*	95.00
5751	Reline Complete Mandibular Denture (laboratory)*	95.00
5760	Reline Maxillary Partial Denture (laboratory)*	95.00
5761	Reline Mandibular Partial Denture (laboratory)*	95.00
5850	Tissue Conditioning - Maxillary Upper Denture	25.00
5851	Tissue Conditioning - Mandibular Lower Denture	25.00
5862	Precision Attachment, by Report*	100.00

### Fixed Prosthodontics

<b>Pontic</b>		
6210	Cast High Noble Metal*	235.00
6211	Cast Predominantly Base Metal*	235.00
6212	Cast Noble Metal*	235.00
6240	Porcelain Fused to High Noble Metal*	235.00
6241	Porcelain Fused to Predominantly Base Metal*	235.00
6242	Porcelain Fused to Noble Metal*	235.00
6251	Resin with Predominantly Base Metal*	235.00
6545	Retainer - Cast Metal for Resin Bonded Fixed Prosthesis*	110.00
<b>Crown</b>		
6721	Resin with Predominantly Base Metal*	235.00
6750	Porcelain Fused to High Noble Metal*	235.00
6751	Porcelain Fused to Predominantly Base Metal*	235.00
6752	Porcelain Fused to Noble Metal*	235.00
6780	3/4 Cast High Noble Metal*	235.00

ADA Code	Plan Dentist Treatment	Member Copayment
<b>Crown - (Continued)</b>		
6790	Full Cast High Noble Metal*	235.00
6791	Full Cast Predominantly Base Metal*	235.00
6792	Full Cast Noble Metal*	235.00
6930	Recement Fixed Partial Denture	15.00
6940	Stress Breaker	150.00
6950	Precision Attachment	150.00
6980	Fixed Partial Denture Repair, by Report*	45.00
None	Resin Bonded Bridge Pontic, Per Unit* ***	235.00

### Oral Surgery

7111	Extraction, Coronal Remnants - Deciduous Tooth	9.00
7140	Extraction, Erupted Tooth or Exposed Root ( <i>elevation and/or forceps removal</i> )	9.00
7210	Surgical Removal of Erupted Tooth Requiring Elevation of Mucoperiosteal Flap and Removal of Bone and/or Section of Tooth	30.00
7220	Removal of Impacted Tooth - Soft Tissue	40.00
7230	Removal of Impacted Tooth - Partial Bony	60.00
7240	Removal of Impacted Tooth - Complete Bony	70.00
7241	Removal of Impacted Tooth - Complete Bony, with Unusual Surgical Complications	80.00
7250	Surgical Removal of Residual Tooth Roots ( <i>cutting procedure</i> )	30.00
7270	Tooth Reimplantation and/or Stabilization of Accidentally Evulsed or Displaced Tooth	65.00
7280	Surgical access of an unerupted tooth	50.00
7310	Alveoloplasty in Conjunction with Extractions - Per Quadrant	35.00
7320	Alveoloplasty Not in Conjunction with Extractions - Per Quadrant	50.00
7471	Removal of Lateral Exostosis ( <i>maxilla or mandible</i> )	70.00
7510	Incision and Drainage of Abscess - Intraoral Soft Tissue	25.00
7910	Suture of Small Wound up to 5 cm.	5.00
7960	Frenulectomy ( <i>frenectomy or frenotomy</i> ) - Separate Procedure	40.00

### Other Services

9220	Deep Sedation/General Anesthesia - First 30 Minutes	180.00
9230	Analgesia, Anxiolysis, Inhalation of Nitrous Oxide - First 30 minutes	8.00
9241	Intravenous Conscious Sedation/Analgesia - First 30 Minutes	180.00
9310	Consultation ( <i>diagnostic service provided by dentist or physician other than practitioner providing treatment</i> )	30.00
9940	Occlusal Guard, by Report	85.00
9951	Occlusal Adjustment - Limited	20.00
9952	Occlusal Adjustment - Complete	110.00

\*Members are responsible for additional laboratory 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, Evidence of Coverage and Copayment Schedule, which determine all rights, benefits, and applicable Limitations and Exclusions.

\*\*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.

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

# Pinnacle Plan

## Sample Copayment Schedule

### For Specialty Benefit Rider

#### How Your Specialty Benefit Rider Works

Should you need the services of a Specialty Dentist, you may do so without a referral from your Plan dentist.

