



## Dental, Vision

Plans for individuals  
age 65 and older



UNITEDHEALTHCARE INSURANCE COMPANY IS THE UNDERWRITER OF THESE POLICIES. BENEFITS ARE ADMINISTERED AS FOLLOWS: DENTAL BENEFITS - DENTAL BENEFIT PROVIDERS, INC. AND VISION BENEFITS - SPECTERA, INC.

Policy Forms: DEN-P-UHC (500 & 500 Plus plans), DEN-PBM-UHC (1000 & 1000 Plus plans), DEN-PBMD-UHC (2000 & 2000 Plus plans), and DEN-PBMI-UHC (3000 & 3000 Plus plans) and other state variations

**UnitedHealthcare**<sup>®</sup>  
UnitedHealthcare Insurance Co.

# Table of Contents

Why choose DV coverage?	3
Dental Plan Options & Network	4
Vision Plan Benefits & Network	6
Exclusions & Limitations	8
Plan Provisions	11
State Variations	12
Privacy and Other Notices	13



# Dental, Vision (DV) Highlights

Coverage for your oral and eye health together in one convenient plan designed with budget-friendly premiums in mind.



### Use dental benefits right away, no wait for most services

Our plans offer you coverage without waiting periods for preventive, basic and most major services<sup>1</sup> so you can start using them right away! This means you have immediate coverage for routine services like exams and cleanings, plus major repairs like crowns and root canals.



### Eye exams and eyewear, no waiting period

Vision health and routine eye exams are not only important for seeing better, but also have been shown to help with early detection of serious medical conditions like diabetes, heart disease, even Parkinson's disease. Our plans offer coverage for your annual vision exams, plus coverage for glasses or contacts. The vision network includes private practice and leading retail providers.



### UnitedHealthcare network of dentists and eye doctors

Get the most value from your benefits when you use a provider in UnitedHealthcare's network of dental and vision professionals. This nationwide network is likely to have a provider nearby, whether your home or traveling the country.

<sup>1</sup> Major services not covered on 500 and 500 Plus plans.

This is an outline only and is not intended to serve as a legal interpretation of benefits. Reasonable effort has been made to have this outline represent the intent of contract language. However, the contract language stands alone, and the complete terms of the coverage will be determined by the policy. State-specific differences may apply.



## Why Dental, Vision Insurance?

Taking care of your health goes beyond regular medical checkups. Dental and vision health are just as important to your overall well-being.

**Original Medicare (Parts A & B) does not cover routine dental and eye exams.** Having a supplemental plan like UnitedHealthcare Dental, Vision can help provide the additional coverage you need to protect your overall health, and budget.

## Helping to enhance your quality of life

Your overall health and well-being rely greatly on your dental and vision care. When you smile more, and can see better, life is naturally more enjoyable. Choosing a DV plan can help enhance your quality of life and help you feel good about yourself.

# Dental Plan Options

Our plan options allow you to select a plan that best balances your premium and out-of-pocket expenses, with your anticipated benefit use, giving you the freedom to choose what works best for you. And no matter which dental plan you choose, vision benefits are included (see pages 6-7 for details).

<b>Plan Availability<sup>1</sup></b> All benefits are per covered person, per calendar year		<b>DV 500<sup>2</sup></b>	<b>DV 1000<sup>2</sup></b>	<b>DV 2000<sup>2</sup></b>	<b>DV 3000<sup>2</sup></b>
<b>Dental Waiting Period</b>		None	None	None	None, except for Implants benefit only
<b>Deductible</b>		None	None	None	None
<b>Dental Calendar Year Maximum</b>	We pay up to:	\$500	\$1,000	\$2,000	\$3,000
<b>Preventive Services<sup>3</sup></b> (includes exams and x-rays) Includes 2 routine exams and cleanings per calendar year	We pay:	100%	100%	100%	100%
<b>Basic Services<sup>3</sup></b> (includes simple fillings)	We pay:	Not covered	100%	100%	100%
<b>Major Services<sup>3</sup></b>					
<b>Bridges, Crowns, Extractions and Root Canals</b>	We pay:	Not covered	50%	50%	50%
<b>Dentures and Partial</b>	We pay:	Not covered	Not covered	50%	50%
<b>Implants</b> (12 month waiting period) \$1,500 Implant Maximum Lifetime Benefit <sup>4</sup>	We pay:	Not covered	Not covered	Not covered	50%

State-specific differences may apply. (See State Variations for details.)

