WASHINGTON TEACHERS' UNION – DENTAL & VISION BENEFITS

RETIREES CHAPTER

2023 - 2024

WASHINGTON TEACHERS' UNION – *Amplifying the Voice of DC Teachers*

Jacqueline Pogue-Lyons, PRESIDENT

1239 Pennsylvania, Avenue, SE Washington, DC 20003 www.wtulocal6.org

Washington Teachers' Union

Amplifying the Voice of DC Teachers

Jacqueline Pogue Lyons, *President*

Dear WTU Retiree -

Today's WTU is dedicated to social and educational justice for the students of the District of Columbia that you fought for. We are dedicated to a fundamental belief that every student – regardless of their zip code or their success in "winning" a school lottery – should receive a well-rounded, enriching education. In short, we are dedicated to preserving the legacy that past generations of teachers fought for and won.

Our Union's foundation is strong because of the work you have done and continue to do, serving and working throughout the D.C. community, and I am deeply thankful. Today, more than ever, we need your support and your ongoing participation in Union activities.

Public education is increasingly under attack both in Washington, D.C. and across our nation. To confront and push back efforts aimed at undermining public education, we need your wisdom, guidance, and support. I hope that you'll continue to be active in your Union and lend your expertise and insight into our work to ensure that we can achieve our vision for public education – a vision that guarantees every student a great education and guarantees our teachers the working conditions, benefits, and compensation that they richly deserve.

In exchange for your ongoing service, my commitment to you as your president is to ensure that your Union continues to be the leading voice of education in the District of Columbia and that we provide the best service possible to you, our members.

We hope that you will take advantage of the many great benefits of your membership of our Union and, more importantly, continue to share your deep knowledge of our profession with future generations. Please do not hesitate to contact Carlton Nettles at benefits@wtulocal6.net or 202.517.0728 if you have any questions about the benefits your membership provides or if we can help you in any way.

Thank you for your continued support!

In Solidarity,

OPEN ENROLLMENT FOR RETIREES' DENTAL AND VISION BENEFITS IS: NOVEMBER 1, 2023 – NOVEMBER 30, 2023

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DENTAL AND VISION OPEN ENROLLMENT
What You Need to Know

OPEN ENROLLMENT FOR RETIREES' DENTAL AND VISION BENEFITS:
NOVEMBER 1, 2023 – NOVEMBER 30, 2023

- Enroll online by **November 30, 2023** in order for your dental and vision benefits to take effect beginning **January 1, 2024**.
- **Attend one of the Open Enrollment - Open House Sessions to sign up for 2024 benefits.**
- REMINDER: Payments are made by Credit / Debit Card or through PayPal
- Check and money order payments are not accepted when using PayPal

PLAN SUMMARIES:

Vision Plan - *benefits include:*

✓ In-Network / Out-of-Network Options

✓ No copays for exams, materials and contact lens fitting (In-Network)

✓ No claims forms needed for In-Network Services

✓ Full coverage options for In-Network providers

(For more information about Vision Benefits – See Page 7)

Dental Plan Options - *choose either the In-Network Dental Plan or the PPO Plan*

In-Network Only Dental Plan provider benefits include:

✓ Access to a national preferred provider organization network

✓ Adult and child orthodontist coverage, In-Network Plan: $2000 per person per lifetime

✓ An annual maximum of $3500 per person per calendar year.

PPO Dental Plan provider benefits include:

✓ The option to visit the dentist of your choice, both In and Out-of-Network, from among 2,000 dentists in the National Capital region.

✓ Child Orthodontist coverage up to the age of 19.

✓ An annual maximum of $1000 per person per calendar year.

(For more information about In-Network and Out-of-Network Dental Plan Benefits – See Page 2)

B.1 DENTAL PLAN SUMMARY

You have a choice between two dental plans, the comprehensive In-Network Only or a PPO Plan. The choice is up to you, but once you are enrolled, there can be no changes until the following year. The INO Plan has a richer benefit but there is absolutely NO OUT OF NETWORK benefit. If your provider is NOT in the network (you can check by calling your provider or go to www.myuhc.com for a list of In Network providers available) then you should consider the PPO Plan with a smaller out of network benefit.

In-Network Only Plan

This is our most popular plan as it offers comprehensive coverage with a greater annual maximum and no deductible. Members of this plan have access to more than 2,000 regional providers and more than 180,000 national providers. You must receive services from providers who accept this In-Network plan, to receive coverage for procedures.

PPO Plan

This Plan gives you access to a vast national network of PPO providers (same as the INO Plan) Members of this plan have the flexibility of receiving coverage from Out-of-Network providers, but there is a deductible and less of an annual maximum. This plan pays Out of Network benefits that are deemed Reasonable and Customary (R&C). Any amounts over the R&C will be your responsibility.

Plan Comparison

	In-Network Only Plan	PPO Plan
Coverage for In-Network Providers	YES	YES
Coverage for Out-of-Network	NO	YES
Access to National PPO Providers	YES	YES
Deductible	$ 0	$ 50 Single / $ 150 Family
Annual Maximum	$ 3500	$ 1000
Orthodontia Coverage	YES: Covered at 50% coinsurance with a $2000 maximum for children and adults	YES: Covered at 50% coinsurance with a $1000 maximum for children only.
Referral Needed for Specialty	NO	NO
Additional Benefits	• No claims forms for In-Network Services • No waiting periods for major services • No need to select one primary care provider • Fixed co-pay options (you will know the out-of-pocket) costs up front • Emergency and pain-relief care covered at in-network rates.	• Consumer Max Multiplier included (you are able to roll over your unused annual maximum if guidelines are followed)
Both plans have access to www.myuhc.com to estimate out-of-pocket costs for treatment		**To find a provider call: 1-866-249-0390**

B.2 DENTAL IN-NETWORK PLAN DETAILS

	NON-ORTHODONTICS		ORTHODONTICS	
	NETWORK	NON-NETWORK	NETWORK	NON-NETWORK
Individual Annual Deductible	None		None	
Family Annual Deductible	None		None	
Annual Maximum Benefit *(The total benefit payable by the plan will not exceed the highest listed maximum amount for either Network or Non-Network services.)*	$3500 per person per calendar year		$2000 per person per lifetime	
Waiting Period	No waiting period			

