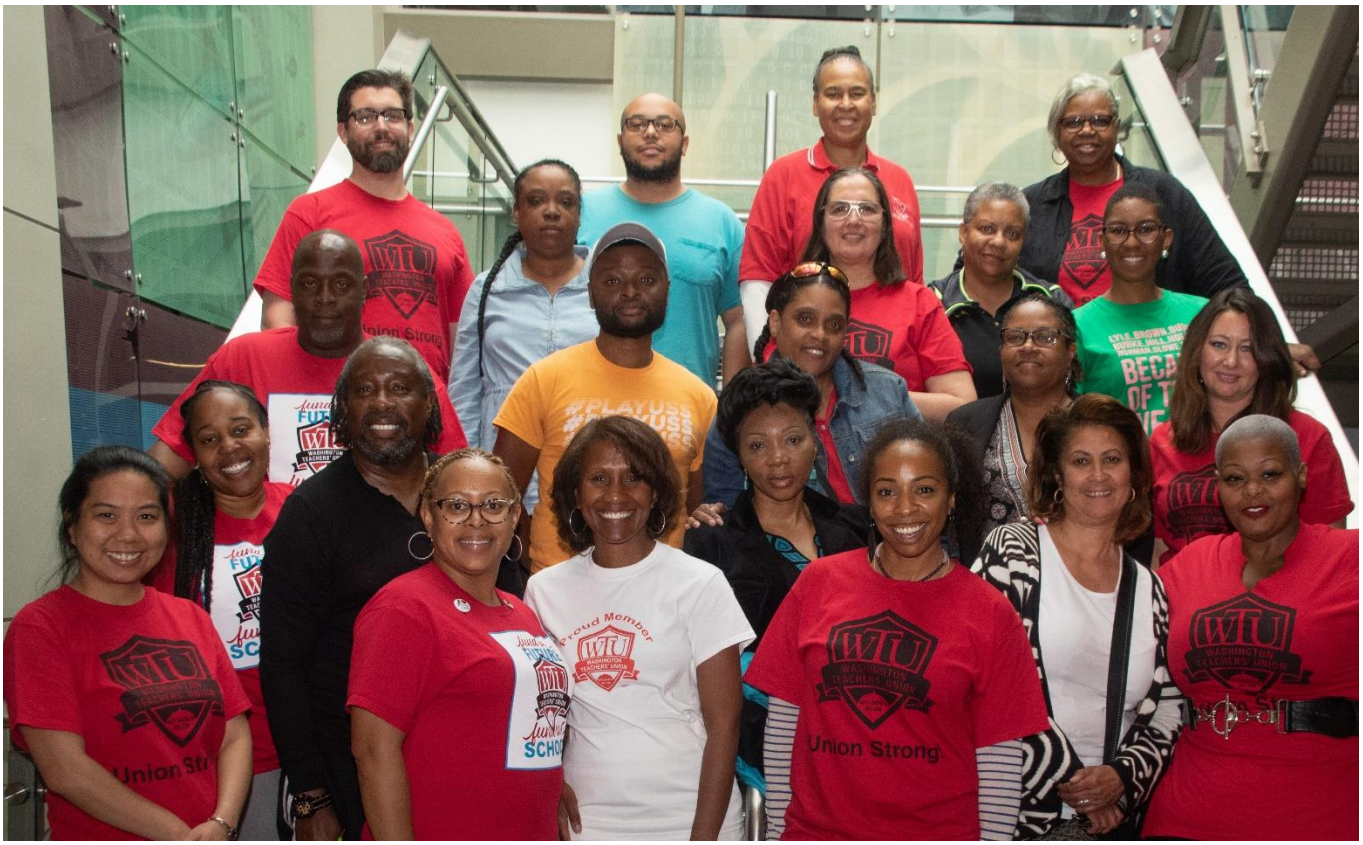


WASHINGTON TEACHERS' UNION

DENTAL AND VISION BENEFITS

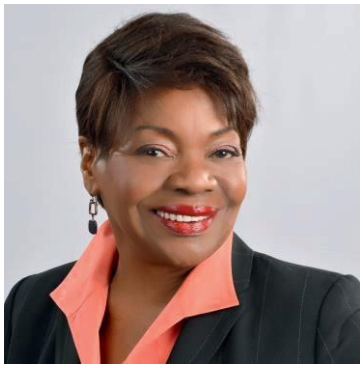
SCHOOL YEAR: 2020•2021

OPEN ENROLLMENT

DCPS PEOPLESOFT ONLINE ENROLLMENT

Washington Teachers' Union
Amplifying the Voice of DC Teachers
Elizabeth A. Davis, President
1239 Pennsylvania Avenue, S.E. Washington, D.C. 20003 • 202.517.1477 • www.wtulocal6.org

Dear DCPS Educator,



I urge you to read this booklet carefully. It describes the dental and vision medical benefits available to DCPS educators, fully paid for by the employer. We have these benefits because the members of the Washington Teachers' Union stood together and won them.

