

Washington Teachers' Union - Retirees UnitedHealthcare Dental & Vision

January 2012



Quick Notes

- ▶ Enclosed is your *2012 Membership and Benefits* brochure.
- ▶ Membership (\$55.00 yearly) is automatically checked because you must be a WTU member to receive benefits.
- ▶ If you do not want Dental or Vision, you can elect to be a WTU member for 2012 (only pay \$55 for the year).
- ▶ Single coverage for either dental plan is \$360.00 for the year.
- ▶ Family coverage for either dental plan is \$720.00 for the year.
- ▶ Vision coverage single or family is \$184.80 for the year.
- ▶ Both dental options, INO or PPO, include the same PPO dental network.
- ▶ In Network Only dental option does not have “out of network” coverage.
- ▶ Dental Provider Directory is available at: www.myuhcdental.com or call 800-445-9090.
- ▶ Vision Provider Directory is available at: www.myuhcvision.com or call 800-638-3120.
- ▶ Benefits are effective January 1st, 2012 thru December 31st, 2012.
- ▶ You must complete online enrollment by November 30th, 2011. (Please see “How To Enroll “ instructions in the brochure.)
- ▶ Payments must be sent to the WTU Benefits Office using the page in the back of this brochure by November 30th, 2011.
- ▶ “Waived” means not covered or that you don’t want coverage.
- ▶ Please call the WTU Benefits Office at 202-293-8600 with questions or concerns.

In This Guide

| | |
|----------------------------------------------|--------------|
| Welcome Letter | 1 |
| 2012 Dental & Vision Plan Options | 2-3 |
| How to Enroll | 4-10 |
| Dental INO Frequently Asked Questions | 11 |
| Dental INO Benefit Summary | 12-13 |
| Dental PPO Benefit Summary | 14-15 |
| Vision Benefit Summary | 16-17 |
| Payment Form | 18 |

Dear WTU Retiree:

It is time to join the Retiree Chapter and renew your benefits. Open enrollment is November 1st-30th. Providers include: **United Healthcare Dental** and **United Healthcare Vision**. Benefits will be effective January 1, 2012 and your enrollment may be completed online.

Please review the enclosed information and follow the "How to Enroll" steps. Dependents can be covered up to age 26 with supporting documentation. You will need to provide social security numbers for all covered dependents.

Choose from one of two PPO Dental Plans and an enhanced Vision Plan. Vision benefits will cover standard anti-reflective coating if you use an In-Network provider.

Annual fees for 2012 are:

| | |
|-------------------------------------|----------|
| Membership | \$55.00 |
| Dental In-Network Only PPO – Single | \$360.00 |
| Dental In-Network Only PPO – Family | \$720.00 |
| Dental PPO – Single | \$360.00 |
| Dental PPO – Family | \$720.00 |
| Vision – Single / Family | \$184.80 |

All documentation and full payment must be submitted to the WTU Benefits office by 5 pm November 30th. After November 30th, changes cannot be made until the 2013 Open Enrollment season unless you have a qualified lifestyle change.

For questions or concerns, please contact Tonia Pollard at tpollard@wtulocal6.net or at 202-293-8617.

Best Regards,

Nathan A. Saunders
President

Retiree 2012 Dental Plan Choices

In Network Only Plan Choice

- Utilizes National PPO Dental Network
- \$3500 Annual Maximum
- \$2000 Lifetime Ortho Maximum (adults and children)
- No deductibles
- Low co-pays
- No claim forms
- **NO** Out-Of-Network benefits



PPO Plan Choice

- Utilizes National PPO Dental Network
- \$1000 Annual Maximum
- \$1000 Lifetime Ortho Maximum (for children only)
- \$50/\$150 deductibles
- Out of Network benefits available
- No claim forms when you use Network providers
- Consumer MaxMultiplier (CMM) included
 - Carry over a portion of your unused Annual Maximum
 - CMM funds become available in the following year
 - Earn \$100 additional CMM funds when you use a network provider for all dental services
 - When you exceed your Annual Maximum, CMM funds are made available for any additional claims costs (not to exceed CMM balance)

