Supplemental Benefit

Platinum Dental Rider Supplement Benefit

Additional coverage that may make you smile

As a UnitedHealthcare® member, you have the option to get dental coverage through the Platinum Dental Rider for an additional monthly fee. You can purchase the rider anytime during the year. Simply call the number on the back of your member ID card to tell us you'd like to enroll in the Platinum Dental Rider. You may start using the benefit on the first day of the month after the rider is purchased.

For $43 a month (in addition to any premium you pay for your Medicare Advantage plan and your Medicare Part B coverage), you'll get:

- ✓ $0 copay for covered fillings and preventive and diagnostic services such as oral exams, X-rays, routine cleanings, and fluoride
- ✓ No deductible
- ✓ Nationwide coverage
- ✓ $1,000 yearly maximum (the total amount the plan will pay for covered services in the calendar year, this includes preventive, diagnostic, basic and major services)
- ✓ Freedom to see any dentist you choose[1]

With the Platinum Dental Rider, you'll enjoy 100% coverage for preventive care and fillings with 50% coverage for additional procedures in-network. Out-of-network coverage is available. Please see the back of this page for coverage details and benefit guidelines.

To find a network dentist in your area, go to www.UHCMedicareDentistSearch.com and select the National Medicare Advantage Network.

For more information on the Platinum Dental Rider, to find a network dentist or to enroll, call the number on the back of your member ID card.

[1]You can see any dentist. However, you'll get greater savings from a network dentist. When you see an out-of-network dentist, the plan pays according to a maximum allowable fee schedule; you pay the rest. For your convenience, you can change dentists as long as you complete any dental service currently in progress.

Platinum Dental Rider Covered Services

Description of Dental Procedure	Frequency	Criteria and Exclusions	Copay or Coinsurance
Exams			
Routine periodic exam completed during check-up	Two procedures per plan year	Covers periodic, limited, comprehensive, and detailed/ extensive oral exams. Does not cover periodontal exams separate from periodic, limited, or comprehensive exams. Only one exam code covered per appointment.	$0*
Limited exam to evaluate a problem	One procedure per plan year		$0*
Comprehensive exam (for a new patient, or an established patient after 3 or more years of inactivity from dental treatment)	One procedure every three plan years		$0*
Detailed and extensive problem focused exam	One procedure per plan year		$0*
X-rays			
Full-mouth/Complete X-ray set for evaluation of the teeth and mouth	One procedure every three plan years	Covers intraoral complete series of radiographs. Does not cover CTs, cephalograms, or MRIs.	$0*
X-rays for closer evaluation around the roots of teeth	Unlimited per plan year	Covers periapical X-rays. Does not cover CTs, cephalograms, or MRIs. Not covered on the same day as full-mouth/complete X-ray set for evaluation of the teeth and mouth.	$0*
Bitewing X-rays for evaluation of the teeth and bone	One procedure per plan year	Not covered in the same year as a full-mouth/complete X-ray set for evaluation of the teeth and mouth.	$0*
Panoramic X-ray for evaluation of the teeth and mouth	One procedure every three plan years	Covers panoramic radiographs. Does not cover CTs, cephalograms, or MRIs.	$0*
Cleanings			
Standard adult dental cleaning	Two procedures per plan year	Covers adult prophylaxis. Not covered on the same day as Routine dental cleaning for an adult who has documented history of gum disease or cleaning buildup off the teeth to allow for proper visibility of the teeth for examination.	$0*
Routine dental cleaning for an adult who has documented history of gum disease	Three procedures per plan year	Covers periodontal maintenance. Only covered with history of scaling and root planing (deep cleaning) or periodontal surgery.	$0*

Description of Dental Procedure	Frequency	Criteria and Exclusions	Copay or Coinsurance
Other Preventive Services			
Fluoride	Two procedures per plan year	Covers topical application of fluoride (either varnish or excluding varnish).	$0*
Nutritional Counseling	One procedure per plan year	Covers counseling on dietary habits as a part of treatment and control of gum disease and/or cavities.	$0*
Application of medication to a tooth to stop or inhibit cavity formation	Unlimited per plan year	Covers application of interim caries arresting medicament-per tooth to a non-symptomatic carious tooth.	$0*
Fillings			
Metal or tooth-colored fillings placed directly into the mouth on front, middle or back teeth.	Unlimited per plan year	Covers amalgam and resin-based composite fillings. Does not cover gold foil fillings, sealants, or preventive resin restorations.	$0*
Medicine placed under fillings to promote pulp healing	Unlimited per plan year	Covers pulp capping for an exposed or nearly exposed pulp. Does not cover bases and liners when all caries has been removed.	$0*
Crowns, Inlays, and Onlays			
Cap (crown) or partial crown called an inlay or onlay — made of metal, porcelain/ceramic, porcelain fused to metal, or titanium. Made outside the mouth and then placed into the mouth.	One procedure per tooth every five plan years	Covered when there is extensive decay or destruction of the tooth where the tooth cannot be fixed with only a filling. Does not cover crowns for cosmetic reasons or for closing gaps. Veneers are not covered. Implant crowns are not covered. Does not cover "3/4" crowns.	50%*
Other Restorative Services			
Recementing a crown that has fallen off	Unlimited per plan year	Only covered for a tooth with an existing crown. Not covered for cementing a new crown the day of delivery.	50%*
Small filling needed prior to fitting a tooth with a crown	One procedure per tooth every five plan years	Has to be performed together with a crown.	50%*
Filling or pins placed when preparing a tooth for a crown	One procedure per tooth every five plan years		50%*