COVERED SERVICES*	SAMPLE PROCEDURE CODE	NETWORK ENROLLEE PAYS**	NON-NETWORK ENROLLEE PAYS***	BENEFIT GUIDELINES
DIAGNOSTIC SERVICES				
Periodic Oral Evaluation	D120	None	100%	Limited to 2 times per consecutive 12 months.
Radiographs	D274/D330	None	100%	Bitewing: Limited to 1 series of films per calendar year. Complete/Panorex: Limited to 1 time per consecutive 36 months.
Lab and Other Diagnostic Tests		None	100%	
PREVENTIVE SERVICES				
Dental Prophylaxis (Cleanings)	D1110	None	100%	Limited to 2 times per consecutive 12 months.
Fluoride Treatments	D1203	None	100%	Limited to covered persons under the age of 16 years and limited to 2 times per consecutive 12 months.
Sealants	D1351	None	100%	Limited to covered persons under the age of 16 years and once per first or second permanent molar every consecutive 36 months.
Space Maintainers	D1515	$61	100%	For covered persons under the age of 16 years, limit 1 per consecutive 60 months.
BASIC DENTAL SERVICES				
Restorations *(Amalgam or Composite)*	D2331	None	100%	Multiple restorations on one surface will be treated as a single filling.
Palliative Treatment	D9110	$25	$25	Covered as a separate benefit only if no other service was done during the visit other than X-rays.
General Anesthesia	D9220	$171	100%	When clinically necessary.
Simple Extractions	D7140	$23	100%	Limited to 1 time per tooth per lifetime.
Oral Surgery *(includes surgical extractions)*	D7240	$189	100%	
Periodontics	D4260/D4341/D4910	$387/$70/$36	100%	Perio Surgery: Limited to 1 quadrant or site per consecutive 36 months per surgical area. Scaling and Root Planning: Limited to 1 time per quadrant per consecutive 24 months. Periodontal Maintenance: Limited to 2 times per consecutive 12 months following active and adjunctive periodontal therapy, exclusive of gross debridement.
Endodontics	D3330	$333	100%	Limited to 1 time per tooth per lifetime.
MAJOR DENTAL SERVICES				
Inlays/Onlays/Crowns	D2520/D2542/D2750	$288/$333/$356	100%	Limited to 1 time per tooth per consecutive 60 months.
Dentures and other Removable Prosthetics	D5110/D5214/D9940	$410/$432/$171	100%	Full Denture/Partial Denture: Limited to 1 per consecutive 60 months. No additional allowances for precision or semi precision attachments. Occlusal Guard: Covered only if prescribed to control habitual grinding and limited to 1 guard every consecutive 36 months.
Fixed Partial Dentures (Bridges)	D6240	$351	100%	Limited to 1 time per tooth per consecutive 60 months.
ORTHODONTIC SERVICES - Adult and Child				
Diagnose or correct misalignment of the teeth or bite	D8080	50%	50%	Course of treatment is typically 24 months, with initial payment at banding of 20% and remaining payment spread over the course of treatment

* Your dental plan provides that where two or more professionally acceptable dental treatments for a dental condition exist, your plan bases reimbursement on the least costly treatment alternative. If you and your dentist have agreed on a treatment which is more costly than the treatment on which the plan benefit is based, you will be responsible for the difference between the fee for service rendered and the fee covered by the plan. In addition, a pre-treatment estimate is recommended for any service estimated to cost over $500; please consult your dentist. ** The network enrollee copay will be the lesser of the copay shown above and the discounted fee negotiated with the provider.

*** The non-network orthodontic percentage of benefits is based on the usual and customary charges prevailing in the geographic area in which the expenses are incurred. The non-network palliative treatment percentage is based on the allowable amount applicable for the same service that would have been rendered by a network provider.

The Prenatal Dental Care and Oral Cancer Screening programs are covered under this plan. The material contained in the above table is for informational purposes only and is not an offer of coverage. Please note that the above table provides only a brief, general description of coverage and does not constitute a contract. For a complete listing of your coverage, including exclusions and limitations relating to your coverage, please refer to your Certificate of Coverage or contact your benefits administrator. If differences exist between this Summary of Benefits and your Certificate of Coverage/benefits administrator, the Certificate/benefits administrator will govern. All terms and conditions of coverage are subject to applicable state and federal laws. State mandates regarding benefit levels and age limitations may supersede plan design features.

United Healthcare Dental® In-Network Only PPO (INO) is either underwritten or provided by: united Healthcare Insurance Company, Hartford, Connecticut; united Healthcare Insurance Company of New York, Hauppauge, New York; Unimerica Insurance Company, Milwaukee, Wisconsin; Unimerica Life Insurance Company of New York, New York, New York; or United HealthCare Services, Inc.

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B.2 DENTAL IN-NETWORK PLAN DETAILS

GENERAL LIMITATIONS

PERIODIC ORAL EVALUATION Limited to 2 times per consecutive 12 months.

COMPLETE SERIES OR PANOREX RADIOGRAPHS Limited to 1 time per consecutive 36 months. Exception to this limit will be made for Panorex Radiographs if taken for diagnosis of third molars, cysts, or neoplasms.

BITEWING RADIOGRAPHS Limited to 1 series of films per calendar year.

EXTRAORAL RADIOGRAPHS Limited to 2 films per calendar year.

DENTAL PROPHYLAXIS Limited to 2 times per consecutive 12 months. **FLUORIDE TREATMENTS** Limited to covered persons under the age of 16 years and limited to 2 times per consecutive 12 months. **SPACE MAINTAINERS** Limited to covered persons under the age of 16 years, limited to 1 per consecutive 60 months. Benefit includes all adjustments within 6 months of installation

SEALANTS Limited to covered persons under the age of 16 years, and once per first or second permanent molar every consecutive 36 months. **RESTORATIONS** Multiple restorations on one surface will be treated as a single filling. **PIN RETENTION** Limited to 2 pins per tooth; not covered in addition to cast restoration.

INLAYS AND ONLAYS Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. **CROWNS** Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.

POST AND CORES Covered only for teeth that have had root canal therapy. S**EDATIVE FILLINGS** Covered as a separate benefit only if no other service, other than x-rays and exam, were performed on the same tooth during the visit.