Before we organized into a Union, DC teachers had virtually no benefits at all and no rights. As a union, we won a contract that guarantees benefits, protects our rights and lays out the ground rules for how administrators and teachers work together.

Over the years we've realized that just because we won a victory yesterday, doesn't mean that tomorrow we can't lose what we won. We have seen that in order to protect and improve our rights and benefits, we must constantly work to maintain and strengthen our unity.

Without unity we will have no voice in developing the plans and programs that we as professionals know our students need. Many of our schools continue to suffer from under-funding and opportunity and achievement gaps continue to grow across our city. We know that the current teacher evaluation system, IMPACT, encourages educators to place too much emphasis on standardized tests and is a barrier to ensuring that DCPS students receive educational opportunities that serve them best. With unity, we can improve our city's educational systems and the opportunities available to all students.

If you are not already active in the WTU, become active. Check out our website at http://www.wtulocal6.net/. Ensure you #VOTE in local elections. And, please, join us at the WTU Representative Assemblies the second Tuesday of each month during the school year. I also invite you to join one of the Union's many taskforces and committees to get involved in the issues that you care about.

Please read this booklet carefully so that you understand the dental and vision benefits to which you are entitled, but remember, we must actively work to keep them. For more information about benefits, please contact https://ess.dc.gov.

It is my honor to serve you as president. Together we can maintain and strengthen our Union for many years to come. Feel free to call me to share your ideas and insights or to learn more about our union. You can contact me at 202- 957-3119 or edavis@WTULocal6.net.

In Solidarity,

Elizabeth A. Davis, *President*

Washington Teachers' Union

TABLE OF CONTENTS

A. ACTION REQUIRED / OVERVIEW OF PLANS

ACTION REQUIRED -

Enroll online through PeopleSoft https://ess.dc.gov in order for your benefits to take effect on January 1.

OVERVIEW OF PLANS -

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.

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

B. COVERING DEPENDENTS

WHO IS ELIGIBLE FOR DEPENDENT COVERAGE?

Your Spouse

Your Domestic Partner

Your Child – Unmarried children, including biological, adopted, placed with you for adoption or stepchildren, as well as any child for whom you have legal custody or guardianship is eligible for coverage.

Children may be covered until their 26th birthday.

Your Disabled Adult Child – Disabled children older than age 26 may be covered if the disability occurred prior to age 19.

If you would like your plan to cover a spouse, child or other dependents who are not already covered, you must enroll them during Open Season and provide proper documentation.

Without this information your dependents will not have coverage.

If your dependent(s) is currently covered, simply verify their date(s)-of-birth and social security number – in this instance, additional documentation is not required.

C.1 DENTAL PLAN SUMMARY

YOU HAVE A CHOICE BETWEEN TWO DENTAL PLANS: IN-NETWORK ONLY OR PPO PLAN.

There are no payroll deductions for either plan, no matter whether you opt for Single or Family Coverage. If you have dependents you would like to add to your union dental and vision plan –

Make sure your DCPS PeopleSoft account the program you use to enroll into your DCPS health insurance plan; shows **Self or Self and Family** coverage.

IN-NETWORK ONLY PLAN

This is our most popular plan as it offers comprehensive coverage and little to no out-of-pocket costs to you.

Your out-of-pocket cost will be less than the traditional Dental PPO plan.

Members of this plan have access to more than 2000 regional providers and more than 180,000 national providers.

You must receive services from In-Network providers to receive coverage for procedures.

There are no Out-of-Network benefits with this plan.

This plan has a larger annual maximum and has no deductibles. You will pay less out of your pocket with this plan.

PPO PLAN

This plan gives you access to a vast national network of PPO providers.

Members of this plan have the flexibility of receiving coverage for both In-Network and Out-of-Network providers, but there is a co-pay, a deductible and less coverage.

This plan will pay Out-of-Network benefits that are deemed Reasonable and Customary (R&C).

Any cost for benefits over what is reasonable and customary will be your responsibility.

