Washington Teachers' Union
Retiree Dental & Vision Benefits
2018-2019

Open Enrollment
November 1-30, 2018

Washington Teachers' Union

Amplifying the Voice of DC Teachers

Elizabeth A. Davis, President

1239 Pennsylvania Avenue, S.E. • Washington, DC 20003 • 202.517.1477 • www.wtulocal6.org

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Dear WTU Retirees,

Every educator who works in a DCPS classroom today owes you a debt of gratitude, especially members of the Washington Teachers' Union (WTU).

As President of the WTU, I work every day to ensure that the path our union is taking continues to follow the trail you blazed. You built a union that is strong, and is dedicated to creating and sustaining the conditions it takes to ensure that each and every student in Washington, D.C., receives a world-class education.

You deserve and have earned the benefits listed in this booklet. What's more, you fought for and won these benefits; nobody gave them to you without a fight.

We often talk about "active" and "retired" members of the WTU. This is a false dichotomy. While you may have dropped out of teaching in a classroom, a large number of you have not dropped out of union activism. Every day you perform services and tasks without which our union could not function.

Moreover, a growing number of members of the WTU Retirees Chapter are deeply involved in working to improve the DC community and in efforts to ensure excellence in DC public education. Members of the Retirees Chapter do everything from distributing union literature and staffing important WTU activities to helping to support pro-education candidates in DC elections and running for public offices themselves.

Today more than ever, we need your wisdom, your knowledge and your energy because today the WTU, and all unions, face unprecedented challenges. Furthermore, we need your guidance to help us address educational issues and problems that you brought to light years ago but that did not become front and center in the public mind until very recently.

I urge you to stay active and help the WTU live up to the standards you set.

In unity,

Elizabeth A. Davis,

President, Washington Teachers Union

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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.myuhcdental.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 providers	**NO**	**YES**
Access to National PPO Providers	**YES**	**YES**
Deductible	**$0**	**$50 single/$150 family**
Annual maximum	**$3,500**	**$1,000**
Orthodontia coverage	Yes, covered at 50% coinsurance, with a $2,000 maximum, for both children and adults	Yes, covered at 50% coinsurance, with a $1,000 maximum, for children only
Referrals needed for specialty services	**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'll know the out-of-pocket costs up front) • Emergency and pain-relief care covered at in-network rates	• Consumer Max Multiplier included (you're able to roll over your unused annual maximum if guidelines are followed)

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

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 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.
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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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. SEDATIVE 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 jaw bone 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.

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)*	$1000 per person per Calendar	$1000 per person per Calendar	$1000 per person per Lifetime	$1000 per person per Lifetime
New enrollee's waiting period:				
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.

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.
29. 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

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.

	In-Network Provider	Out of Network Reimbursement
Comprehensive Exam	**No Co-pay**	**Up to $25**
Lenses (Standard) **Single Vision** **Bifocal** **Trifocal** **Lenticular** **Frames**	 **Covered in full** **Covered in full** **Covered in full** **Covered in full** **Up to $130**	 **Up to $25** **Up to $30** **Up to $70** **Up to $70** **Up to $15**
Contact Lenses (in lieu of eyeglasses) **Elective** **Medically Necessary**	 **$150 or up to 6 boxes 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 one for you to United Healthcare	You must submit a claim to United Healthcare for benefit reimbursement: P.O. Box 30928, Salt Lake City, Utah 84130
	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 t 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 which includes fitting fee. If fitting fee is $30, you have $120 to purchase contacts.

Laser Vision Benefit

United Healthcare Vision has partnered with the Laser Vision Network of America (LVNA) to provide our members with access to discounted laser correction providers. Call 1-888-563-4497 or visit www.uhclasik.com for more information.

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.

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, eye glasses 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.