SCALING AND ROOT PLANING Limited to 1 time per quadrant per consecutive 24 months.

PERIODONTAL MAINTENANCE Limited to 2 times per consecutive 12 months following active and adjunctive periodontal therapy, exclusive of gross debridement.

FULL DENTURES Limited to 1 time every consecutive 60 months. No additional allowances for precision or semi-precision attachments.

PARTIAL DENTURES Limited to 1 time every consecutive 60 months. No additional allowances for precision or semi-precision attachments.

RELINING AND REBASING DENTURES Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.

REPAIRS TO FULL DENTURES, PARTIAL DENTURES, BRIDGES Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months. **PALLIATIVE TREATMENT** Covered as a separate benefit only if no other service, other than the exam and radiographs, were performed on the same tooth during the visit.

OCCLUSAL GUARDS Limited to 1 guard every consecutive 36 months and only if prescribed to control habitual grinding.

FULL MOUTH DEBRIDEMENT Limited to 1 time every consecutive 36 months.

GENERAL ANESTHESIA Covered only where clinically necessary.

OSSEOUS GRAFTS Limited to 1 per quadrant or site per consecutive 36 months.

PERIODONTAL SURGERY Hard tissue and soft tissue periodontal surgery are limited to 1 per quadrant or site per consecutive 36 months per surgical area.

ROOT CANAL THERAPY Limited to 1 time per tooth per lifetime. Dentist who performed the original root canal should not be reimbursed for the retreatment for the first 12 months.

REPLACEMENT OF COMPLETE DENTURES, FIXED OR REMOVABLE PARTIAL DENTURES, CROWNS, INLAYS OR ONLAYS Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per consecutive 60 months from initial or supplemental placement. This includes retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances.

GENERAL EXCLUSIONS

The following are not covered:

1. Dental Services that are not necessary.
2. Hospitalization or other facility charges.
3. Any dental procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
4. Reconstructive Surgery regardless of whether or not the surgery which is incidental to a dental disease, injury, or Congenital Anomaly when the primary purpose is to improve physiological functioning of the involved part of the body.
5. Any dental procedure not directly associated with dental disease.
6. Any procedure not performed in a dental setting.
7. Procedures that are considered to be Experimental, Investigational or Unproven. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.
8. Services for injuries or conditions covered by Worker's Compensation or employer liability laws, and services that are provided without cost to the covered person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.
9. Expenses for dental procedures begun prior to the covered person becoming enrolled under the Policy.
10. Dental services otherwise covered under the Policy but rendered after the date individual coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual coverage under the Policy terminates.
11. Services rendered by a provider with the same legal residence as a covered person or who is a member of a covered person's family, including spouse, brother, sister, parent or child.
12. Foreign Services are not covered unless required as an Emergency.
13. Replacement of crowns, bridges, and fixed or removable prosthetic appliances inserted prior to plan coverage unless the patient has been eligible under the plan for 12 continuous months. If loss of a tooth requires the addition of a clasp, pontic, and/or abutment(s) within this 12 month period, the plan is responsible only for the procedures associated with the addition.
14. Replacement of missing natural teeth lost prior to the onset of plan coverage until the patient has been covered under the Policy for 12 continuous months.
15. Replacement of complete dentures fixed and removable partial dentures, or 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 patient non- compliance, the patient is liable for the cost of replacement.
16. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
17. Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial over dentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.
18. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
19. Placement of dental implants, implant-supported abutments and prostheses
20. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
21. 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.
22. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
23. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jawbone surgery (including that related to the temporomandibular joint). No coverage is provided for orthographic surgery, jaw alignment, or treatment for the temporomandibular joint.
24. Acupuncture: acupressure and other forms of alternative treatment, whether or not used as anesthesia.
25. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
26. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours' notice.
27. Occlusal guards used as safety items or to affect performance primarily in sports-related activities.
28. Dental services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
29. Orthodontic coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, any surgical procedure to correct malocclusion, or replacement of lost or broken retainers and/or habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the plan.

Dental Services described in this section are covered when such services are:

A. Necessary
B. Provided by or under the direction of a Dentist or other appropriate provider as specifically described
C. The least costly, clinically accepted treatment
D. Not excluded as described in the Section entitled: General Exclusions.

B.3 DENTAL PPO PLAN DETAILS

	NON-ORTHODONTICS		ORTHODONTICS	
	NETWORK	NON-NETWORK	NETWORK	NON-NETWORK
Individual Annual Deductible	$50	$50	$0	$0
Family Annual Deductible	$150	$150	$0	$0
Maximum *(the sum of all Network and Non-Network benefits will not exceed annual maximum)*	$1,000 per person per Calendar	$1,000 per person per Calendar	$1,000 per person per Lifetime	$1,000 per person per Lifetime
Annual deductible applies to preventive and diagnostic services			No	
Annual deductible applies to orthodontic services			No	
Orthodontic eligibility requirement			Child (up to age 19)	

COVERED SERVICES	NETWORK LAN PAYS*	NON-NETWORK PLAN PAYS**	BENEFIT GUIDELINES
PREVENTIVE & DIAGNOSTIC			
Oral Evaluations (Diagnostic)	100%	80%	Covered as a separate benefit only if no other service was done during the visit other than X-rays. Limited to 2 times per consecutive 12 months.
X Rays (Diagnostic)	100%	80%	Bite-wing: Limited to 1 series of film per calendar year. Complete/Panorex: Limited to one time per consecutive 36 months.
Lab and Other Diagnostic Tests	100%	80%	
Prophylaxis (Preventive)	100%	80%	Limited to 2 times per consecutive 12 months.
Fluoride Treatment (Preventive)	100%	80%	Limited to Covered Persons under the age of 16 years, and limited to 2 times per consecutive 12 months. Treatment should be done in conjunction with dental prophylaxis.
Sealants	100%	80%	Limited to Covered Persons under the age of 16 years and once per first or second permanent molar every consecutive 36 months.
BASIC SERVICES			
Restorations (Amalgams and Resin Based Only)	80%	60%	Multiple restorations on one surface will be treated as a single filling. Composite: for anterior teeth only.
General Services (incl. Emergency Treatment)	80%	60%	Covered as a separate benefit only if no other service was done during the visit other than X-rays. General Anesthesia: when clinically necessary.
Space Maintainers	80%	60%	Limited to Covered Persons under the age of 16 years, once per lifetime. Benefit includes all adjustment within 6 months of installation.
Simple Extractions	80%	60%	
Oral Surgery (includes surgical extractions)	50%	40%	
Periodontics	50%	40%	Perio Surgery: Limited to once every consecutive 36 months per surgical area. Root Planning: Limited to one time per quadrant per consecutive 24 months. Perio Maintenance: Limited to 2 times per consecutive 12 months period following active and adjunctive periodontal therapy, within the prior 24 months, exclusive of gross debridement.
Endodontics	50%	40%	
MAJOR SERVICES			
Inlays/Onlays/Crowns	50%	40%	Limited to one time per tooth per consecutive 60 months. Covered only when silver fillings cannot restore the tooth.
Dentures and other Removable Prosthetics	50%	40%	Once every 60 months. No additional allowances for overdentures or customized dentures.
Fixed Prosthetics	50%	40%	Limited to one time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.(alternate benefits for a partial denture may be applied)
ORTHODONTIC SERVICES			
Orthodontia	50%	50%	Preauthorization required