<sup>1</sup> Plan and network availability vary by state and ZIP code. <sup>2</sup> For covered Dental expenses, non-network provider benefits are determined by ZIP code. They are either based on the network negotiated rate or are based on the reasonable and customary charge (reasonable and customary benefits are identifiable by the word “Plus” added to the plan name). Non-network dentists can bill a patient for any remaining amount up to the billed charge. <sup>3</sup> Limitations and exclusions may apply based on type of service. <sup>4</sup> The Implant Maximum Lifetime Benefit is separate from, and not subject to, the Dental Calendar Year Maximum.



### Dental Benefits and How They Work

Dental benefits are administered by Dental Benefit Providers, Inc. We will cover dental services subject to the terms, conditions, exclusions and limitations of the policy. All services are subject to Dental Calendar Year Maximum and applicable coinsurance. State-specific differences may apply. (See State Variations for details.)

### Network Provider Services

You can see any dentist you want, anywhere across the country. When you choose a dentist who is part of the plan's large national network, you can receive network discounts without the hassle of negotiations. Visit [YourDentalPlan.com/DentistSearch](https://YourDentalPlan.com/DentistSearch) to find a provider and present the provider with your dental ID card. We will pay the provider the covered benefit, and the provider will bill you for the remainder.



**There are no claim forms to fill out when obtaining services from a network provider.**

### Non-network Provider Services

The non-network provider may submit the claim to us directly. The provider can then bill you for any remaining amount due up to the billed charge. If a provider does not wish to submit the claim to us, you will need to pay in full at the time of service. You can then submit the claim for reimbursement by going to [myuhc.com](https://myuhc.com) and completing the dental claim form.

# Vision Plan Benefits

These vision benefits are included with your DV plan, regardless of the dental plan you choose.

Vision Benefits per covered person		
Vision Waiting Period	None	
	Network <sup>1</sup>	Non-network
<b>Eye Exam</b> Once every 12 months	We pay 100%	We pay up to a \$50 allowance
<b>Standard Lenses<sup>2</sup> and Frames<sup>3</sup></b> Once every 24 months in lieu of contact lenses <sup>4</sup>	Single-Vision Lenses	We pay 100%
	Bifocal-lined Lenses	We pay 100%
	Trifocal-lined Lenses	We pay 100%
	Frames	We pay up to \$175 allowance
<b>Contact Lenses</b> Once every 24 months in lieu of frames and lenses <sup>4</sup> ; up to 12-month supply	Selection <sup>5</sup> : We pay 100%	
	Non-Selection: We pay up to a \$175 allowance; fitting and evaluation may be at an additional cost	We pay up to a \$105 allowance

State-specific differences may apply. (See State Variations for details.)

<sup>1</sup> You may go outside the network, but you are eligible for better discounts using network providers. Go to myuhcvision.com for a list of providers. <sup>2</sup> Standard lenses include single vision, bifocal, and trifocal/lenticular lenses, including standard scratch-resistant coating for eligible lenses as prescribed by a vision provider. <sup>3</sup> Standard frames include eyeglass frames, their fitting, and subsequent adjustments to maintain comfort and efficiency. <sup>4</sup> Select either eyeglasses (lenses and/or frames) or contacts, not both. <sup>5</sup> If you choose disposable lenses, depending on frequency of replacement, this may not cover a full 12-month supply. Work with your provider to determine what is covered.



### Vision Benefits and How They Work

Vision benefits are administered by Spectera, Inc. We will cover vision services subject to the terms, conditions, exclusions and limitations of the policy, Vision Benefit Rider SA-S-2074-UHC, and other state variations. (See State Variations for details.)