Retiree 2012 Vision Plan Choices



| Current Plan | Additional Benefits for January 2012 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|
| <p>\$0 / \$0 Copays</p> <p>Frequency 12/12/12</p> <ul style="list-style-type: none"> • 12 Months for Exam • 12 Months for Lenses • 12 Months for Frames <p>Covered IN FULL Options</p> <ul style="list-style-type: none"> • Scratch Resistent Lenses • Tints / UV Coating • Basic & High End Progressives <p>Polycarbonate and Transition lenses covered in full when using a Network Provider</p> <p>Contact lens allowance \$150 per member per year Covered Contact Lenses up to 6 Boxes</p> | <p>For 2012 Standard Anti-Reflective Coating added as a Covered In Full Option at an In Network Provider</p> |
| Out-of-Network Benefits | |
| <p>Frequency 12/12/12</p> <p>No change to Out-of-Network Benefits</p> <p>Member has 12 months to submit a paid-in-full receipt to UnitedHealthcare Vision for reimbursement, directly to the member</p> <p>Out-of-Network Copays</p> <p>\$25 Exam \$25 Single Vision Lenses \$30 Bifocal Lenses \$70 Trifocal Lenses \$70 Disposable Contacts \$100 Medically Necessary Contacts</p> | |

How to Enroll

Step # 1

Log on to
www.wtu.bswift.com
Click on bswift log in.

Welcome to **Washington Teachers' Union** dental and vision benefits enrollment website presented by *UnitedHealthcare Specialty Benefits*.

- **Retirees**-Open enrollment November 1-30, 2011. Please contact the WTU Benefits Office during that time if you have questions or don't receive materials.

Username: Last name and last 4 digits of your Social Security Number. Example; smith1234

Password: Last 4 digits of your Social Security number.

- **New Teachers**- Please contact the WTU Benefits Office for enrollment instructions at 202-293-8600.
- **Active Teachers**- WTU open enrollment ended September 9, 2011. To access your benefit information please use the following:
Username: First letter of your first name followed by your last name and MMDD of your birthday. Example; jsmith0915
Password: Last 4 digits of your Social Security number.

If you have questions, please call the WTU Benefits Office at 202-293-8600.

Username:

Password:

Login

[First Time User?](#) [Forget Password?](#)

Current 2011 Retirees

User Name - log in using your last name followed by the last four digits of your social security number (SSN).

Password - is the last four digits of your SSN.

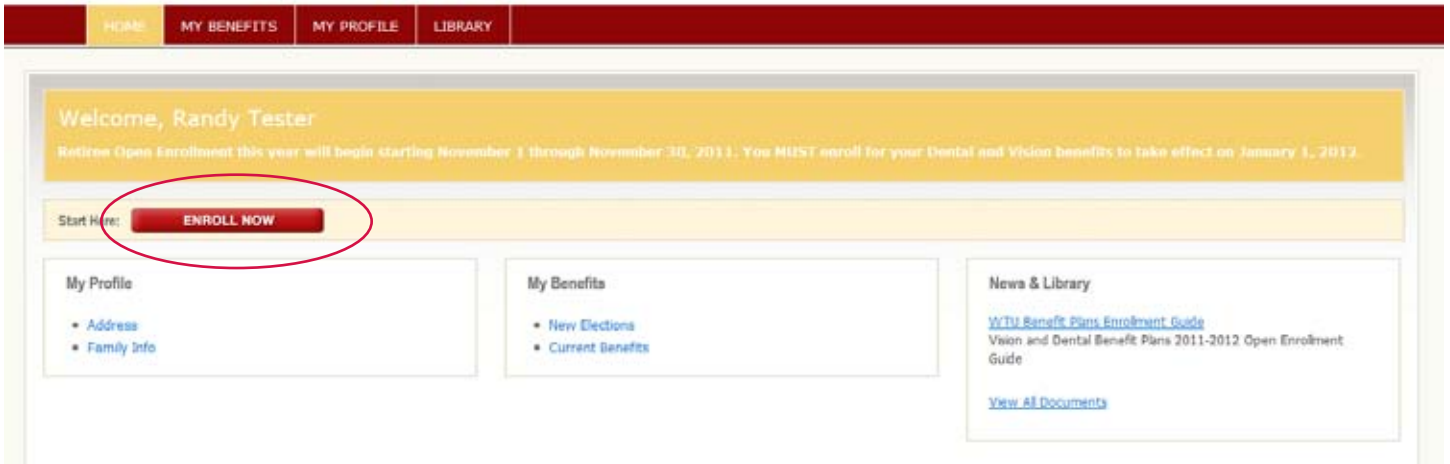
New Members

If you're new to the Retiree Chapter, register by clicking on "First Time User?"