 # This plan includes a roll-over maximum benefit. Some of the unused portion of your annual maximum may be available in future periods. *The network percentage of benefits is based on the discounted fee negotiated with the provider.

****The benefit percentage applies to the schedule of maximum allowable charges. Maximum allowable charges are limitations on billed charges in the geographic area in which the expenses are incurred.**

Your dental plan provides that where two or more professionally acceptable dental treatments for a dental condition exist, your plan bases reimbursement on the least costly treatment alternative. If you and your dentist have agreed on a treatment which is more costly than the treatment upon which the plan benefit is based, your actual out-of-pocket expense will be: the procedure charge for the treatment upon which the plan benefit is based, plus the full difference in cost between the fee for the service actually rendered and the fee for the service upon which the plan benefit is based..

The material contained in the above table is for informational purposes only and is not an offer of coverage. Please note that the above table provides only a brief, general description of coverage and does not constitute a contract. For a complete listing of your coverage, including exclusions and limitations relating to your coverage, please refer to your Certificate of Coverage or contact your benefits administrator. If differences exist between this Summary of Benefits and your Certificate of Coverage/benefits administrator, the certificate/benefits administrator will govern. All terms and conditions of coverage are subject to applicable state and federal laws. State mandates regarding benefit levels and age limitations may supersede plan design features.

united Healthcare Dental Options PPO Plan is either underwritten or provided by: United HealthCare Insurance Company, Hartford, Connecticut; United HealthCare Insurance Company of New York, Hauppauge, New York; or United HealthCare Services, Inc.

B.3 DENTAL PPO PLAN DETAILS

United Healthcare/ Dental Exclusions and Limitation

General Limitations

ORAL EXAMINATIONS Covered as a separate benefit only if no other service was done during the visit other than X-rays. Limited to 2 times per consecutive 12 months.

COMPLETE SERIES OR PANOREX RADIOGRAPHS Limited to one time per consecutive 36 months.

BITEWING RADIOGRAPHS Limited to 1 series of films per calendar year.

EXTRAORAL RADIOGRAPHS Limited to 2 films per calendar year.

DENTAL PROPHYLAXIS Limited to 2 times per consecutive 12 months.

DIAGNOSTIC CASTS Limited to one time per consecutive 24 months.

FLUORIDE TREATMENTS Limited to Covered Persons under the age of 16 years, and limited to 2 times per consecutive 12 months. Treatment should be done in conjunction with dental prophylaxis.

SEALANTS Limited to Covered Persons under the age of 16 years and once per first or second permanent molar every consecutive 36 months.

SPACE MAINTAINERS Limited to Covered Persons under the age of 16 years, once per lifetime. Benefit includes all adjustment within 6 months of installation.

AMALGAM RESTORATIONS Multiple restorations on one surface will be treated as a single filling.

PIN RETENTION Limited to 2 pins per tooth; not covered in addition to Cast Restoration.

GOLD INLAYS AND ONLAYS Limited to one time per tooth per consecutive 60 months. Covered only when silver fillings cannot restore the tooth.

CROWNS Limited to one time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.

POST AND CORES Covered only for teeth that have had root canal therapy.

SEDATIVE FILLINGS Covered as a separate benefit only if no other service, other than X-rays and exam, were done during the visit.

SCALING AND ROOT PLANING Limited to 1 time per quadrant per consecutive 24 months.

PERIODONTAL MAINTENANCE Limited to 2 times per consecutive 12 months period following active and adjunctive periodontal therapy, within the prior 24 months, exclusive of gross debridement.

FULL DENTURES Once every 60 months. No additional allowances for over-dentures or customized dentures.

PARTIAL DENTURES No additional allowances for precision or semi precision attachments.

RELINING DENTURES Limited to relining done more than 6 months after the initial insertions. Limited to 1 time per consecutive 12 months.

REPAIRS TO FULL DENTURES, PARTIAL DENTURES, BRIDGES Limited to repairs or adjustments done more than 12 months after the initial insertion.

PALLIATIVE TREATMENT Covered as a separate benefit only if no other service, other than exam and radiographs, were done during the visit.

OCCLUSAL GUARDS Limited to one guard per consecutive 36 months. Only covered for habitual grinding.