Description of Dental Procedure	Frequency	Criteria and Exclusions	Copay or Coinsurance
Buildup of filling around a post to prepare the tooth for a crown	One procedure per tooth every five plan years	Has to be performed together with a crown. Tooth also has to have had root canal treatment.	50%*
Root Canals (Endodontic Services)			
Root canal treatment for a front, middle, or back tooth (excluding filling or crown needed after the root canal)	One procedure per tooth per lifetime of the member	This is a root canal performed for the first time on tooth. Does not include root canal treatment for a tooth that has already had a root canal (retreatment), or root canals performed from the root tip by access through the gums.	50%*
Scaling and Root Planing			
Deep cleaning for 4 or more teeth in a mouth quadrant	One procedure per quadrant every two plan years, not to exceed four unique quadrants every two plan years	Covered when bone loss is shown on the X-rays in addition to recorded tartar buildup and pocketing of the gums sufficient to warrant deep cleaning.	50%*
Deep cleaning for 1-3 teeth in a mouth quadrant	One procedure per quadrant every two plan years, not to exceed four unique quadrants every two plan years		50%*
Cleaning buildup off the teeth to allow for proper visibility of the teeth for examination	One procedure every three plan years	Used when there is extensive buildup that needs to be removed in order to perform an exam. Cannot be performed same day as a Standard adult dental cleaning or Routine dental cleaning for an adult who has documented history of gum disease.	50%*
Medicine applied to gum space around a tooth (per tooth) for management of gum disease	Unlimited per plan year	Cannot be used same day as deep cleaning for 4 or more teeth in a mouth quadrant or deep cleaning for 1-3 teeth in a mouth quadrant.	50%*
Complete Dentures			
Complete upper denture	One procedure every five plan years	Denture covered when there are no erupted teeth remaining in the mouth.	50%*
Complete lower denture	One procedure every five plan years		50%*

Description of Dental Procedure	Frequency	Criteria and Exclusions	Copay or Coinsurance
Complete upper denture delivered at the time of extracting remaining upper teeth	One procedure per lifetime of member	Denture covered when there are no erupted teeth remaining in the mouth.	50%*
Complete lower denture delivered at the time of extraction of remaining lower teeth	One procedure per lifetime of member		50%*
Partials (Removable Partial Dentures)			
Upper partial denture — resin base	One procedure every five plan years	Partial denture covered when remaining/supporting teeth are free of cavities and have good bone to support the partial denture. Includes retentive/clasping materials, rests and teeth.	50%*
Lower partial denture — resin base	One procedure every five plan years		50%*
Upper partial dentures — cast metal framework with resin denture bases	One procedure every five plan years		50%*
Lower partial denture — cast metal framework with resin denture base	One procedure every five plan years		50%*
Upper partial denture delivered at the time of extractions — resin base	One procedure every five plan years		50%*
Lower partial denture delivered at the time of extractions — resin base	One procedure every five plan years		50%*
Upper partial denture — flexible base	One procedure every five plan years		50%*
Lower partial denture — flexible base	One procedure every five plan years		50%*
Adjustments and Repairs for Complete Dentures			
Denture adjustments or tissue conditioning for complete upper and/or lower denture	Two of each type of procedure per denture per plan year	Covers adjustments, relines, repairs, tissue conditioning, and replacing of missing or broken teeth for complete dentures. Cannot be billed within 6 months of delivery of the new denture.	50%*
Repairs and relines for broken complete upper and/or lower dentures	One of each type of procedure per denture per plan year		50%*