Step # 2 – Current Retirees

Click on “Enroll Now “

* Have the SSN ready for all dependents before you begin.



New Retirees

Enter Co. Code WTU-82556

The screenshot shows the "First Time Registration" form. On the left, there is a dark red sidebar with the WTU logo and links for "First Time User?", "Forgot Password?", and "Log In". The main content area has the title "First Time Registration" and the instruction: "In order to use the Company HR Portal, you must first register. Please enter your Company Code below and click continue." A red circle highlights the "Company Code" input field, which is currently empty. A red box next to it contains the text "Enter Co. Code WTU-82556". Below the input field are "Continue" and "Cancel" buttons. At the bottom, there is a note: "* Company Code is a unique identifier used solely for your company. You must get this code from your HR Department or HR Administrator."

Step # 3 – Personal Information

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Current benefits New Elections

Personal Information

1 Employee 2 Family 3 Enroll 4 Confirm

Before beginning enrollment, all of your personal and family information must be complete. Please complete the required fields below, or, if the information has already been entered, please make sure it is accurate and if necessary make changes. To update your address please call the WTU Benefits Office at 202-293-8600.

Click "I Agree". Click the "Save" button at the bottom of the page to continue.

Demographics

Demographics

*First Name Randy

Middle Initial

*Last Name Tester

*Social Security Number 333-66-8888

*Date of Birth 1/1/1980 (mm/dd/yyyy)

* Fields are required.

Address

*Address 1 123 Main St.

Address 2

*City Chicago

*State IL - Illinois

*Zip 60640

Home Phone

Cell Phone

Home Email jsuvatne@bswift.com

* Fields are required.

I agree that I have reviewed and updated the above information and it is correct.

I agree

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1. Current Retirees
Verify your information – make any necessary changes
New Retirees
Enter information

2. Click "I agree" at the bottom left of the page.

3. Click "Continue"

Step # 4 – Family/Dependent Information

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Current Benefits New Elections

Family Information

Current Retirees: 1. Verify or add dependent information for benefits.

1 Employee 2 Family 3 Enroll 4 Confirm

Please enter all family information before beginning enrollment. To do so, click on "Add Family Member." To verify or edit the information of a family member who has already been entered, click on the person's name. You must click "I Agree" whether you have family members or not then click on "Continue".

| Name | SSN | Relationship | Date of Birth | Gender | Add family member>> |
|------------------------------|-------------|--------------|---------------|--------|-------------------------------------------|
| Bandy Tester | 333-66-8888 | Employee | 01/01/1980 | M | |
| JL Jones | 123-00-9999 | Spouse | 01/01/1980 | F | |

Current and New Retirees: 2. To add dependent information click "Add family member."

Dependent Information Notice
Washington Teachers' Union has restrictions for qualified dependent coverage under our benefit plans. Enrolling someone who is not qualified below to understand some of the restrictions for qualified dependents and possible consequences for insurance fraud.

Who is a qualified dependent?

- Your legally married husband/wife
- Your Domestic partner (Same sex or opposite sex)
- Your unmarried child(ren) under the age of 26
- Your incapacitated children of any age who are: Unmarried, Incapable of self-support, Incapacitated before the age of 19, and claimed as a dependent on your income tax return.

Children include: natural children, stepchildren, legally adopted children, children placed for adoption, and children who you are legally appointed as guardian or limited guardian (cannot be temporary guardian).

Who is NOT a qualified dependent?