General Exclusions

The following are not covered:

1. Dental Services that are not necessary.
2. Hospitalization or other facility charges.
3. Any dental procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
4. Reconstructive Surgery regardless of whether or not the surgery which is incidental to a dental disease, injury, or Congenital Anomaly when the primary purpose is to improve physiological functioning of the involved part of the body.
5. Any dental procedure not directly associated with dental disease.
6. Any procedure not performed in a dental setting.
7. Procedures that are considered to be Experimental, Investigational or Unproven. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.
8. Services for injuries or conditions covered by Worker's Compensation or employer liability laws, and services that are provided without cost to the Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.
9. Expenses for dental procedures begun prior to the Covered Person's eligibility with the Plan.
10. Dental Services otherwise Covered under the Policy but rendered after the date individual Coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual Coverage under the Policy terminates.
11. Services rendered by a provider with the same legal residence as a Covered Person or who is a member of a Covered Person's family, including spouse, brother, sister, parent or child.
12. Dental Services provided in a foreign country, unless required as an Emergency.
13. Replacement of crowns, bridges, and fixed or removable prosthetic appliances inserted prior to plan coverage unless the patient has been eligible under the plan for 12 continuous months. If loss of a tooth requires the addition of a clasp, pontic, and/or abutment(s) within this 12-month period, the plan is responsible only for the procedures associated with the addition.
14. Replacement of missing natural teeth lost prior to the onset of plan coverage until the patient has been eligible for 12 continuous months.
15. Replacement of complete dentures fixed and removable partial dentures or 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 patient non-compliance, the patient is liable for the cost of replacement.
16. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
17. Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.
18. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
19. Placement of dental implants, implant-supported abutments and prostheses (D6053-D6199). This includes pharmacological regimens and restorative materials not accepted by the American Dental Association (ADA) Council on Dental Therapeutics.
20. Placement of fixed partial dentures (D6210- D6793, D6920) solely for the purpose of achieving periodontal stability.
21. Billing for incision and drainage (ADA Code D7510, D7520) if the involved abscessed tooth is removed on the same date of service.
22. Treatment of malignant or benign neoplasms, cysts, or other pathology, except excisional removal. Treatment of congenital malformations of hard or soft tissue, including excision. (D7413D7415, D7440-D7441, D7485-D7490).
23. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue (D7610-D7780).
24. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral (D7810-D7899). Upper and lower jawbone surgery (including that related to the temporomandibular joint). No coverage is provided for orthographic surgery (D7920-D7949), jaw alignment or treatment for the temporomandibular joint.
25. Acupuncture; acupressure and other forms of alternative treatment.
26. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
27. Occlusal guard used as safety items or to affect performance primarily in sports-related activities(D9941).
28. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours' notice.

Services of a participating provider than can be effectively treated by a less costly, clinically acceptable alternative procedure in accordance with the "Standards of Care" established by DBP with its participating providers. These services, if appropriate, will be covered under the less costly clinically acceptable alternative price.

To find a provider call:
1-866-249-0390

UnitedHealthcare

C.1 VISION PLAN SUMMARY

United Healthcare Vision has been trusted for more than 40 years to deliver affordable, innovative vision care solutions to the nation's leading employers through experienced, customer-focused people and the nation's most accessible, diversified vision care network.

Benefits Comparison	In-Network Only Provider	Out-of-Network Provider
Comprehensive Exam	No Co-Pay	Up to $25
Lenses (Standard):		
Single Vision	Covered In Full	Up to $25
Bifocal	Covered In Full	Up to $30
Trifocal	Covered In Full	Up to $70
Lenticular	Covered In Full	Up to $70
Frames	Up to $130	Up to $15
Contact Lenses: (in lieu of eyeglasses): **Elective / Medically Necessary**	Up to 6 boxes or $150 of certain contacts from formulary	Up to $70 Up to $100
Benefit Frequency	12 Months	12 Months
Submitting a Claim	You do not need to submit a claim for this plan. Your doctor should submit a claim on your behalf to United Healthcare.	You must submit a claim to United Healthcare for benefit reimbursement: United Healthcare PO Box 30928, Salt Lake City, Utah 84130
Both plans have access to www.myuhc.com to estimate out-of-pocket costs for treatment		**To find a provider call: 1-800-839-3242**

Lens Options

Lens options are: Standard Scratch Resistant Coating, Polycarbonates, Basic and High-End Progressives, Tints/UV and Transition, Lenses, Standard Anti-Reflective Coating.

Contact Lens Benefit

The covered-in-full contact lens benefit at network providers includes fitting/evaluation, contacts, and two follow-up visits (after $0 co-pay). For those who choose disposable lenses, up to 6 boxes are included when obtained from a network provider; not all brands apply. Non-covered in full contacts receive $150 allowance. If fitting fee is $30, you have $120 to purchase contacts.

Laser Vision Benefit

UHC partners with QualSight LASIK and all QualSight LASIK surgeons offer members a discount of up to 35% off national pricing. To learn more, and to find a surgeon in network, visit uhc.qualsight.com/ or call 1-855-321-2020

Additional Materials Discount Program

United Healthcare Vision now offers an Additional Materials Discount Program. At a participating network provider, you will receive a 20% discount on an additional pair of eyeglasses or contact lenses.

1. Necessary contact lenses are determined at the provider's discretion for one or more of the following conditions: Following post cataract surgery without intracular lens implant; to correct extreme vision problems that cannot be corrected with spectacle lenses; with certain conditions of anismetropia; with certain conditions of keratoconus. If your provider considers contacts necessary, you should ask your provider to contact United Healthcare Vision and confirm reimbursement before you purchase such contacts

C.2 VISION PLAN DETAILS

United Healthcare Vision has been trusted for more than 40 years to deliver affordable, innovative vision care solutions to the nation's leading employers through experienced, customer-focused people and the nation's most accessible, diversified vision care network.

In-network, covered-in-full benefits (after applicable copay) include a comprehensive exam, eyeglasses with standard single vision, lined bifocal, or lined trifocal lenses, standard scratch-resistant coating[1] and the frame, or contact lenses in lieu of eye glasses.

