Medicare Advantage Dental Coverage Election Form

Please note that all members will be enrolled into the selected plan. The dental rider will be provided to you with your annual enrollment materials. Electing this plan replaces your existing dental rider.

	☐ Rider 592	☐ Rider 591	☐ Rider 590
Enrollee Only Monthly Rate	$6	$8.50	$11
Annual Maximum	$250 Reimbursement	$500 Reimbursement	$1,000 Reimbursement
Preventive Exam (per 12 months)	(2 cleanings, 2 exams)	(2 cleanings, 2 exams)	(2 cleanings, 2 exams)
X-rays (per 12 months)	(1 X-ray)	(1 X-ray)	(1 X-ray)
Restorative (fillings and crowns)	Not Available	Covered*	Covered*

**Please see your plan documents for more details.*

Group# _____ Group Name _____

Signature _____ Date _____

Title _____

Phone _____ Email _____

This benefit information is only a summary and not intended or designed to replace or serve as the Group Contract. Please consult the *Evidence of Coverage* for a complete description of plan benefits, limitations and exclusions. In the event of any inconsistency between this document and the *Evidence of Coverage*, the terms of the *Evidence of Coverage* will prevail.