Supplemental Benefit

Platinum Dental Rider

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 enroll in the dental rider at the time you enroll in your plan or within 3 months after the effective date of your plan. If you enroll in the rider at the time you enroll in your plan, you will have access to rider coverage on your plan effective date. If you wait to enroll within the 3 months after your plan effective date, you will be able to start using your rider coverage on the first day of the month after the rider is purchased.

Call Customer Service at **1-800-555-5757** to learn more or tell us you'd like to enroll in the rider. For current members, please call the number on the back of your Member ID card. You can also enroll in the Platinum Dental Rider through the Coverage & Benefits section of your digital member portal at **www.medicare.uhc.com**.

For $56 a month (in addition to any premium you pay for your Medicare Advantage plan and your Medicare Part B coverage), you'll get access to dental coverage that includes:

- No deductible.
- Up to $1,500 per year for covered dental services.
- $0 copay for in-network exams, X-rays, cleanings, fluoride, fillings, crowns, bridges, root canals, extractions, dentures, implants and all other covered comprehensive services.
- Access to Medicare Advantage's largest dental network, the UHC Dental National Medicare Advantage Network. Out-of-network coverage is available, but 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.

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

The provider network may change at any time. You will receive notice when necessary.

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.