If you use a Specialty Dentist who is a part of our provider network for a procedure listed below on the Specialty Benefit Rider (SBR), you will simply pay the Member Copayment amount at the time of service. However, if the procedure is not listed on the SBR (ex. orthodontic services), your charges will be 25%, (Exception: 15% from Endodontists, includes root canal therapy) less than the Specialty Dentist's normal retail costs.

If you choose to go to a Specialty Dentist who is not a part of

our provider network, you may still receive benefits! For any procedure performed that is listed below on the SBR, the Plan will pay up to the total out of network scheduled amount. Your financial responsibility will be the difference, if any, between the out of network scheduled amount and the Specialty Dentist's normal retail cost.\* If you have a procedure performed that is not listed on the SBR by a Non-Plan Specialty Dentist, you will receive no benefits.

#### No Annual Maximum!

There is no annual maximum for procedures performed by a Plan Specialty Dentist. For procedures performed by a Non-Plan Specialty Dentist, there is a \$2,000 annual maximum benefit.

ADA** Code	Plan Dentist Treatment	In Network Member Copayment	Out of Network Plan Payment Schedule*
<b>Appointments</b>			
140	Limited Oral Evaluation - Problem Focused	25.00	15.00
150	Comprehensive Oral Evaluation - New or Established Patient	25.00	15.00
<b>Endodontics (Root Canals)</b>			
3320	Root Canal Therapy - Bicuspid (excluding final restoration)	235.00	265.00
3330	Root Canal Therapy - Molar (excluding final restoration)	320.00	330.00
3346	Retreatment of Previous Root Canal Therapy - Anterior	335.00	215.00
3347	Retreatment of Previous Root Canal Therapy - Bicuspid	430.00	220.00
3348	Retreatment of Previous Root Canal Therapy - Molar	475.00	300.00
3410	Apicoectomy / Periradicular Surgery - Anterior	200.00	250.00
3421	Apicoectomy / Periradicular Surgery - Bicuspid, First Root	230.00	350.00
3425	Apicoectomy / Periradicular Surgery - Molar, First Root	265.00	335.00
3430	Retrograde Filling - Per Root	65.00	60.00
<b>Periodontics</b>			
4210	Gingivectomy or Gingivoplasty - Four or More contiguous Teeth or Bounded Teeth Spaces Per Quadrant	225.00	125.00
4211	Gingivectomy or Gingivoplasty - One to Three Teeth, Per Quadrant	135.00	75.00
4260	Osseous Surgery, (including flap entry and closure) - Four or More Contiguous Teeth or Bounded Teeth Spaces Per Quadrant	390.00	310.00
4261	Osseous Surgery, (including flap entry and closure) - One to Three Contiguous Teeth or Bounded Teeth Spaces Per Quadrant	234.00	186.00
4341	Periodontal Scaling and Root Planing - Four or More Contiguous Teeth or Bounded Teeth Spaces Per Quadrant	80.00	70.00

ADA** Code	Plan Dentist Treatment	In Network Member Copayment	Out of Network Plan Payment Schedule*
4342	Periodontal Scaling and Root Planing - One to Three Teeth, Per Quadrant	48.00	42.00
4355	Full Mouth Debridement to Enable Comprehensive Evaluation and Diagnosis	55.00	35.00
4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevical or tissue, per tooth, by report	60.00	40.00
<b>Oral Surgery</b>			
7210	Surgical Removal of Erupted Tooth Requiring Elevation of Mucoperiosteal Flap and Removal of Bone and / or Section of Tooth	60.00	90.00
7220	Removal of Impacted Tooth - Soft Tissue	80.00	95.00
7230	Removal of Impacted Tooth - Partial Bony	105.00	120.00
7240	Removal of Impacted Tooth - Complete Bony	150.00	100.00
7241	Removal of Impacted Tooth - Complete Bony, with Unusual Surgical Complications	160.00	130.00
7250	Surgical Removal of Residual Tooth Roots (cutting procedure)	60.00	100.00
7281	Surgical Exposure of Impacted or Unerupted Tooth to Aid Eruption	150.00	110.00
7310	Alveoloplasty in Conjunction with Extractions, Per Quadrant	100.00	40.00
7320	Alveoloplasty Not in Conjunction with Extractions, Per Quadrant	85.00	100.00
7471	Removal of Lateral Exostosis (maxilla or mandible)	220.00	140.00
7510	Incision and Drainage of Abscess - Intraoral Soft Tissue	70.00	35.00
7960	Frenulectomy (frenectomy or frenotomy) - Separate Procedure	145.00	115.00
<b>Other Services</b>			
9241	Intravenous Conscious Sedation / Analgesia - First 30 Minutes	130.00	100.00