- Boyfriend/girlfriend
- Parents
- Grandparents/relatives
- Brothers or sisters

I agree

3. Click "I agree" at the bottom left of the page.

4. Click "Continue"

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Step # 5

1. Click "GET STARTED"
 2. Click on your 2012 Dental option to enroll. (Dependents will be shown.)
 3. Click "Next."
 4. Click box next to vision if you want to add Vision for 2012.
 5. Click "Continue."
- * BE SURE TO CLICK "COVER" IF YOU ARE COVERING YOUR DEPENDENTS FOR VISION AND DENTAL.



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Current Benefits View Elections

Enrollment

1 Employee 2 Family 3 Enroll 4 Continue

Your Total Costs Per Pay Period
\$55.00

Company Wide Enrollment

To Do:

Plan Selection

Getting Started with Your Enrollment is Easy

You are now eligible to make your 2012 open enrollment benefit elections effective January 1, 2012. To enroll in dental and/or vision you must be a member of the Washington Teachers' Union Retiree Chapter and the dues are \$55 annually.

[Get Started](#)

1. Get Started

| Complete | Coverage | Annual Cost Per Pay Period (Pre-Tax) |
|----------------------------------------------------------------------------------------------------------------------------------------------|----------|--------------------------------------|
| <input checked="" type="checkbox"/> WTU membership (WTU membership) Washington Teachers' Union Membership | | \$55.00 |
| <input type="checkbox"/> Dental Incomplete: Choose/Decline Coverage | | |

Please make your dental selection and choose the dependents you wish to cover, then click "Next".

Plan Selection: [Employee Plans](#) Compare Costs: [Employee](#)

- [In Network Only Dental](#) \$360.00
- PPO Dental
- Waiver Dental

[Next](#) [Calculate Costs](#) [Add Dependents](#)

2. Select a Dental Option (In Network Only or PPO).

3. Click "Next"

Vision

4. Click if you want to add Vision for 2012.

[Continue](#)

5. Click "Continue"

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Step # 6

Review selections, dependent coverage and **TOTAL COST**

Enrollment

1 Employee 2 Family 3 **Enroll** 4 Confirm

Your Total Cost:
Per Pay Period
\$239.00

Company Wide Enrollment
To Do:
[Plan Selection](#)

Almost Finished!

Please Review All of Your Selections
Once you've completed your review, click the "Save My Enrollment" button at the bottom of the page.

My Benefits
* Indicates changed benefits

| Complete: | Coverage | Annual Cost Per Pay Period (Pre-Tax) |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|--------------------------------------|
| <input checked="" type="checkbox"/> WTS membership (WTS membership) Washington Teachers' Union Membership | | \$55.00 |
| <input checked="" type="checkbox"/> * Dental (Dental) <small>(This benefit election is pending until approved by Benefits Department)</small> PPO Dental | Employee | \$160.00 |
| Dependents: | | |
| Relationship | Name | Coverage |
| (Employee) | Randy Testar | Cover |
| (Spouse) | JL Jones | None |
| <input checked="" type="checkbox"/> Vision (Lot) Vision PPO | Employee + Family | \$184.00 |
| Dependents: | | |
| Relationship | Name | Coverage |
| (Employee) | Randy Testar | Cover |
| (Spouse) | JL Jones | Cover |

Once You've Reviewed All Your Selections:

Participation

I understand that the benefit elections I have made are in effect for one full benefit plan year and cannot be changed until the next enrollment period, unless I have a qualified family status change. I also understand that if I do have a qualified family status change, I have 30 days from the date of the life event to make changes to my benefit plan elections, that any changes must be consistent with that change in status, and that I may be required to furnish proof of the event for myself or my eligible dependents.

I agree, and I'm finished with my enrollment.

[Save My Enrollment!](#)

1. Be sure to click "I agree and I am finished" at the bottom of the page – first – before you click "Save my enrollment"

Step # 7

Mail your check or money order with the Payment Receipt (last page of this booklet) to the WTU address on Payment Receipt Page.

Payment TOTAL is your annual amount for membership and benefits.

Enrollment will be pending until your payment is received by WTU Benefits Office.

Payment **MUST BE RECEIVED BY November 30, 2011.**



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Current Benefits View Elections

Print or email a confirmation page for your records.