Benefit Frequency	
Comprehensive Exam(s)	Once every 12 months
Eyeglass Lenses	Once every 12 months
Frames	Once every 12 months
Contact Lenses instead of Eyeglasses	Once every 12 months
In-Network Services	
Copays	
Exam(s)	$ 0.00
Eyeglasses (lenses and frame)	$ 0.00
Contact lenses instead of Eyeglasses	$ 0.00
Frame Benefit - for frames that exceed the allowance, an additional 30% discount may be applied to the overage[1]	
Private Practice Provider	$ 130.00 retail frame allowance
Retail Chain Provider	$ 130.00 retail frame allowance
Lens Options - this list highlights the discounted cost on our most popular lens options. Exact pricing may vary; confirm cost with your provider prior to purchase.	
Standard Scratch Coating	$0
Scratch Warranty	$10
Tint	$0
UV Coating	$0
Photochromic	$0
Anti-Reflective Tier I	$0
Anti-Reflective Tier II	$50
Anti-Reflective Tier III	$75
Anti-Reflective Tier IV	$95
Roll and Polish Edges	$13
Progressive Tier I	$0
Progressive Tier II	$0
Progressive Tier III	$0
Progressive Tier IV	$0
Progressive Tier V	$0
High Index (<1.66)	$53
High Index (1.66-1.73)	$63
Polycarbonate for Adults	$0
Polycarbonate for Dependent Children	$0
Contact Lens Benefit[2] - Formulary contact lenses refer to contact lenses available on our formulary contact list. Contact lenses not on this list are referred to as Non-Formulary. A copy of the list can be found at myuhcvision.com.	
Formulary contact lenses The fitting/evaluation fees, contact lenses, and up to two follow-up visits are covered in full after copay.	If you choose disposable contacts, up to 6 boxes are included when obtained from an in-network provider.
Non-Formulary contact lenses An allowance is applied toward the purchase of contact lenses outside the Formulary. The allowance is for materials. No portion will be applied to the fitting and evaluation. Contact lens copay is waived.	$150.00
Necessary contact lenses[3]	Covered in full after copay (if applicable).

C.2 VISION PLAN DETAILS

Discounts

Laser vision

UnitedHealthcare has partnered with QualSight LASIK, the largest LASIK manager in the United States, to provide our members with access to discounted laser vision correction services. Member savings represent up to 35% off the national average price of Traditional LASIK. Contracted prices start at $945 per eye for Traditional LASIK and $1,395 per eye for Custom LASIK. Discounts are also provided on newer technologies such as Custom Bladeless (all laser) LASIK. For more information, visit myuhcvision.com.

Additional Material

At a participating in-network provider you will receive up to a 20% discount on an additional pair of eyeglasses or contact lenses. This program is available after your vision benefits have been exhausted. Please note that this discount shall not be considered insurance, and that UnitedHealthcare shall neither pay nor reimburse the provider or member for any funds owed or spent. Additional materials do not have to be purchased at the time of initial material purchase.

Contact Lens

Order extra contact lenses at uhccontacts.com for 10% off.

Hearing Aids

As a UnitedHealthcare Vision plan member, you can save on custom-programmed hearing aids when you buy them from UnitedHealthcare Hearing. To find out more go to UHCHearing.com. When placing your order use promo code MYVISION to get the special price discount.

Blue Light Eyesafe

UnitedHealthcare Vision has collaborated with Eyesafe® to provide members with a 20% discount off the retail price on blue-light screen filters for their devices. Members can receive the discount by visiting myuhcvision.com and clicking on the Eyesafe link.

[1]30% discount available at most participating in-network provider locations. May exclude certain frame manufacturers. Please verify discounts with your provider.
[2]Contact lenses are instead of eyeglass lenses and/or eyeglass frames. Coverage for Formulary contact lenses does not apply at all in-network providers.
[3]Necessary contact lenses are determined at the provider's discretion for certain conditions. If your provider considers your contacts ne your provider to contact UnitedHealthcare Vision confirming the reimbursement that UnitedHealthcare will make before you purchase such contacts.

[1] On all orders processed through a company owned and contracted Lab network.

[2] The out-of-network reimbursement applies to materials only. The fitting/evaluation is not included.

[3] Necessary contact lenses are determined at the provider's discretion for one or more of the following conditions: Following post cataract surgery without intraocular lens implant; to correct extreme vision problems that cannot be corrected with spectacle lenses; with certain conditions of anisometropia; with certain conditions of keratoconus. If your provider considers your contacts necessary, you should ask your provider to contact United Healthcare Vision confirming reimbursement that United Healthcare Vision will make before you purchase such contacts.

[4] Coverage for Covered Contact Lens Selection does not apply at Walmart or Sam's Club locations. The allowance for non-selection contact lenses will be applied toward the fitting/evaluation fee and purchase of all contacts.

Important to Remember:

- Benefit frequency based on last date of service.
- Your $150.00 contact lens allowance is applied to the fitting/evaluation fees as well as the purchase of contact lenses. For example, if the fitting/evaluation fee is $30, you will have $120.00 toward the purchase of contact lenses. The allowance may be separated at some retail chain locations between the examining physician and the optical store.
- You can log on to our website to print off your personalized ID card. An ID card is not required for service but is available as a convenience to you should you wish to have an ID card to take to your appointment.
- Out-of-Network Reimbursement, when applicable: Receipts for services and materials purchased on different dates must be submitted together at the same time to receive reimbursement. Receipts must be submitted within 12 months of date of service to the following address: United Healthcare Vision Attn. Claims Department P.O. Box 30978 Salt Lake City, UT 84130 FAX: 248.733.6060.
- At a participating network provider, you will receive a 20% discount on an additional pair of eyeglasses or contact lenses. This program is available after your vision benefits have been exhausted. Please note that this discount shall not be considered insurance, and that United Healthcare Vision shall neither pay nor reimburse the provider or member for any funds owed or spent. Not all providers may offer this discount. Please contact your provider to see if they participate. Discounts on contact lenses may vary by provider. Additional materials do not have to be purchased at the time of initial material purchase. Additional materials can be purchased at a discount any time after the insured benefit has been used.

Please note: If there are differences in this document and the Group Policy, the Group Policy is the governing document. Please consult the applicable policy/certificate of coverage for a full description of benefits, including exclusions and limitations.

The following services and materials are excluded from coverage under the Policy: Post cataract lenses; Non-prescription items; Medical or surgical treatment for eye disease that requires the services of a physician; Worker's Compensation services or materials; Services or materials that the patient, without cost, obtains from any governmental organization or program; Services or materials that are not specifically covered by the Policy; Replacement or repair of lenses and/or frames that have been lost or broken; Cosmetic extras, except as stated in the Policy's Table of Benefits.

United Healthcare Vision coverage provided by or through United Healthcare Insurance Company or its affiliates. Administrative services provided by Spectera, Inc., United HealthCare Services, Inc. or their affiliates. Plans sold in Texas use policy form number VPOL.06.TX and associated COC form number VCOC.INT.06.TX

UnitedHealthcare®

To find a provider call:
1-800-839-3242

D. HOW TO ENROLL

To receive benefits coverage for the calendar year 2024, you will need to pay the full year's premium during Open Enrollment in November 2023. You must also be a member of the WTU Retirees' Chapter and pay yearly dues of $55 to receive benefit coverage.