#### Network Provider Services

These plans use the UnitedHealthcare Vision Network.\* You will get the most value from your coverage when you see a provider in this large national network of eye doctors, optometrists and ophthalmologists, including both local doctors and well-known retail providers. Choose from network providers by visiting [myuhcvision.com](https://myuhcvision.com). Contact the provider, identify yourself as having UnitedHealthcare Vision coverage, and provide your name and date of birth to get started.



**No ID card is needed, and there are no claim forms to fill out when obtaining services from a network provider.**

#### Non-network Provider Services

You will need to pay in full at the time of service. You may then submit the details to us for reimbursement of covered benefits. See Vision Rider in the policy for details.

\* Not all providers participate in all plans. Check with your provider before using your benefits.



# Exclusions/Limitations

## (insurance plans)

This is only a general outline of the exclusions. It is not an insurance contract, nor part of the insurance policy. You will find complete coverage details in the policy. Some state exceptions may apply (see State Variations). The purchase of this plan is not contingent upon purchasing or having any individual or group health insurance coverage.

### Dental Exclusions & Limitations

#### General Exclusions and Limitations

No benefits will be paid for any service or treatment for which charges incurred are not identified and included as covered expenses under the policy. You will be fully responsible for payment for any services for which charges incurred are not covered expenses under the policy.

**For ALL plans**, the policy does not pay benefits for any service or treatment caused by, resulting from, for, which are, or relating to any of the following:

- Provided prior to the effective date or after the termination date of the policy.
- In excess of the frequency limitations or maximum benefits as shown in the policy.
- Covered expenses which exceed the non-network provider reimbursement, as shown in the policy.
- A service that is not rendered or that is not rendered within the scope of the provider's license.
- Telephone consultations or for failure to keep a scheduled appointment without giving the dental office the notice required.
- Any service incurred as a result of the covered person being intoxicated, as defined by applicable state law in the state in which the loss occurred, or under the influence of illegal narcotics or controlled substance unless administered or prescribed by a doctor or voluntary taking of any over the counter drug unless taken in accordance with the manufacturer's recommended dosage.
- Experimental or investigational treatment or for complications there from.
- Which arise out of, or in the course of, employment for wage or profit, if the covered person is insured, or is required to be insured, by workers' compensation insurance pursuant to the applicable state or federal law.
- Intentionally self-inflicted bodily harm.
- Any act of declared or undeclared war.
- The covered person taking part in a riot.
- The covered person's commission or attempt to commit a felony.
- Provided by a government plan, program, hospital or other facility, unless by law a covered person must pay and it is otherwise a covered expense or which by law must be provided by an educational institution.
- Provided without cost to a covered person in the absence of insurance covering the charge.
- Provided by an immediate family member or someone who ordinarily resides with a covered person.
- Received outside of the United States, except for a dental emergency.
- Related to the temporomandibular joint (TMJ), upper and lower jaw bone surgery or orthognathic surgery.
- Teeth that can be restored by other means; for purposes of periodontal splinting; to correct abrasion, erosion, attrition, bruxism, abfraction, or for desensitization; or teeth that are not periodontally sound or have a questionable prognosis.
- Performed solely for cosmetic/aesthetic reasons.
- Mouthguards; precision or semi-precision attachments; duplicate dentures; harmful habit appliances; occlusal guard except if expressly provided in the policy; replacement of lost or stolen appliances; treatment splints; bruxism appliance; sleep disorder appliance.
- Oral hygiene instructions; plaque control; charges for completing dental claim forms; photographs; any dental supplies including but not limited to take-home fluoride; sterilization fees; diagnostic casts; treatment of halitosis and any related procedures; lab procedures.
- Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the covered person's dental visit.



# Exclusions/Limitations continued

## (insurance plans)

This is only a general outline of the exclusions. It is not an insurance contract, nor part of the insurance policy. You will find complete coverage details in the policy. Some state exceptions may apply (see State Variations). The purchase of this plan is not contingent upon purchasing or having any individual or group health insurance coverage.

