Routine Dental Benefit Basics

Our best and most flexible dental coverage ever. Routine dental care is important to your teeth and overall health, but it's not covered by Original Medicare. A routine dental benefit can help protect your teeth and gums and provide coverage for dental care otherwise not included. It's just one of the many extra benefits you get with this plan.

Dental benefits may include:

Up to $1,000 for all covered network dental with $0 copays for preventive and diagnostic dental care such as exams, routine cleanings, x-rays, fluoride and fillings when using in-network providers

50% coinsurance applies to crowns, bridges, root canals, extractions, dentures, implants and all other covered comprehensive services

No annual deductible

Access to Medicare Advantage's largest national dental network

Freedom to see any dentist who accepts Medicare, seeing an out-of-network dentist may cost more

To find a network dentist near you, visit uhcdental.com

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, sales tax, or duplicating/copying patient records.
14. Tooth bleaching and/or enamel microabrasion.
15. Veneers
16. Orthodontics
17. Sustained release of therapeutic drug (D9613)
18. COVID screening, testing, and vaccination
19. Charges aligned to dental case management, case presentation, consultation with other medical professionals or translation/sign language services.
20. Space Maintenance
21. Any unspecified procedure by report (Dental codes: D##99)

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Treatment plans and recommended dental procedures may vary. Talk to your dentist about treatment options, risks, benefits, and fees. CDT code changes are issued annually by the American Dental Association. Procedure codes may be altered during the plan year in accordance with discontinuation of certain dental codes.

Benefits vary by plan/area. Limitations and exclusions apply. If your plan offers out-of-network dental coverage and you see an out-of-network dentist, you might be billed more. Network size varies by local market.

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This information is not a complete description of benefits. Call the plan for more information.

The provider network may change at any time. You will receive notice when necessary. Network size varies by market and exclusions may apply.

Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

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