Open enrollment is **November 1, 2023, to November 30, 2023,** (Your new benefit choices go into effect January 1, 2024). Instructions for enrollment are below.

OPEN ENROLLMENT ASSISTANCE

This year Open Enrollment assistance will be available through the following sources -

A. Retiree Volunteer(s): Chandrai Jackson – Saunders 202-491-8421

Retiree Volunteers can assist you in navigating the online enrollment process. They cannot take credit card payments.

B. WTU Staff Members: Carlton Nettles 202-957-1773
Ebone Baty 202-517-1477

WTU staff members can provide assistance in all areas of the Dental / Vision enrollment process. Please be prepared by having with your debit or credit card, social security numbers for you and all dependents you wish to include, and documents verifying your dependents as required (i.e. a marriage certificate, birth certificate, or tax return).

WTU RETIREE CHAPTER – 2024 OPEN ENROLLMENT ASSISTANCE SCHEDULE

WTU-RC Officers, WTU Open Enrollment Volunteers and the WTU Membership and Benefits Team will provide Dental / Benefits enrollment assistance throughout the month of November 2023 at the following location and according to the schedule:

Lamond-Riggs/Lillian J. Huff Neighborhood Library
5401 South Dakota Ave NE
Washington, DC 20011
202-541-6255

November 8, 2023 -	Wednesday	10:00 AM – 2:00 PM
November 14, 2023 -	Tuesday	10:00 AM – 2:00 PM

E. CHECK LIST and RATE CHART

CHECK LIST

- ☐ Determine whether you need Vision Benefits, Dental Benefits or both
- ☐ Decide if you need "Single" or "Family" coverage
- ☐ If you decide on "Family" be sure to have each dependent's birth date and SSN
- ☐ Complete online enrollment and add your dependents **ONLINE**
- ☐ Put November 2024 Open Enrollment on your personal calendar for next year

RATES:

All retirees must sign up to be a member of the WTU Retiree Chapter every year. Membership does not carry over from one year to the next. Retirees MUST pay yearly retiree dues to be eligible for Dental and/or Vision benefits. Membership Dues are: $ 55.00 / year.

WTU RETIREES CHAPTER – 2024 DENTAL / VISION BENEFITS RATES				
CHAPTER DUES	**VISION (Single or Family)**	**DENTAL SINGLE**	**DENTAL FAMILY**	**TOTAL DUE**
$ 55.00				**$ 55.00**
$ 55.00	$ 311.16			**$ 366.16**
$ 55.00	$ 311.16	$ 549.96		**$ 916.12**
$ 55.00	$ 311.16		$ 1,099.92	**$ 1,466.08**
$ 55.00		$ 549.96		**$ 604.96**
$ 55.00			$ 1,099.92	**$ 1,154.92**
INDICATE DENTAL PLAN TYPE:		**IN-NETWORK or PPO**		

Questions? Call WTU 202-517-1477

You are required to re-enroll in Membership, Vision, and Dental benefits during open enrollment every year. Open enrollment occurs each year – November 1 through November 30.

THIS IS NOT A HEALTH INSURANCE PLAN

THIS PLAN COVERS ONLY DENTAL AND/OR VISION BENEFITS, DEPENDING ON YOUR ELECTION

F. 2024 OPTIONS RATE CHART

OPTIONS CHART:

Use the Options Chart below to help you determine the cost of your benefits for 2024. The chart includes all possible choices.

Option 1
In Network Only Dental & Vision (Member Only) + Dues - **$ 916.12**

Option 2
In Network Only Dental & Vision (Family) + Dues - **$ 1,466.08**

Option 3
PPO Dental & Vision (Member Only) + Dues **$ 916.12**

Option 4
PPO Dental & Vision (Family) + Dues **$ 1,466.08**

Option 5
In Network Only Dental (Member Only) + Dues - **$ 604.96**

Option 6
In Network Only Dental (Family) + Dues - **$ 1,154.92**

Option 7
PPO Dental (Member Only) + Dues - **$ 604.96**

Option 8
PPO Dental (Family + Dues) - **$ 1,154.92**

Option 9
Vision + Dues (Member Only) - **$ 366.16**

Option 10
Vision (Family) + Dues - **$ 366.16**

Option 11
Union Membership Dues Only - **$ 55.00**

G. DENTAL / VISION BENEFITS ENROLLMENT GUIDE

This Dental / Vision Benefits Enrollment Guide allows you to directly access and update your Washington Teachers' Union Dental / Vision enrollment benefits via the Internet.

Our secure (https) site uses the latest technology to ensure that the information entered is secure and adheres to industry security standards.

- You can review and/or update your demographic information, dependents, and benefit elections.
- You can access the WTU-Retiree Dental / Vision enrollment benefits system from any computer with an internet connection.

LOGGING IN

1. Launch an Internet browser such as: Internet Explorer / GOOGLE

2. Navigate to https://www.workterra.net/Platform

3. Enter the information below and click **Login**

   Username: First Letter of First Name + Full Last Name +
   First 4 digits of Date of Birth + Last 4 digits of SSN
   Example: atest03095555 (all lowercase)

   Password: Full Last Name + First Letter of First Name +
   Last 4 digits of SSN
   Example: testa5555 (all lowercase)

   Company: WTU RC

WELCOME PAGE

1. Read the Welcome Page Information

2. Read and accept the Employee Usage Agreement and Legal Agreement

3. Select CONTINUE to move to the next page.

G. DENTAL / VISION BENEFITS ENROLLMENT GUIDE

CONFIRM RETIREE INFORMATION

1. Review your information for accuracy

2. If you need to make changes to fields that are locked, please contact the WTU RC Benefits Administrator – 202-517-1477

3. If all of your information is correct, click SAVE AND CONTINUE

ADDING DEMOGRAPHIC INFORMATION FOR DEPENDENTS

The instructions below will guide you as you review, add, or update demographic information for your dependent spouse, domestic partner or dependent child/children.

1. Add or verify demographic information for your deppendent spouse, as needed. If you have no dependent children - Click "SAVE AND CONTINUE".