C.2 DENTAL PLAN DETAILS

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PLAN COMPARISON	In-Network Only Plan	PPO
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
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 will know out-of-pocket costs up front) ▪ Emergency and pain relief care covered at in-network rates	▪ Consumer MaxMultiplier 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**

UnitedHealthcare® dental plan

In Network Only Options PPO 20/covered dental services Custom PIO17

	NON-ORTHODONTICS NETWORK	ORTHODONTICS NETWORK OR NON-NETWORK
Individual Annual Deductible	$0	$0
Family Annual Deductible	$0	$0
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 plan year	$2000 per person per lifetime
Annual Deductible Applies to Preventive and Diagnostic Services	No	
Annual Deductible Applies to Orthodontic Services	No	
Waiting Period	No waiting period	
Orthodontic Eligibility Requirement	Children and adult	

COVERED SERVICES*	SAMPLE PROCEDURE	NETWORK ENROLLEE PAYS**	BENEFIT GUIDELINES
DIAGNOSTIC SERVICES			
Periodic Oral Evaluation	D0120	$0	Limited to 2 times per consecutive 12 months.
Radiographs	D0274/D0330	$0/$0	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		$0	
PREVENTIVE SERVICES			
Dental Prophylaxis (Cleanings)	D1110	$0	Limited to 2 times per consecutive 12 months.
Fluoride Treatments	D1203	$0	Limited to covered persons under the age of 16 years and limited to 2 times per consecutive 12 months.
Sealants	D1351	$0	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	For covered persons under the age of 16 years, limit 1 per consecutive 60 months.
BASIC DENTAL SERVICES			
Restorations (Amalgam or Anterior Composite)*	D2331	$0	Multiple restorations on one surface will be treated as a single filling.
Palliative Treatment	D9110	$25	Covered as a separate benefit only if no other service was done during the visit other than X-rays.
General Anesthesia	D9220	$171	When clinically necessary.
Occlusal Guard	D9940	$171	Covered only if prescribed to control habitual grinding, and limited to 1 guard every consecutive 36 months.
Simple Extractions	D7140	$23	Limited to 1 time per tooth per lifetime.
Oral Surgery (includes surgical extractions)	D7240	$189	
Periodontics	D4260/D4341/D4910	$387/$70/$36	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	Root Canal Therapy: Limited to 1 time per tooth per lifetime.
MAJOR DENTAL SERVICES			
Inlays/Onlays/Crowns*	D2520/D2542/D2750	$288/$333/$356	Limited to 1 time per tooth per consecutive 60 months.
Dentures and other Removable Prosthetics	D5110/D5214	$410/$432	Full Denture/Partial Denture: Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.
Fixed Partial Dentures (Bridges)*	D6240	$351	Limited to 1 time per tooth per consecutive 60 months
ORTHODONTIC SERVICES	D8080		
Diagnose or correct misalignment of the teeth or bite		50%	

* 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. In accordance with the Illinois state requirement, a partner in a Civil Union is included in the definition of Dependent. For a complete description of Dependent Coverage, please refer to your Certificate of Coverage.

The Prenatal Dental Care (not available in WA) 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 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 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.

UnitedHealthcare Dental® In Network Only (INO) Plan is either underwritten or provided by: UnitedHealthcare Insurance Company, Hartford, Connecticut; UnitedHealthcare Insurance Company of New York, Hauppage, New York; Unimerica Insurance Company, Milwaukee, Wisconsin; Unimerica Life Insurance Company of New York, New York, New York; or United HealthCare Services, Inc

UnitedHealthcare/dental exclusions and limitations

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

A. Necessary;

B. Proviced by or under the direction of a Dentist or other appropriate provider as specifically described;

C. The least costly, clinically accepted treatment; and

D. Not excluded as described in the Section entitled, General Exclusions.

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.

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.

ROOT CANAL THERAPY Limited to 1 time per tooth per lifetime.

PERIODONTAL MAINTENANCE Limited to 2 times per consecutive 12 months following active or 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 covered if prescribed to control habitual grinding.

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

GENERAL ANESTHESIA Covered only when 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 quadrant or site per consecutive 36 months per surgical area.

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 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 dental 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 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.
14. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
15. 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.
16. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
17. Placement of dental implants, implant-supported abutments and prostheses
18. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
19. 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.
20. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
21. 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 orthognathic surgery, jaw alignment, or treatment for the temporomandibular joint.
22. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
23. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
24. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
25. Occlusal guards used as safety items or to affect performance primarily in sports-related activities.
26. 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.
27. 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 a malocclusion, 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.

