

Routine Dental Benefit Basics

Additional coverage that may make you smile.

Routine dental care is important for your teeth and overall health, but it's not covered by Original Medicare. Some UnitedHealthcare® plans include certain dental services. Below are the routine dental services included in the plan you selected.

With Routine Dental, you get:			
✓	No deductible.	✓	\$0 copay on preventive dental care from our network including exams, x-rays, routine cleanings, and fluoride.
✓	Access to Medicare Advantage's largest dental network.	✓	Freedom to see any dentist you choose. Seeing an Out-of-Network dentist may cost more.

To find a network dentist in your area, go to www.UHCMedicareSolutions.com and click on 'Search Dentists' located under the 'Shop For a Plan' tab. When prompted, select the National Medicare Advantage Network. For all other questions or more information, please call the Customer Service number on the back of your member ID card.

Covered Routine Dental Services

– Level 1

American Dental Association (ADA) Codes:	Description of Dental Procedure:	Frequency:	Criteria and Exclusions:	Copayment
Covered dental procedures are listed by ADA code. These codes are used by dentists to submit dental claims. Categories provide easy reference.	Easy to interpret description of the dental procedure code	How often UnitedHealthcare will pay for the dental procedure	Conditions under which UnitedHealthcare would pay for this procedure and situations where UnitedHealthcare would NOT pay for the procedure	*\$0 cost-share for network dental care, specified services only. If your plan offers out-of-network dental coverage and you see an out-of-network dentist you might be billed more, even for services listed as \$0 copay.

Exams

D0120	Routine periodic exam completed during check-up	Two procedures per plan year	Covers periodic, limited, comprehensive, and detailed/	\$0*
D0150	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	extensive oral exams. Does not cover periodontal exams separate from periodic, limited, or comprehensive exams. Only one exam code covered per appointment.	\$0*

X-Rays

D0210	Full-mouth/ Complete x-ray set for	One procedure every three plan years	Covers intraoral complete series of radiographs.	\$0*
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American Dental Association (ADA) Codes:	Description of Dental Procedure:	Frequency:	Criteria and Exclusions:	Copayment
	evaluation of the teeth and mouth		Does not cover CTs, cephalograms, or MRIs.	
D0270, D0272, D0273, D0274, D0277	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 set of x-rays (D0210)	\$0 *
D0330	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				
D1110	Standard adult dental cleaning	Two procedures per plan year	Covers adult prophylaxis. Not covered on the same day as D4910 or D4355.	\$0 *
D4910	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 *
Other Preventive Services				
D1206, D1208	Fluoride	Two procedures per plan year	Covers topical application of fluoride (either varnish or excluding varnish)	\$0 *
D1310	Nutritional Counseling	One procedure per plan year	Covers counseling on dietary habits as a part of treatment and control of	\$0 *

American Dental Association (ADA) Codes:	Description of Dental Procedure:	Frequency:	Criteria and Exclusions:	Copayment
			gum disease and/or cavities	
D1354	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 *

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. Any services not listed above are not covered.



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.

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.