

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.

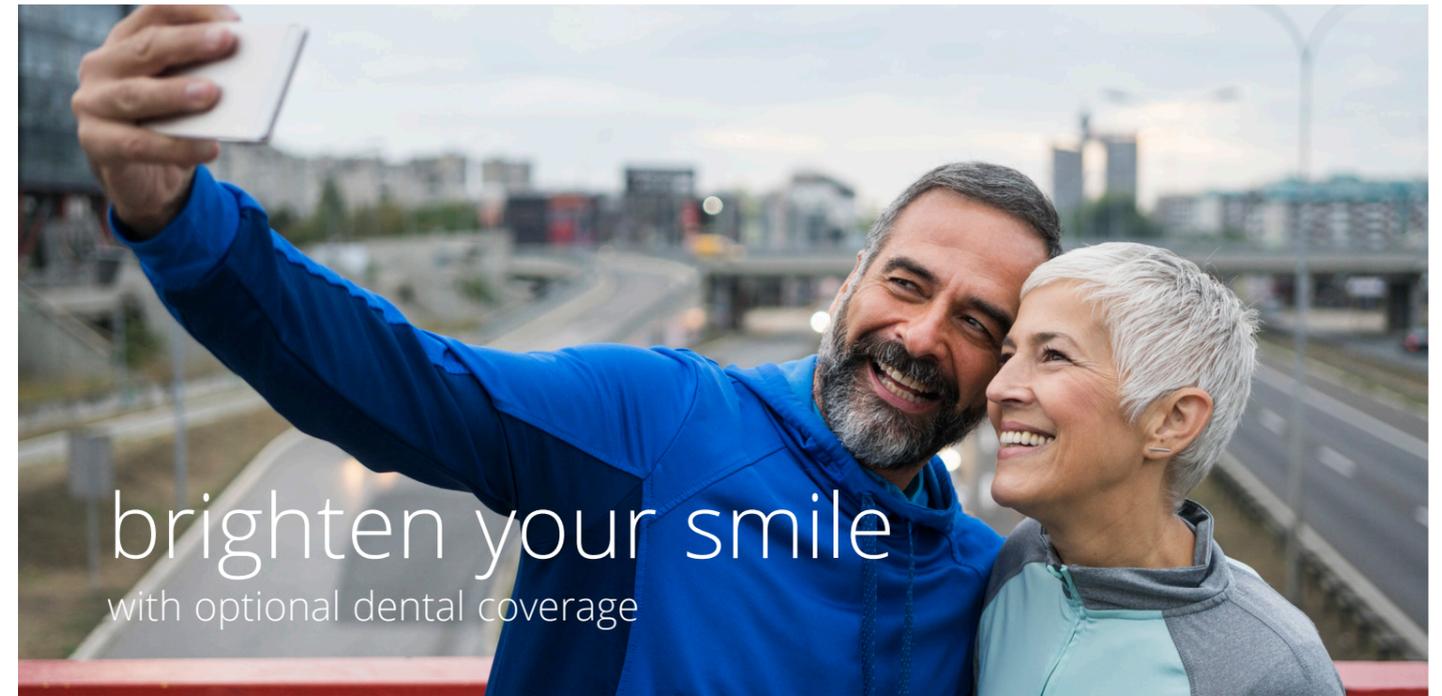
Implant Services: Replacing a single missing anterior (front) tooth. Coverage for implants is limited to one per lifetime per tooth (also see Exclusion #19).

Exclusions of Services

While some of the exclusions shown below may be covered services under the terms of the Evidence of Coverage (EOC), the following are not covered dental services under the dental rider:

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 EOC.
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 EOC.
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 EOC.
26. Space maintainers.



Add comprehensive dental today!

This optional dental coverage, UCare Classic Choice Dental, enhances the preventive coverage that's already included with select UCare Medicare Group Plans (HMO-POS).

You can enroll in this extra dental coverage when you first enroll in your UCare Medicare Group Plan by completing the enrollment form included in your enrollment kit. You are still eligible to enroll 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	\$21 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 preventive 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 – 8 pm, seven days a week

Visit dentalcareforu.org to learn more!



overview of benefits

COVERAGE AND WHAT YOU PAY	
TYPE OF DENTAL SERVICES	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 I.V. 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
Periodontics <ul style="list-style-type: none"> Periodontal maintenance cleanings (deep cleaning of the gums) Full-mouth debridement. Non-surgical periodontics: Procedures necessary for the treatment of diseases of the gingival (gums). Surgical periodontics: The surgical procedures necessary for the treatment of the gingival (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 best benefit 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 dentalcareforu.org, 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. This information is not a complete description of benefits. Contact the plan for more information. Benefits, provider network, premium, and/or copayments/coinsurance may change on January 1 of each year. Limitations, copayments and restrictions may apply.

COVERAGE AND WHAT YOU PAY	
TYPE OF DENTAL SERVICES	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, you may also use an out-of-network licensed dentist (who has not opted out or been excluded from Medicare) within the United States and its territories. Services rendered by dentists who have opted out or been excluded from Medicare are not eligible for reimbursement. If you receive dental services from a non-network licensed provider, you may be responsible for submitting your bills and paying the cost share and any difference between the dentist's fees and the allowable amount. To request out-of-network reimbursement, submit the payment receipt obtained from your dentist to Delta Dental, P.O. Box 330, Mpls., MN 55440-0330.

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 612-676-6500/1-866-457-7144 (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 612 676-6500/1-866-457-7144 (TTY: 612-676-6810/1-800-688-2534).