2. If you need to add demographic information for dependent children: click CONTINUE (red arrow)

3. The system will then prompt you to add demograpic information for your dependent children, one at a time.

   For DISABLED CHILDREN, please make sure to classify the child as a "Disabled Child" in the child relatinoship box and enter "YES" in the Disabled child field.

   Click "ADD ANOTHER CHILD" after each child has been added.

4. When all demographic information has been added for all dependents – spouse and children – Click "SAVE AND CONTINUE".

ENROLLING IN BENEFITS – UNION DUES

To receive Dental / Vision benefits you must pay the annual dues for membership in the WTU – Retiree Chapter.

If you waive this election, you will not be able to enroll in Dental / Vision benefits.

To pay your WTU – Retiree Chapter dues for 2024 – Click "KEEP PLAN".

G. DENTAL / VISION BENEFITS ENROLLMENT GUIDE

ENROLLING IN BENEFITS – DENTAL / VISION

1. After you complete your Annual Chapter Dues election, the next screen prompts you to Waive or Enroll in Dental benefits.

2. If you wish to waive Dental benefits for the calendar year 2024, indicate your preference by clicking the "WAIVE" button at the top of the screen

3. The system also prompts you to change your Dental benefits from "In Network Only (INO)" to "PPO (Preferred Provider Option)". If you wish to remain in the same plan, indicate your Dental benefit preference by clicking: "KEEP PLAN"

4. If you wish to switch plans indicate your Dental benefits preference by clicking: "ENROLL NOW"

5. The system will prompt you regarding Vision benefits. If you wish to waive Vision benefits for the calendar year 2024, indicate your preference by clicking the "WAIVE" button at the top of the screen.

6. If you wish to keep your Vision benefits, indicate your preference by clicking; "KEEP PLAN".

7. The next screen shows a summary of the benefits and associated costs to be paid, while the lower section of the screen takes you to "Pay Pal" for payment.

ENROLLING IN BENEFITS – MAKING YOUR PAYMENT

You are not required to create or use your personal Pay Pal account to pay for WTU Dental / Vision benefits.

Your MUST complete the payment process using your credit or debit card through Pay Pal in order to have Dental /Vision benefits for calendar year 2024.

Payments are made using a credit or debit card.

1. Pay Pal Link - To pay for your benefits simply click on the Pay Pal link and follow the prompts – www.paypal.com/us/login.

2. Please make certain to include an email address to receive your confirmation statement.

3. When you have completed payment for your Dental / Vision benefits, the system will ask you to confirm your payment has been made by responding to the statement: "My Pal Pay Payment has been Made".

4. You are required to respond to this prompt with a "NO" or "YES" to complete your Dental / Vision benefits enrollment for 2024.

5. If someone else has agreed to pay for your benefits, please respond with "NO" to the statement and indicate the payor's name, address and payment amount.

ENROLLING IN BENEFITS – CONFIRMING PAYMENT AND EXITING THE SYSTEM

1. When you indicate your payment has been made, the system will display a "Retiree Pay Pal Payment" confirmation in the lower left section of the screen.

2. Click on "CONTINUE", to review information regarding everyone who will be covered by the Dental /Vision plans you selected.

3. To move to the next screen, click on "CONTINUE", the system will display additional details of your account. Please conduct a final review to ensure accuracy.

4. The final step is to either "PRINT" the screen for your records and / or click: "FINISH", to complete the process.

5. To logout of the system:
   a. Locate the menu drop down in the upper right of the screen and click on the upside-down arrowhead (V) next to the "blue circle containing your initials".
   b. Click on: LOGOUT to end your session.

H. FREQUENTLY ASKED QUESTIONS

1. How do I Enroll?

Please refer to Page 10

2. What is an In-Network Only (INO) Dental Plan?

- An INO plan offers comprehensive coverage for dental care at cost-effective rates when you choose providers in the UHC national network
- In general, only In-Network services are covered in an INO plan
- www.myuhc.com is the website for In-Network Only provider look-up
- National options PPO20 is the network for BOTH Dental Plan choices
- No Out-of-Network benefits are available in this plan
- The INO has the following features:
  - No waiting periods
  - $3,500 annual benefits maximum
  - Plan has no deductibles
  - Coinsurance plans help you know out of pocket costs up front
  - Orthodontics covered at 50% coinsurance, $2000 maximum
  - No claim forms for In-Network services
  - Non-Network Emergency Palliative Care at In-Network rates

3. How does an INO plan design differ from the standard Preferred Provider Option (PPO) plan?

- The PPO plan is a traditional plan with copayments, coinsurance and deductibles. Members have access to a network of physicians and hospitals nationwide. The plan offers two levels of coverage – a higher level of benefits for In-Network services, and a lower level of benefits for non-network services with higher deductibles.
- Members may choose any health care professional or facility in the UHC network, including specialists, without a referral. Members can choose services outside the UHC network, which are normally at a higher coinsurance, and/or deductible level.
- The PPO has the following features:
  - The freedom to choose any doctor for health care needs.
  - It is the member's responsibility to obtain approvals for both network and non-Network services.
  - No referral to see a specialist
  - If a non-network physician is chosen, out-of-pocket costs may be higher, and it is the member's responsibility to obtain approvals and submit claims.

4. In summary how do the INO and PPO plans compare?

The standard INO and PPO plans share the following features:

- Coverage provided for comprehensive dental care
- Access to a broad, nationwide network of dental providers that have gone through a rigorous credentialing process
- No need to select a primary care dentist
- No referral for specialty care
- www.myuhc.com has a provider look up for members or you can call Customer Service to locate a provider near you – look for PPO20 network providers on the website.

5. Are there waiting periods for major services?

There are no waiting periods for major services.

6. How do I find a provider?

To find a dentist or an eye doctor, simply perform a search for a doctor near you. Select a provider and give them a call to confirm their acceptance of United Healthcare – Single or Family.

You can log on to www.myuhc.com or www.myuhcvision.com to search for a provider or you can also call UHC Dental at 866-249-0390 or UHC Vision at 800-638-3120

1239 Pennsylvania Ave, SE
Washington, DC 20003
202-517-1477 Main
info@wtulocal6.net
www.wtulocal6.org

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