UnitedHealthcare dental plan

Options PPO/covered dental services for **Washington Teachers Union** Custom **P7951/MAC**

	NON-ORTHODONTICS		ORTHODONTICS	
	NETWORK	NON-NETWORK	NETWORK	NON-NETWORK
Individual Annual Plan Year Deductible	$50	$50	$0	$0
Family Annual Plan Year Deductible	$150	$150	$0	$0
Maximum *(the sum of all Network and Non-Network benefits will not exceed annual maximum)*	$1000 per person per Plan Year	$1000 per person per Plan Year	$1000 per child per Lifetime	$1000 per child per Lifetime

New enrollee's waiting period:		
Orthodontia Eligibility		Child Only (up to age 19)
Annual deductible applies to preventive, diagnostic and orthodontic services		No

COVERED SERVICES*	NETWORK PLAN PAYS**	NON-NETWORK PLAN PAYS***	BENEFIT GUIDELINES
DIAGNOSTIC SERVICES			
Periodic Oral Evaluation	100%	80%	Limited to 2 times per consecutive 12 months.
Radiographs	100%	80%	Bitewing: Limited to 1 series of films per plan year. Complete/Panorex: Limited to 1 time per consecutive 36 months.
Lab and Other Diagnostic Tests	100%	80%	
PREVENTIVE SERVICES			
Prophylaxis (Cleanings)	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.
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.
Space Maintainers	100%	80%	For Covered Persons under the age of 16 years, limited to 1 per consecutive 60 months.
BASIC SERVICES			
Restorations (Amalgams or Composite)	80%	60%	Multiple restorations on one surface will be treated as a single filling.
General Services including Palliative Treatment	80%	60%	General Anesthesia: When clinically necessary. Palliative Treatment: Covered as a separate benefit only if no other service was done during the visit other than X-rays.
Simple Extractions	80%	60%	Limited to 1 time per tooth per lifetime.
MAJOR SERVICES			
Oral Surgery (includes surgical extractions)	50%	40%	
Periodontics	50%	40%	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.
Endodontics	50%	40%	
Inlays/Onlays/Crowns	50%	40%	Limited to 1 time per tooth per consecutive 60 months.
Dentures and other Removable Prosthetics	50%	40%	Full Denture/Partial Denture: Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.
Fixed Partial Dentures (Bridges)	50%	40%	Once per tooth per consecutive 60 months.
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.

* 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 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 In and Out of network percentage of benefits is based on the discounted fees negotiated with the 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.

UnitedHealthcare 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; Unimerica Insurance Company, Milwaukee, Wisconsin; Unimerica Life Insurance Company of New York, New York, New York or United HealthCare Services, Inc.

UnitedHealthcare/Dental Exclusions and Limitations

General Limitations

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

COMPLETE SERIES OR PANOREX RADIOGRAPHS Limited to one time per consecutive 36 months. Exception to this limit will be made for Paronex Radiograph if taken for diagnosis of molars, Cysts or neoplasms

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

EXTRAORAL RADIOGRAPHS Limited to 2 films per **Plan** 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.

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. Limited to 1 per consecutive 60 months. Benefit includes all adjustment within 6 months of installation

RESTORATIONS Multiple restorations on 1 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.

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 time per consecutive 6 months.

PALLIATIVE TREATMENT Covered as a separate benefit only if no other service, other than 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 prescribe to control habitual grinding.

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

GENERAL ANETHSTHESIA Covered only when 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

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 interceptiive 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 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.
14. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
15. 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.
16. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
17. Placement of dental implants, implants-supported abutments and prostheses. (Not applicable for plans with implants)
18. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
19. 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.
20. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue
21. 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 orthognathic surgery, jaw alignment or treatment for the temporomandibular joint.
22. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia
23. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
24. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours' notice.
25. Occlusal guard used as safety items or to affect performance primarily in sports-related activities
26. 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.
27. 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 a malocclusion, 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.

D.1 VISION PLAN SUMMARY

Your vision coverage will be provided by United Healthcare Vision and will include eye exams, frames and lenses or contact lenses. You may choose In-Network or Out-of-Network providers.

Discounts for laser eye surgery (limited to certain locations) are also offered. However, laser eye surgery is not a covered benefit.