Copays for in-network services	
Exam	$0.00
Materials	$0.00
Benefit frequency	
Comprehensive Exam	Once every 12 months
Spectacle Lenses	Once every 12 months
Frames	Once every 12 months
Contact Lenses in Lieu of Eye Glasses	Once every 12 months
Frame benefit	
Private Practice Provider	$130.00 retail frame allowance
Retail Chain Provider	$130.00 retail frame allowance
Lens options	
Standard scratch-resistant coating, Standard, Deluxe progressive lenses, Standard anti-reflective coating, Photochromic lenses, Polycarbonate lenses, Ultraviolet coating, Tints -- covered in full. Other optional lens upgrades may be offered at a discount. (Discount varies by provider.)	
Contact lens benefit	
Covered-in-full elective contact lenses [4] 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 a network provider. **All other elective contact lenses** A $150.00 allowance is applied toward the fitting/evaluation fees and purchase of contact lenses outside the covered selection (materials copay does not apply). Toric, gas permeable and bifocal contact lenses are examples of contact lenses that are outside of our covered contacts. **Necessary contact lenses**[3] Covered in full after applicable copay.	
Out-of-network reimbursements up to (Copays do not apply)	
Exam	$25.00
Frames	$15.00
Single Vision Lenses	$25.00
Bifocal Lenses	$30.00
Trifocal Lenses	$70.00
Lenticular Lenses	$70.00
Elective Contacts in Lieu of Eye Glasses[2]	$70.00
Necessary Contacts in Lieu of Eye Glasses[3]	$100.00
Laser vision benefit	
United Healthcare Vision has partnered with the Laser Vision Network of America (LVNA) to provide our members with access to discounted laser vision correction providers. Members receive 15% off usual and customary pricing, 5% off promotional pricing at over 500 network provider locations and even greater discounts through set pricing at Lasik Plus locations. For more information, call 1-888-563-4497 or visit us at www.uhclasik.com.	

VISION PLAN DETAILS

[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

HOW TO ENROLL

To receive coverage for the calendar year 2019 you will need to pay the full year's premium during open enrollment in November 2018. 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, 2018 to November 30, 2018, (your new benefit choices go into effect on January 1, 2019). Instructions for enrollment are below.

You must enroll online. If you cannot enroll online, you must enroll in person during the retiree chapter meeting.

Online Enrollment

1. Log onto **www.wtulocal6.org**
2. At the very top of the page, click on "**Members Only**"
3. Enter your username and password. Username = first initial of the first name with full last name combined with 2 digits of the month and 2 digits of the day of your birth day. Password = last 4 digits of your social security number.
4. Call 202-517-1477 to get your username or password if you do not remember them.
5. If you are retiring for the first time ever this year, click "First Time User" and follow the prompts to enter the company code: **WTU-82556**
6. Remember to save your progress often at the bottom of each page.
7. We are excited to announce our new credit card payment option through PayPal! Retirees may now use our online payment option to remit payment for Retiree chapter membership dues, and dental and vision premiums.

Check and money order payments are no longer accepted.

Attn: Retiree Enrollment 2018

In Person Enrollment

You can sign up for benefits in person, during the Retiree Chapter Meeting on **November 14, 2018, at 9:30 a.m.** at the American University, School of Education ***–4801 Massachusetts Avenue NW in Washington, DC. 20016.***

Please come prepared with your debit or credit card, you, and/or your dependents' social security numbers, and documents verifying your dependents (i.e. a marriage certificate, birth certificate, or tax return). WTU membership staff will be on site to assistyou.

Washington Teachers' Union invites retired educators to join its Retiree Chapter and participate in activities with former teacher friends, old and new.

Meetings

Stoddard Baptist Global Care @ Washington Center for the Aging
2601 18th St., NE in Washington, DC
Fellowship at 9:30 am - Meetings at 10:00 am

Dates

November 14, 2018 – American University
December 12, 2018 - Chapel
February 13, 2019 - Crystal Room
March 13, 2019 - Crystal Room
April 10, 2019 - Crystal Room
May 15, 2019 - Chapel

PAYMENT FORM

DUE NOVEMBER 30, 2018

Check List

- ☐ PayPal
- ☐ Complete online enrollment and add your dependents **ONLINE**
- ☐ Put November 2019 open enrollment on your personal calendar for next year

Retiree Chapter Membership Dues $55

*Please note, you MUST pay yearly retiree dues to be eligible for Dental and/or Vision benefits.

Open enrollment Annual Fees- Please check the plan that you enrolled in ONLINE

☐ Dental In-Network Only PPO	Single	$435.60
☐ Dental In-Network Only PPO	Family	$871.20
☐ Dental PPO	Single	$435.60
☐ Dental PPO	Family	$871.20
☐ Vision	Single	$224.16
☐ Vision	Family	$224.16

Total 2018 Coverage Cost =_____ ($55 + Dental Premium + Vision Premium)

Questions? Call WTU 202-517-1477
You will be required to re-enroll in Membership, Vision, and Dental benefits during open enrollment every year. Open enrollment occurs each November.

THIS IS NOT A HEALTH INSURANCE PLAN.
THIS PLAN COVERS ONLY DENTAL AND/OR VISION BENEFITS, DEPENDING ON YOUR ELECTION.

Washington Teachers' Union

Amplifying the Voice of DC Teachers

www.wtulocal6.org

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1239 Pennsylvania Avenue, S.E. Washington, DC 20003