



Brighten your smile
with optional dental coverage

Add comprehensive dental today!

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

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).

| | CLASSIC CHOICE DENTAL |
|----------------|--|
| Premium | \$22 per month |
| Deductible | \$50 per year (not applicable for some services) |
| Annual maximum | \$1,200 per covered person, per coverage year* |

* This annual maximum is in addition to the routine dental coverage provided in your UCare Medicare Group Plan.

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.



Overview of benefits

| TYPE OF DENTAL SERVICES | COVERAGE AND WHAT YOU PAY CLASSIC CHOICE DENTAL |
|--|--|
| Basic services <ul style="list-style-type: none"> • Silver or resin fillings • Emergency treatment for relief of pain (minor procedures) • General anesthesia or IV sedation | 20% coinsurance |
| Endodontics <ul style="list-style-type: none"> • Root canal therapy on permanent teeth, including pulpotomies • Indirect pulp-cap • Root canal retreatment (mutually exclusive of final restoration) | 20% coinsurance |
| Periodontal maintenance Deep cleaning of the gums | \$0 copay |
| Other periodontics <ul style="list-style-type: none"> • Full-mouth debridement • Non-surgical periodontics: Procedures necessary for the treatment of diseases of the gingival tissues (gums) • Surgical periodontics: The surgical procedures necessary for the treatment of the gingival tissues (gums) and bone supporting the teeth | 20% coinsurance |
| Oral/maxillofacial surgery <ul style="list-style-type: none"> • Surgical and non-surgical extractions for tooth removal, including pre- and post-operative care • Bone grafting as part of surgical procedure | 20% coinsurance |

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.

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.

| TYPE OF DENTAL SERVICES | COVERAGE AND WHAT YOU PAY CLASSIC CHOICE DENTAL |
|--|--|
| Major restorative services <ul style="list-style-type: none"> • Emergency services — major procedures • Special restorative procedures to restore lost tooth structure as a result of tooth decay or fracture • Crowns, when the amount of lost tooth structure does not enable the placement of a filling material • Cast onlays for treatment of severe carious lesions and severe fractures when the tooth cannot be restored with amalgam, porcelain, or plastic crown | 50% coinsurance |
| Prosthetics <ul style="list-style-type: none"> • Repairs and adjustments on removable and fixed bridges, standard partial dentures, and full dentures for the replacement of fully extracted permanent teeth | 50% coinsurance |
| Implant services <ul style="list-style-type: none"> • Surgical placement of an implant body to replace single missing natural anterior (front) tooth • Porcelain or ceramic crown over implant body | 50% coinsurance |

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.

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).

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 612 676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534).

Limitations

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

Periodontics: 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 anterior (front) tooth. Coverage for implants is limited to one per lifetime per tooth (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.

- Services rendered by dentists who have opted out or been excluded from Medicare are not eligible for reimbursement
- Dental services that are not necessary or specifically covered
- Hospitalization or other facility charges
- Prescription drugs
- Any dental procedure performed solely as a cosmetic procedure
- Charges for dental procedures completed prior to the member's effective date of coverage
- Anesthesiologist services
- 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
- 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
- Artificial material implanted or grafted into soft tissue, including surgical removal of implants, with exceptions
- Oral hygiene instruction and periodontal exam
- Services for teeth retained in relation to an overdenture. Overdenture appliances are limited to an allowance for a standard full denture.
- Any oral surgery that includes surgical endodontics (apicoectomy, retrograde filling) other than that listed under Oral Surgery in the Evidence of Coverage
- Analgesia (nitrous oxide)
- Removable unilateral dentures
- Temporary procedures
- Splinting
- Consultations by the treating provider and office visits
- 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.
- Occlusal analysis, occlusal guards (night guards) and occlusal adjustments (limited and complete)
- Veneers (bonding of coverings to the teeth)
- Orthodontic treatment procedures
- Corrections to congenital conditions, other than for congenital missing teeth
- Athletic mouth guards
- Retreatment or additional treatment necessary to correct or relieve the results of previous treatment, except as noted in the Evidence of Coverage
- Space maintainers