Add comprehensive dental today!

Classic Choice Dental enhances the routine preventive dental coverage included with select UCare Medicare Group Plans (HMO-POS).

If your plan has the option to add comprehensive dental coverage, you can enroll in this extra dental coverage when you complete your UCare Medicare Group Plan enrollment application, during your first covered month, and after that, annually for coverage beginning January 1. (Forms cannot be accepted after December 31.)

Questions?

Call 612-676-6900 or 1-877-598-6574
(TTY 612-676-6810 or 1-800-688-2534)
8 am – 5 pm, Monday – Friday

Visit ucare.org/dental to learn more.
You will get the most coverage by using a network dentist. UCare Medicare Group Plans use the Delta Dental Medicare Advantage Network administered by Delta Dental of Minnesota (Delta Dental). You can find a list of network providers online at ucare.org/dental, or you can call the number on the front page for assistance.

Unlike most other dental plans, UCare Medicare Group Plans include out-of-network coverage. If you receive services from an out-of-network licensed provider, you're responsible for submitting your bills and paying the cost share and any difference between the dentist's fees and the allowable amount.

UCare Minnesota is an HMO-POS plan with a Medicare contract. Enrollment in UCare Minnesota depends on contract renewal. Benefits, provider network, premium, deductible, and/or copayments/coinsurance may change on January 1 of each year. Limitations, copayments and restrictions may apply.

Out-of-network/non-contracted providers are under no obligation to treat UCare members, except in emergency situations. For a decision about whether we will cover an out-of-network service, you or your provider can ask us for a pre-service organization determination. Please call our Customer Service number or see your Evidence of Coverage for more information.

Benefits, provider network, premium, deductible and/or copayments/coinsurance may change on January 1 of each year. Limitations, copayments and restrictions may apply.
Limitations

**Endodontics**: Limited to one (1) per tooth per lifetime.

**Periodontics** (other than periodontal maintenance cleanings): Coverage is limited to one (1) non-surgical periodontal treatment and one (1) surgical periodontal treatment per quadrant every 36 months.

**Oral/maxillofacial surgery**: Coverage is limited to once per site (upper/lower ridge) in conjunction with building the bony ridge needed for successful placement of an implant or removable prosthetics (partial/full dentures).

**Major restorative services**: Benefit for the replacement of a crown or an onlay will be provided only after a five (5) year period, measured from the last date the covered dental service was performed.

**Prosthetics — removable and fixed**: A prosthetic appliance (denture or bridge) for the purpose of replacing an existing appliance will be covered only after five (5) years.

**Implant services**: Replacing a single missing tooth. Coverage for implants is limited to once per tooth per lifetime (also see Exclusion #19).

**Exclusions of Services**

While some of the exclusions shown below may be covered services under the terms of the Evidence of Coverage for non-dental services, the following are not covered dental services under this comprehensive dental benefit package:

1. Services rendered by dentists who have opted out or been excluded from Medicare are not eligible for reimbursement
2. Dental services that are not necessary or specifically covered
3. Hospitalization or other facility charges
4. Prescription drugs
5. Any dental procedure performed solely as a cosmetic procedure
6. Charges for dental procedures completed prior to the member's effective date of coverage
7. Anesthesiologist services
8. Dental procedures, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition (wear), realignment of teeth, periodontal splinting, and gnathologic recordings.
9. Direct diagnostic surgical or non-surgical treatment procedures applied to jaw joints or muscles, except as provided under Oral Surgery in the Evidence of Coverage
10. Artificial material implanted or grafted into soft tissue, including surgical removal of implants, with exceptions
11. Oral hygiene instruction and periodontal exam
12. Services for teeth retained in relation to an overdenture. Overdenture appliances are limited to an allowance for a standard full denture.
13. Any oral surgery that includes surgical endodontics (apicoectomy, retrograde filling) other than that listed under Oral Surgery in the Evidence of Coverage
14. Analgesia (nitrous oxide)
15. Removable unilateral dentures
16. Temporary procedures
17. Splinting
18. Consultations by the treating provider and office visits.
19. Initial installation of implants, full or partial dentures or fixed bridgework to replace a tooth or teeth extracted prior to the member's effective date. **Exception**: This exclusion will not apply for any member who has been continuously covered under the comprehensive dental benefit package for more than 24 months.
20. Occlusal analysis, occlusal guards (night guards) and occlusal adjustments (limited and complete)
21. Veneers (bonding of coverings to the teeth)
22. Orthodontic treatment procedures
23. Corrections to congenital conditions, other than for congenital missing teeth
24. Athletic mouth guards
25. Retreatment or additional treatment necessary to correct or relieve the results of previous treatment, except as noted in the Evidence of Coverage
26. Space maintainers
Statement of nondiscrimination

UCare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 612 676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534).


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