New Elections, Confirmation Statement for Randy Tester

ENROLLMENT COMPLETE!

Your enrollment is now complete. Please view your confirmation statement by clicking the "Printer Friendly" link or e-mail yourself a copy by clicking "Send me an e-mail confirmation" for your records. You may click on the links to make changes or get details about each plan.

Mail check or money order with receipt page in back of brochure to:

**WTU RETIREES' CHAPTER
1825 K ST NW
SUITE 1050
WASHINGTON, DC 20006**

Your Benefits 1/1/2012

Your Total Cost Per Pay Period: **\$959.00** Per Year: **\$959.00**

View your benefits as of another date:
1/1/2012
Recalculate

| Plan Name | Relation | Effective | Coverage | Your Cost Pre-Tax |
|-------------------------------------------------------|----------|-----------|-------------------|-------------------|
| WTU membership | | | | |
| Washington Teachers' Union Membership | | 1/1/2012 | | \$53.00 |
| Dental | | | | |
| PPO Dental | | 1/1/2012 | Employee + Family | \$,726.00 |
| Randy Tester | Employee | 1/1/2012 | Covered | |
| JJ Jones | Spouse | 1/1/2012 | Covered | |
| Vision | | | | |
| Vision PPO | | 1/1/2012 | Employee + Family | \$,144.00 |
| Randy Tester | Employee | 1/1/2012 | Covered | |
| JJ Jones | Spouse | 1/1/2012 | Covered | |
| Totals: | | | | \$959.00 |

Created on: 10/25/2011

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Dental Plan Options

In-Network Only Plan

It offers comprehensive coverage and the lowest out-of-pocket costs to you. The plan includes many excellent benefits, including no deductibles, a \$3,500 annual maximum, access to more than 2,000 regional providers and more than 100,000 national providers, orthodontia coverage and more.

PPO Plan

The PPO Plan option gives you access to a vast national network of PPO providers. This plan offers you the flexibility of having coverage for both in-network and out-of-network providers.

When you choose to use an in-network provider, you'll have a higher level of coverage, and you'll pay less out-of-pocket. When you choose to use an out-of-network provider, this plan will pay benefits that are deemed Reasonable and Customary (R & C). Any amounts over the R & C will be your responsibility.

Highlights and Advantages by Plan

| | 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: | <ul style="list-style-type: none"> • No claims forms for in-network services • No waiting periods for major services • No need to select one primary care provider • Fixed copay options (you'll know the out-of-pocket costs upfront) • Emergency and pain-relief care covered at in-network rates | <ul style="list-style-type: none"> • Consumer MaxMultiplier included (you're able to roll over your unused annual maximum if guidelines are followed) |

Both plans have access to www.myuhcdental.com to estimate out-of-pocket costs for treatments.

To find a provider in the UnitedHealthcare PPO Network, visit www.myuhcdental.com or call (877) 816-3596.

UnitedHealthcare Dental®
In Network Only PPO (INO)/covered dental services

dental plan
 PIN65

| | NON-ORTHODONTICS | | ORTHODONTICS | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|-------------|--------------------------------|-------------|
| | NETWORK | NON-NETWORK | NETWORK | NON-NETWORK |
| Individual Annual Deductible | None | | None | |
| Family Annual Deductible | None | | None | |
| Annual Maximum Benefit <i>(The total benefit payable by the plan will not exceed the highest listed maximum amount for either Network or Non-Network services.)</i> | \$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 <i>(Amalgam or Composite)</i> | 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 <i>(includes surgical extractions)</i> | 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.

UnitedHealthcare Dental® In-Network Only PPO (INO) is either underwritten or provided by: UnitedHealthcare Insurance Company, Hartford, Connecticut; UnitedHealthcare 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

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; 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. 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 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
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 orthognathic 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 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.

Options PPO/covered dental services

| | 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 PLAN 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 over-dentures 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.

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; or United HealthCare Services, Inc.

100-3301 12/04 ©2004 United HealthCare Services, Inc

UnitedHealthcare/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.

OCCUSAL 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. (D7413-D7415, 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 orthognathic 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 procedure.