### Dental Exclusions & Limitations, continued

- Hospital or other facility charges and related anesthesia charges.
- Charges for dental services that are not documented in the dentist records, that are not directly associated with dental disease, or that are not performed in a dental setting.
- Two or more dental services are submitted and the dental services are considered part of the same dental service to one another, we will pay the most comprehensive dental service.
- Two or more dental services are submitted on the same day and the dental services are considered mutually exclusive (when one dental service contradicts the need for the other dental service), we will pay for the dental service that represents the final treatment.

**For plans covering Major Services**, the policy does not pay benefits for any service or treatment caused by, resulting from, for, which are, or relating to any of the following:

- Veneers, implant crowns, and  $\frac{3}{4}$  crowns.
- Replacement of bridges, crowns, or onlay which can be repaired or restored to natural function.
- Billed for incision and drainage if the involved abscessed tooth is removed on the same date of service.
- Reconstructive surgery when the primary purpose is to improve physiological functioning of the involved part of the body.
- Changing vertical dimension; restoring occlusion; bite analysis, congenital malformation.

- Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
- Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal.
- Treatment of malignant neoplasms or congenital anomalies of hard or soft tissue, including excision.
- Replacement of crowns, if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the dentist. If replacement is necessary because of the covered person's non-compliance, the covered person is liable for the cost of the replacement.
- Removal of sound functional restorations; temporary crowns and temporary prosthetics; provisional crowns and provisional prosthesis.
- Altering vertical dimension and/or restoring or maintaining occlusion. Non-intravenous conscious sedation, analgesia, anxiolysis, inhalation of nitrous oxide and conscious sedation, unless expressly provided for in the policy.
- Orthodontic services.
- Acupuncture; acupressure and other forms of alternative treatment.
- Bone grafts, guided tissue regeneration, biologic materials to aid in soft and osseous tissue regeneration when performed in edentulous (toothless areas, ridge augmentation or preservations).
- Surgical extractions of wisdom teeth.

# Exclusions/Limitations continued

## (insurance plans)

This is only a general outline of the exclusions. It is not an insurance contract, nor part of the insurance policy. You will find complete coverage details in the policy. Some state exceptions may apply (see State Variations). The purchase of this plan is not contingent upon purchasing or having any individual or group health insurance coverage.

**For plans covering Dentures and Partial,** the policy does not pay benefits for any service or treatment caused by, resulting from, for, which are, or relating to any of the following:

- Replacement within 60 consecutive months of the last placement for full and partial dentures.
- Replacement of complete dentures, fixed and removable partial dentures, if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the dentist. If replacement is necessary because of the covered person's non-compliance, the covered person is liable for the cost of the replacement.
- Replacement of full or partial removable dentures which can be repaired or restored to natural function.
- Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
- Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.

**For plans covering Implants,** the policy does not pay benefits for any service or treatment caused by, resulting from, for, which are, or relating to any of the following:

- Covered expenses incurred during the waiting period.
- Any implant procedures performed which are not listed as covered implant procedures.
- Replacement of implants, implant crowns, implant prosthesis and implant supporting structures (such as connectors), if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the dentist. If replacement is necessary because of the covered person's non-compliance, the covered person is liable for the cost of the replacement.

### Vision Exclusions & Limitations

Covered vision expenses will not include and no benefits are payable for any charges incurred for the following:

- Services or treatments that are already excluded in the General Exclusions and Limitations.
- Orthoptics or vision therapy training and any associated supplemental testing.
- Non-prescription items (e.g. plano lenses).
- Oversize lenses.
- Lenses not listed in the policy.
- Replacement of eyeglass frame and eyeglass lenses furnished under the Vision Rider which are lost or broken except at the normal intervals when services are otherwise available.
- Medical or surgical treatment of the eyes.
- Any eye examination or any corrective eyewear, required by an employer as a condition of employment.
- Corrective vision treatment of an experimental or investigative nature.
- Corrective surgical procedures such as, but not limited to, Radial Keratotomy (RK) and Photo-refractive Keratectomy (PRK).
- Contact lenses if an eyeglass frame and eyeglass lenses are received in the same 24 months.
- Eyeglass frame and eyeglass lenses if contact lenses are received in the same 24 months.
- Eyewear except prescription eyewear.
- Charges that exceed the allowance amount listed in the policy.
- Optional lens extras.

