

Brighten your smile

with dental coverage in
select UCare Medicare
Group Plans



Select UCare Medicare Group Plans include dental coverage and some give you the flexibility to purchase optional dental coverage.

These include \$2,500 plan maximum in routine dental coverage for no extra premium. You may add \$2,500 in restorative dental coverage with **Classic Choice Dental**, for an additional \$25 per month.

How to enroll

New members: If your plan has the option to add Classic Choice 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 Jan. 1. (Forms cannot be accepted after Dec. 31.)

Current members: A separate enrollment form is required if you did not enroll in UCare Classic Choice Dental when you first joined UCare. Visit ucare.org/dental to find the form.

Learn more

Visit ucare.org/dental

UCare Medicare Group Plans
1-877-598-6574 (TTY 1-800-688-2534)
8 am – 8 pm, Monday – Friday

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).

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.

2024 overview of dental benefits

	Classic Choice Dental
Coverage includes	Routine dental with optional coverage available
Premium	+ \$25 per month
Deductible	\$50 per year
Annual plan maximum	\$2,500
Oral examinations	Two per year*
Routine cleanings	Three per year*
X-rays	Annual bitewing and full mouth every 5 years*
Fluoride treatment	Covered*
Periodontal maintenance cleanings	Three per year*
Basic restorative services (e.g., fillings, root canals, periodontal services)	20% coinsurance with purchase of optional coverage
Major restorative procedures (e.g., crowns, bridges, dentures, implants)	50% coinsurance with purchase of optional coverage

*These services are included without purchase of optional coverage and no deductible applies. Members must be enrolled in plan for 24 consecutive months before coverage applies to bridges, dentures, prosthetics and implants.

You will get the most coverage by using a network dentist. UCare Medicare Group Plans use the Delta Dental National 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, this plan includes out-of-network coverage. If you receive services from an out-of-network licensed dental provider, for most plans, you will be responsible for submitting your bills and paying the cost share and any difference between the actual billed charge and the Delta Dental dental fee schedule.

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 Jan. 1 of each year. Limitations, copayments and restrictions may apply.

Dental coverage limitations

Frequency limits and waiting periods do not apply to plans with a yearly dental allowance. Otherwise these limitations apply to all plans.

- 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.
- Bone grafting: 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 60 month 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 60 months.
- Implant services: Replacing a single missing tooth. Coverage for implants is limited to once per tooth per lifetime (also see Exclusion #18).

Dental coverage exclusions

These exclusions are specific to dental coverage. Some of these exclusions may be covered under your medical benefit:

1. Dental services that are not necessary or specifically covered
2. Hospitalization or other facility charges
3. Prescription drugs
4. Any dental procedure performed solely as a cosmetic procedure
5. Charges for dental procedures completed prior to the member's effective date of coverage
6. Anesthesiologist services
7. 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

8. 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
9. Artificial material implanted or grafted into soft tissue, including surgical removal of implants, with exceptions
10. Oral hygiene instruction and periodontal exam
11. Services for teeth retained in relation to an overdenture. Overdenture appliances are limited to an allowance for a standard full denture
12. Any oral surgery that includes surgical endodontics (apicoectomy, retrograde filling) other than that listed under Oral Surgery in the Evidence of Coverage
13. Analgesia (nitrous oxide)
14. Removable unilateral dentures
15. Temporary procedures
16. Splinting
17. Consultations by the treating provider and office visits
18. 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 a UCare Medicare Plan for more than 24 months
19. Occlusal analysis, occlusal guards (night guards) and occlusal adjustments (limited and complete)
20. Veneers (bonding of coverings to the teeth)
21. Orthodontic treatment procedures
22. Corrections to congenital conditions, other than for congenital missing teeth
23. Athletic mouth guards
24. Retreatment or additional treatment necessary to correct or relieve the results of previous treatment, except as noted in the Evidence of Coverage
25. Space maintainers