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 Glasses) **Elective** **Medically Necessary**	(Fully covered contacts or $150 allowance, not all brands apply) **Up to 6 boxes or $150 allowance up to 6 boxes**	**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: PO Box 30928, Salt Lake City, Utah 84130

Both plans have access to: www.myuhcvision.com **To find a provider call: 1-800-839-3242**

LENS OPTIONS – Lens Options Include: Standard Scratch Resistant Coating, Polycarbonates, Basic and High-End Progressives, Tints / UV and Transition Lenses, Stand Anti-Reflective Coating

CONTACT LENS BENEFIT – Coverage for full contact lens benefits at network providers includes fitting and 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 BENEFITS – 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.

Note: 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 or anisometropia; 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.

D.2 VISION PLAN DETAILS

Washington Teachers' Union
Benefit Plan

UnitedHealthcare®
Vision Benefit Summary

Customer Service and Provider Locator: (800) 638-3120
myuhcvision.com

UnitedHealthcare vision has been trusted for more than 50 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 (up to the plan allowance and after applicable copay) include a comprehensive exam, eyeglasses with standard single vision, lined bifocal, lined trifocal, or lenticular lenses, standard scratch-resistant coating and the frame, or contact lenses in lieu of eyeglasses.

	Exam with Materials
Benefit Frequency	
Comprehensive Exam(s)	Once every 12 months
Spectacle Lenses	Once every 12 months
Frames	Once every 12 months
Contact Lenses in Lieu of Eyeglasses	Once every 12 months
In-Network Services	
Copays	
Exam(s)	$ 0.00
Materials	$ 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	
Photochromic Lenses, Tints, Standard Anti-Reflective Coating, Standard Scratch-resistant Coating ,Ultraviolet Coating, Standard Progressive Lenses, Deluxe Progressive Lenses, Premium Progressive Lenses, Platinum Progressive Lenses, Polycarbonate Lenses for Adults, Polycarbonate Lenses for Dependent Children (up to age 19) - covered in full. Other optional lens upgrades may be offered at a discount (discount varies by provider). The Lens Options list can be found at myuhcvision.com.	
Contact Lens Benefit[2] (Selection contact lenses refers to our formulary contact list. Contact lenses not listed on the formulary are referred to as non-selection. A copy of the list can be found at myuhcvision.com).	
Selection contact lenses The fitting/evaluation fees, contact lenses, and up to two follow-up visits are covered in full after copay (if applicable).	If you choose disposable contacts, up to 6 boxes are included when obtained from an in-network provider.
Non-selection contact lenses An allowance is applied toward the purchase of contact lenses outside the selection. Materials copay (if applicable) is waived.	$150.00
Necessary contact lenses[3]	Covered in full after copay (if applicable).
Out-of-Network Reimbursements (Copays do not apply)	
Exam(s)	Up to $25.00
Frames	Up to $15.00
Single Vision Lenses	Up to $25.00
Lined Bifocal Lenses	Up to $30.00
Lined Trifocal Lenses	Up to $70.00
Lenticular Lenses	Up to $70.00
Elective Contacts in Lieu of Eyeglasses[2]	Up to $70.00
Necessary Contacts in Lieu of Eyeglasses[3]	Up to $100.00

Discounts	
	Laser vision UnitedHealthcare 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 standard or 5% off promotional pricing at more than 550 network provider locations and even greater discounts through set pricing at LasikPlus® locations. For more information, call 1-888-563-4497 or visit us at www.uhclasik.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.
	Hearing Aids As a UnitedHealthcare vision plan member, you can save on high-quality hearing aids when you buy them from hi Health Innovations™. To find out more go to hiHealthInnovations.com. When placing your order use promo code my Vision to get the special price discount.

[1]30% discount available at most participating in-network provider locations. May exclude certain frame manufacturers. Please verify all discounts with your provider.
[2]Contact lenses are in lieu of eyeglass lenses and/or eyeglass frames. Coverage for Selection contact lenses does not apply at Costco, Walmart or Sam's Club locations. The allowance for Non-selection contact lenses applies to materials. No portion will be exclusively applied to the fitting and evaluation.
[3]Necessary contact lenses are determined at the provider's discretion for one or more of the following conditions: Following cataract surgery without intraocular lens implant; to correct extreme vision problems that cannot be corrected with eyeglass lenses and/or frames; with certain conditions such as anisometropia, keratoconus, irregular corneal/astigmatism, aphakia, facial deformity; or corneal deformity. If your provider considers your contacts necessary, you should ask your provider to contact UnitedHealthcare vision confirming the reimbursement that UnitedHealthcare will make before you purchase such contacts.