Description of Dental Procedure	Frequency	Criteria and Exclusions	Copay or Coinsurance
Adjustments and Repairs for Partial Dentures			
Adjustment of upper and/or lower partial denture	Two procedures per denture per plan year	Covers partial denture adjustments and relines. Covers repairs to framework of the partial denture, repair or replacement of missing or broken partial denture teeth, and addition of clasps or denture teeth to an existing partial denture. Cannot be billed within 6 months of delivery of the new partial denture.	50%*
Repair or reline for upper and/or lower partial denture	One procedure of each procedure type per partial denture per plan year		50%*
Bridges			
Part of the bridge that is the fake tooth replacing the missing tooth (the pontic)	One procedure per tooth every five plan years	Can only be used to replace a missing tooth. Covers bridges made of porcelain/ceramic; porcelain fused to high noble, predominately base, or noble metal; full cast high noble, predominately base, or noble metal; and titanium. Does not cover any part of an implant supported bridge.	50%*
Crowns that are placed on teeth supporting the bridge (retainer crowns)	One procedure per tooth every five plan years	Only covers crowns that are part of a bridge. Does not support any part of an implant supported bridge.	50%*
Re-cementing a bridge that has fallen off	Unlimited per plan year	Does not cover cementing a bridge on the day of initial bridge delivery.	50%*
Extractions and Oral Surgery Procedures			
Extractions	One procedure per tooth per lifetime of the member	Covers extraction of erupted permanent teeth, exposed tooth roots, and remnants of primary teeth. Covers surgical extraction of erupted teeth or exposed tooth roots. Does not cover extraction of impacted (unerupted) teeth.	50%*
Reshaping of the bone that surrounds the teeth or tooth spaces	One procedure per quadrant per plan year, up to four procedures on different/unique quadrants per plan year	Covers alveoloplasty either in conjunction with or not in conjunction with extractions.	50%*

Description of Dental Procedure	Frequency	Criteria and Exclusions	Copay or Coinsurance
Surgical drainage of an abscess	Unlimited per plan year	Covers incision and drainage of an abscess through soft tissue in the mouth (intraoral). Does not cover incision and drainage through the skin outside the mouth (extraoral).	50%*
Emergency Treatment of Pain and Other			
Minor procedure for emergency treatment of dental pain	Unlimited per plan year	Covered for an urgent or emergent visit only.	50%*
Application of desensitizing agent to a tooth or teeth	Unlimited per plan year	Covered once per visit. Does not cover bases, liners or adhesives used under restorations.	50%*
Nitrous Oxide and Sedation			
Evaluation for sedation or general anesthesia	Unlimited per plan year	Covers administration of, evaluation for, and monitoring for intravenous moderate (conscious) sedation/ analgesia, deep sedation/general anesthesia, and nitrous oxide/ analgesia — anxiolysis. Medications used for these procedures is considered included in the procedure code and cannot be billed for separately.	50%*
Deep Sedation/General Anesthesia	Unlimited per plan year		50%*
Nitrous Oxide	Unlimited per plan year		$0*
IV sedation	Unlimited per plan year		50%*
Splints			
Splint used to treat the TMJ	One procedure every three plan years	Covers occlusal orthotic devices provided for treatment of TMJ dysfunction.	50%*
Adjustment of occlusal guard	Two procedures per plan year	Not covered within 6 months of occlusal guard delivery.	50%*
Top or bottom, full-arch hard occlusal guard	One procedure every three plan years	Only covered in association with documented tooth clenching or grinding. Does not cover any type of sleep apnea, snoring or TMD appliances.	50%*

*Providers are paid based on Maximum Allowable Charge (MAC). You may be billed by the out-of-network provider for any amount greater than the payment made by the plan to the provider or any services not covered by the plan. Generally, an out-of-network provider will submit a claim on your behalf. If your provider does not submit the claim on your behalf and you pay for out-of-network services.

Exclusions may apply.

1. Services performed by an out-of-network dentist if your plan does not have out-of-network coverage.
2. Dental services that are not necessary.
3. Hospitalization or other facility charges.
4. Any dental procedure performed solely for cosmetic and/or aesthetic reasons.
5. Any dental procedure not directly associated with a dental disease.
6. Any procedure not performed in a dental setting.
7. Reconstructive surgery of any type, including reconstructive surgery related to a dental disease, injury, or congenital anomaly.
8. Procedures that are considered experimental, investigational or unproven. This includes pharmacological regimens not accepted by the American Dental Association Council on dental therapeutics. The fact that an experimental, investigational or unproven service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in coverage if the procedure is considered to be experimental, investigational or unproven in the treatment of that particular condition.
9. Service for injuries or conditions covered by workmen's compensation or employer liability laws, and services that are provided without cost to the covered persons by any municipality, county, or other political subdivision. This exclusion does NOT apply to any services covered by Medicaid or Medicare.
10. Expenses for dental procedures begun prior to the covered person's eligibility with the plan.
11. Dental services rendered (including otherwise covered dental services) after the date on which individual coverage under the policy terminates, including dental services for dental conditions arising prior to the date on which individual coverage under the policy terminates.
12. Services rendered by a provider with the same legal residence as a covered person or who is a member of a covered person's family, including a spouse, brother, sister, parent or child.
13. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
14. Any services not listed above are not covered.