*This is a Sample 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.*

\*If a Member chooses to receive a dental service listed on the schedule above from a non-Plan Specialty Dentist, he will be responsible for paying that specialty dentist's entire normal retail charge for the service at the time the service is received or in accordance with specialty dentist's billing procedures. Member may then submit a completed claim form, with an itemized bill attached, to the Plan. (Member may obtain claim forms by contacting the Plan.) The Plan will pay Member lesser of the amount shown in "Out of Network Plan Payment Schedule" column of the sample schedule above or the amount charged by specialty dentist for the service.

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# TEXAS Limitations & Exclusions

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

## RENEWABILITY

After the initial Plan Year, each Plan Year of Agreement shall have a twelve month term. Agreement will be automatically renewed at the Anniversary Date unless otherwise terminated.

## TERMINATION

The Agreement may be terminated by Plan as follows:

- 1) for failure to pay proper monthly Prepayment Fees; or
- 2) for fraud or misrepresentation of fact in obtaining coverage under Plan; or
- 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; or
- 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. Plan provides for routine prophylaxis/cleanings as determined clinically necessary by the Plan Dentist.
3. 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. Such benefits may not be covered or may be limited.
4. 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.
5. Replacement of dentures, appliances or bridgework due to loss or theft is not covered.
6. 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.
7. Failure to follow prescribed treatment may result in additional charges. Accidents occurring during the course of any treatment may result in additional charges.
8. Restorations and endodontic posts and cores placed after root canal therapy are separate procedures from actual root canal treatment. Therefore, the specific copayments listed for restorations or posts and cores will apply.
9. 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.
10. Orthodontic treatment involving therapy for myofunctional problems, T.M.J. dysfunctions, micrognathia, macroglossia, or hormonal imbalances causing growth and developmental abnormalities, is not covered.
11. Extractions for Orthodontic purposes only are at a 25% discount off of Plan Provider's normal retail charge.
12. Orthodontic cases, involving orthognathic surgery, are not covered.
13. Treatment for malignancies, neoplasms or cysts, including biopsy, is not covered.
14. Services provided by non-Plan dentists are not covered unless preauthorized by Plan or unless specified otherwise elsewhere in the Evidence of Coverage.
15. Copayments listed for restorations do not include the cost of lab fees.
16. Restorations and splints used to increase vertical dimension, restore occlusion, or replace/stabilize tooth structure loss by attrition are not covered.
17. 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.
18. Complete oral rehabilitation or reconstruction involving replacement of six (6) or more missing teeth using fixed prosthetic restorations and/or appliances is not covered.
19. Dental treatment is not covered if Member's general health or physical limitations prevent provider from rendering appropriate dental treatment.
20. Costs associated with prescriptions or over the counter medications are not covered.
21. Implants, surgery for the insertion of implants, all related implant appliances and restorations, removable or fixed, are not covered.
22. 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.

# Primary Family Dentist Selection Form

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

Name \_\_\_\_\_  
Last First Initial

Social Security # \_\_\_\_\_

Spouse \_\_\_\_\_  
Last First Initial

Child \_\_\_\_\_  
Last First Initial

Child \_\_\_\_\_  
Last First Initial

Employee DDS Selection \_\_\_\_\_ DDS ID# \_\_\_\_\_

Spouse DDS Selection \_\_\_\_\_ DDS ID# \_\_\_\_\_

Child DDS Selection \_\_\_\_\_ DDS ID# \_\_\_\_\_

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

Complete, detach and mail to:  
Attn: Customer Relations / GV-6  
3595 Grandview Pkwy, Suite 150  
Birmingham, AL 35243



**ASSURANT**

Employee  
Benefits

2801 Highway 280 South  
Birmingham, AL 35223

[www.assurantemployeebenefits.com](http://www.assurantemployeebenefits.com)