Important to Remember:

In-Network

- Always identify yourself as a UnitedHealthcare vision member when making your appointment. This will assist the provider in obtaining your benefit information.
- Your participating provider will help you determine which contact lenses are available in the UnitedHealthcare selection.
- Your $150.00 contact lens allowance applies to materials. No portion will be exclusively applied to the fitting and evaluation. Your material copay is waived when purchasing non-selection contacts.
- Patient options such as UV coating, progressive lenses, etc., which are not covered-in-full, may be available at a discount at participating providers. The Lens Options list can be found at myuhcvision.com.

Choice and Access of Vision Care Providers

UnitedHealthcare offers its vision program through a national network including both private practice and retail chain providers. To access the Provider Locator service or for a printed directory, visit our website myuhcvision.com or call (800) 638-3120, 24 hours a day, seven days a week. You may also view your benefits, search for a provider or print an ID card online at myuhcvision.com.
Retain this UnitedHealthcare vision benefit summary which includes detailed benefit information and instructions on how to use the program.
Please refer to your Certificate of Coverage for a full explanation of benefits.
In-Network Provider - Copays and non-covered patient options are paid to provider by program participant at the time of service.
Out-of-Network Provider - Participant pays full fee to the provider, and UnitedHealthcare reimburses the participant for services rendered up to the maximum allowance. Copays do not apply to out-of-network benefits. All receipts must be submitted at the same time to the following address: UnitedHealthcare Vision, Attn. Claims Department, P.O. Box 30978, Salt Lake City, UT 84130. Written proof of loss should be given to the Company within 90 days after the date of loss. If it was not reasonably possible to give written proof in the time required, the Company will not reduce or deny the claim for this reason. However, proof must be filed as soon as reasonably possible, but no later than 1 year after the date of service unless the Covered Person was legally incapacitated.

Customer Service is available toll-free at (800) 638-3120 from 8:00 a.m. to 11:00 p.m. Eastern Time Monday through Friday, and 9:00 a.m. to 6:30 p.m. Eastern Time on Saturday.

This Benefit Summary is intended only to highlight your benefits and should not be relied upon to fully determine coverage. This benefit plan may not cover all of your healthcare expenses. More complete descriptions of benefits and the terms under which they are provided are contained in the certificate of coverage that you will receive upon enrolling in the plan. If this Benefit Summary conflicts in any way with the Policy issued to your employer, the Policy shall prevail.

E. BENEFITS GLOSSARY

Annual Maximum	The highest amount of money your insurance plan will pay out to you in one year.
Coinsurance	The percentage your insurance company will pay after you have met your deductible
Deductible	The dollar amount you must reach before your health benefits and coinsurance can be used. Some services, such as preventive services, may be covered without meeting the deductible first.
In-Network Providers	Health care providers have an agreement with your insurance company to offer a reduce rate for quality care. Your coverage is often the highest when you use an In-Network provider.
Open Enrollment	The annual period in which you can enroll in a benefit plan for the following year.
Out-of-Network Providers	Health care providers that do not have an agreement with your insurance company to offer discounted rates. You may have a lower level of coverage if you use Out-of-Network providers.
PPO (Preferred Provider Organization)	A health care organization that has an agreement with your insurance company to offer a reduced rate for quality of care Organization)

F. Frequently Asked Questions

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

- An INO plan offers comprehensive coverage and access to a national PPO 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

2 How does an INO plan design differ from the standard PPO plan?

Like the PPO products, 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
- No claim forms for In-Network services

The INO also 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
- One national co-payment schedule for each fixed co-payment INO plan design
- Orthodontics covered at 50% coinsurance, $2000 maximum
- Non-Network Emergency Palliative Care at In-Network rates

3 What are the advantages of an INO to employees?

- Coverage provided for comprehensive dental care
- Access to a broad, nationwide network of dental providers that have gone through a rigorous credentialing process
- Fixed co-payment options mean you know out of pocket costs up front
- Orthodontics covered at 50% coinsurance, $2000 maximum
- No need to select a primary care dentist
- No referrals for specialty care
- No deductibles
- No waiting periods
- $3,500 annual benefits maximum
- No claim forms for In-Network services
- 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.

4 Are there waiting periods for major services?

There are no waiting periods for major services.

5 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.

Washington Teachers' Union
Amplifying the Voice of DC Teachers
Elizabeth A. Davis, President
1239 Pennsylvania Avenue, S.E. Washington, D.C. 20003 • 202.517.1477 • www.wtulocal6.org

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to keep up on the latest from your Union.