# Plan Provisions

This is only a general outline of the provisions. It is not an insurance contract, nor part of the insurance policy. You will find complete coverage details in the policy. Some state exceptions may apply (see State Variations). The purchase of this plan is not contingent upon purchasing or having any individual or group health insurance coverage.

## Calendar Year

A calendar year runs from January to December and starts over on January 1 of the following year. The maximum coverage amount applies during the calendar year.

## Eligibility

The primary insured must be 64 and 11 months or older as of the effective date of the policy. The spouse (as defined by state) can be any age. Dependent children are not eligible.

## Misstatement of Age or Residence

If the covered person's age has been misstated and we would not have issued coverage for the covered person, we will refund the premium paid minus any benefit amounts paid by us, and coverage will be void from the effective date.

If you change your residence, you must notify us of your new residence within 60 days of the change. Your premium will be based on your new residence beginning on the first premium due date after the change. If your residence is misstated on your application, or you fail to notify us of a change of residence, we will apply the correct premium amount beginning on the first premium due date you resided at that residence. If the change results in a lower premium, we will refund any excess premium. If the change results in a higher premium, you will owe us the additional premium.

## Non-Network vs. Network

You may pay more using non-network providers. Non-network providers may bill you for any amount up to the billed charge after the portion covered by the policy has been paid. Network providers have agreed to discounted pricing for covered expenses with no additional billing to you other than the coinsurance and deductible amounts.

## Premium

You will be given at least a 31-day notice (or longer if required by your state) of any change in your premium. We will make no change in your premium solely because of claims made by a covered person under the policy. The covered person's type and level of benefits and the place of residence on the premium due date are some of the factors that may be used in determining your premium rates.

## Reimbursement

If dental services are caused by the acts or omissions of a third party, we have the right to be reimbursed to the extent of benefits we paid for dental services, as outlined in the policy.

## Renewability and Termination

The policy is renewable until the earliest of the following:

- Nonpayment of premiums when due, subject to the Grace Period provision in the policy.
- The date we receive a request from you to terminate the policy, or any later date stated in your request.
- The date we decline to renew the policy, as stated in the Guaranteed Renewable Subject to Listed Conditions provision in the policy.
- The date of your death. NOTE: If there is a covered spouse on policy, the spouse can continue coverage upon the primary insured's death.

# State Variations

Please see below for state availability and applicable state-specific benefits, exclusions and limitations.

## Ohio

Forms: DEN-P-UHC-34, DEN-PBM-UHC-34, DEN-PBMD-UHC-34, and DEN-PBMI-UHC-34

- There are no variations.

## Health Plan Notices of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

**VIEW NOTICE *HERE*.** Please review it carefully.

(<https://www.uhc.com/content/dam/uhcdotcom/en/npp/NPP-UHC-EI-UHOne-EN.pdf>)

### Conditions Prior To Coverage (Applicable with or without the Conditional Receipt)

Subject to the limitations shown below, insurance will become effective if the following conditions are met:

1. The application is completed in full and is unconditionally accepted and approved by UnitedHealthcare Insurance Company.
2. The first full premium, according to the mode of premium payment chosen, has been paid on or prior to the effective date and any check is honored on first presentation for payment.
3. The policy is: (a) issued by UnitedHealthcare Insurance Company exactly as applied for within 45 days from date of application; (b) delivered to the proposed insured; and (c) accepted by the proposed insured.

After you have completed the application and before you sign it, reread it carefully. Be certain that all information has been properly recorded.

Keep an electronic copy of this document. It has important information.