UnitedHealthcare Vision

UnitedHealthcare 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.

Annual Rate
Single or Family
\$184.80

Covered in Full (after applicable copays)

In-Network Benefits:

Comprehensive Exam

Lenses

- Standard Single Vision
- Standard Lined Bifocal
- Standard Lined Trifocal
- Standard Lenticular Lenses

Contact Lenses (in lieu of eyeglasses)

- Elective
- Necessary¹

Frame

Lens Options

- Standard Scratch Resistant Coating, Polycarbonates, Basic and High End Progressives, Tints/UV and Transition Lenses, Standard Anti-Reflective Coating

Out-of-Network Reimbursement (network copays do not apply)

Comprehensive Exam

Up to \$25

Lenses

- Single Vision Up to \$25
- Bifocal Up to \$30
- Trifocal Up to \$70
- Lenticular Up to \$70
- Frames Up to \$15

Contact Lenses (in lieu of eyeglasses)

- Elective Up to \$70
- Necessary¹ Up to \$100

You do not need to submit a claim for In-Network benefits. However, you must submit a claim to UnitedHealthcare Vision for Out-of-Network benefit reimbursement.

In-Network Copays

| | |
|--------------------|--------|
| Comprehensive Exam | \$0.00 |
| Materials | \$0.00 |

Benefit Frequency

| | |
|--------------------------------------------|-----------|
| Comprehensive Exam | 12 months |
| Spectacle Lenses | 12 months |
| Frames | 12 months |
| Contact Lenses (in lieu of eye glasses) | 12 months |

Frame Benefit

\$130 retail frame allowance at private practice and retail chain providers.

Network Contact Lens Benefit

Covered-in-full contact lenses in lieu of eyeglasses. The covered-in-full contact lens benefit at network providers includes fitting/evaluation, contacts, and two follow-up visits (after \$0 copay). For those who choose disposable lenses, up to 6 boxes are included when obtained from a network provider.

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

UnitedHealthcare 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.²

1. 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 contacts necessary, you should ask your provider to contact UnitedHealthcare Vision and confirm reimbursement before you purchase such contacts.

2. Once your vision benefits have been exhausted. Note that this discount shall not be considered insurance, and UnitedHealthcare Vision shall neither pay nor reimburse the provider or member for any funds owed or spent. Not all providers 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 purchase. Additional materials can be purchased at a discount any time after the insured benefit has been used.

Important to Remember:

Benefits available every 12 or 24 months (depending on the benefit frequency), based on last date of service.

Your \$150 contact lens allowance is applied to fitting/evaluation fees as well as the purchase of contact lenses. For example, if the fitting/evaluation fee is \$30, you will have \$120 towards the purchase of contact lenses. The allowance may be separated at some retail locations between the examining physician and the optical store. If you choose disposable contacts, you may receive up to 6 boxes of disposable contacts (depending on prescription). Toric, gas permeable, and bifocal are examples of contacts outside of covered-in-full selection.

Out of Network Reimbursement: 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: UnitedHealthcare Vision Attn. Claim Dept. P.O. Box 30978 Salt Lake City, UT 84130

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

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.

UnitedHealthcare Vision coverage provided by or through UnitedHealthcare 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 and associated COC form number VCOC.INT.06.TX.

WTU Retiree Benefit Open Enrollment Payment 2012

Complete the information below and enclose this form with payment and mail to:

WTU Retiree Chapter
1825 K St. NW, Suite 1050
Washington, DC 20006

Please check your selections here and total.

Annual fees for 2012 are:

- Membership \$55.00
- Dental In-Network Only PPO Single \$360.00
- Dental In-Network Only PPO Family \$720.00
- Dental PPO Single \$360.00
- Dental PPO Family \$720.00
- Vision Single/Family \$184.80

Total Amount of Payment \$ _____

Last Name: _____

First Name: _____

Last 4 digits of Social Security #: _____

PAYMENT (please check one):

- Check
- Money Order

Please make checks payable to WTU Retiree Chapter.

REMINDER: Your enrollment will not be processed until payment is received. All payments must be received by November 30, 2011.

