



Washington Teachers' Union - ACTIVE TEACHER
Dental & Vision Benefits
SY 2016-2017



Open Enrollment Period
July 15, 2016 - September 16, 2016

Elizabeth A. Davis, President





Washington Teachers' Union



Dear WTU member:

Welcome to school year 2016-2017! I am extremely proud to serve as the President of the Washington Teachers' Union (WTU) which is now one of the largest local unions in the District of Columbia and the official bargaining agent of all ET-15 and EG-09 educators in the District of Columbia Public School (DCPS) system.

The Washington Teachers' Union is committed to providing our members with the highest quality of personal and professional care. We aim to provide a strong and comprehensive health and wellness partnership to promote a rigorous, effective and positive learning community for all professional educators and students. As a part of this commitment, we provide a wide variety of benefits, services and offerings for you and your loved ones.

We are pleased to offer the following 100% employer paid benefit services to our membership:

- ✓ Dental and Vision Single and Family coverage and discount programs with United Healthcare.
- ✓ Pre-paid Legal Services with Robert Ades & Associates Law Firm.
- ✓ Sick/Maternity/Paternity Leave Bank Programs with DCPS Benefits.

Membership in the WTU comes with powerful privileges! For only an additional \$5.41 a pay period, full members have access to the following services:

- ✓ Official voting rights for local school elections and committees
- ✓ Ability to co-create and vote on the upcoming WTU/DCPS contract
- ✓ Low cost fees for professional development classes and graduate credit
- ✓ Discounts with AT&T and ZipCar
- ✓ Access to numerous support and discount programs from the American Federation of Teachers (AFT), our parent organization, including \$150,000 in accidental death & life insurance and \$2 million dollar professional liability insurance coverage - all yours for no additional charge as a full-dues member.

We will begin our open enrollment period much earlier this year for existing members. Please don't forget to enroll and update your benefits record on July 15 -September 16, 2016. If you wish to have family coverage, your spouse and dependent information must be added to the WTU benefits system as well as the Peoplesoft system. Dependents must be added to both systems to prevent termination of family coverage. To become a full member or ask questions, please do not hesitate to contact us at: info@wtulocal6.net or 202.517.1477. Thank you for your continued support!

In Unity,

Elizabeth A. Davis, President

DENTAL & VISION OPEN ENROLLMENT REQUIREMENT: Action Required

Open enrollment will take place from July 15, 2016 through September 16, 2016.

You must enroll online by September 16th in order for your dental and vision benefits to take effect on October 1, 2016. You must log into your account to update and review your current dental and vision plan coverage, as well as Sick and Maternity/Paternity Leave Bank enrollment status.

Your PeopleSoft tier designation must match your WTU enrollment. All covered DCPS staff will continue to receive two Dental Plan options based on your needs, along with a comprehensive Vision Plan.

Electronic Enrollment

For your convenience, the enrollment for dental and vision benefits and the leave banks are processed electronically. Please refer to page 16 of this guide to learn how to enroll online during the enrollment period of July 15, 2016 – September 16, 2016. As always, the WTU Membership Services Unit is here to help. If you need technical assistance please email us at info@wtulocal6.net or call us at (202) 517-1477.

Vision Plan

Your vision benefits include:

- In-Network and Out-of-Network plan options
- No copays for exam, materials and contact lens fitting (In-Network)
- No claim forms needed for In-Network services
- Full coverage options for In-Network providers

For more information about the vision benefits, see page 13.

Dental Plan Options

Members will have the choice of an In-Network Only Dental Plan or the PPO Dental Plan. When you enroll in the In-Network Only Dental Plan (In-Network providers only) you will enjoy benefits such as:

- Access to a national preferred provider organization network
- Adult and child orthodontist coverage
- A \$3,500 annual maximum

With the PPO Dental Plan, you will have the option to visit the dentist of your choice, both in and out of the network, from among 2,000 dentists in the National Capital region.

For more information about the In-Network Only Plan and the PPO Dental Plan, see page 8.

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Important Dates

Open enrollment period:

July 15, 2016 thru September 16, 2016

Enrollment deadline:

September 16, 2016 ~ Coverage is effective: October 1, 2016

PLEASE NOTE: Changes to your benefits plan will NOT be made after September 16, 2016 unless you have life status change documentation submitted.



WHAT YOU NEED TO KNOW

Your benefit plans are designed to offer you and your family comprehensive coverage for your dental and vision needs. Your benefits will be **effective October 1, 2016**.

Dental Plan Costs

As part of the negotiated contract through the Washington Teachers' Union and the District of Columbia Public Schools, you have no payroll deduction cost for dental and vision insurance benefits coverage. The cost indicated on your paystub under "Employer Paid Benefits" simply demonstrates that your employer is paying 100% of the cost for your dental and vision premium. **Please note the dental and vision benefit coverage is separate from your self-selected and self-pay medical coverage managed in PeopleSoft.**

WTU Elections and Enrollment

WTU Electronic (online) enrollment is mandatory, if you are making changes or if you are a new hire. To continue coverage, you must follow the instructions listed on **page 16** to complete your online enrollment.

If you are currently enrolled you are still required to update your contact information and verify important information like your date of birth and social security number. This verification will prevent claim issues on your plan. Simply follow the same instructions listed on page 16 to complete verification.

If you don't complete electronic enrollment by September 16, 2016, your plan options will be selected for you by the Washington Teachers' Union. The selected plan option will be the In Network Only Dental plan. You won't be able to change plans or coverage until next year's open enrollment period unless you have a life status change, such as marriage, divorce, newborn, adoption or death.

Dependent Eligibility Requirements

If you're planning to cover a spouse or one or more children, you'll need to provide their Social Security number(s), date-of-birth, and submit proper documentation to WTU no later than September 16, 2016. If you don't supply this information, your dependent(s) will not have coverage. See page 7 to learn what documents you need to submit.

Confirmation Statements

In an effort to reduce mailing and be environmentally friendly, you'll receive your confirmation statement via e-mail. After you've provided your e-mail address during enrollment, you'll be sent a statement detailing your benefit elections. You'll also be able to view your benefits on the WTU website throughout the year, using your login name and password.



DEPENDENT COVERAGE

Important Reminder about your DCPS PeopleSoft Account

Make sure your DCPS PeopleSoft account (the program you use to enroll into your DCPS health insurance plan); shows **Self AND Family** coverage if you have dependents that you would like to add to your union dental and vision plan. **If those dependents are not listed in your PeopleSoft account, they will not receive dental and vision coverage for the year 2016-2017.**

If you would like your 2016-2017 plan to offer coverage for a spouse, child or other dependents, (and they are not already covered) you must provide documentation and enroll them during WTU online open enrollment beginning July 15 – September 16, 2016.

If your dependent(s) is currently covered, simply verify their date of birth and social security number, but you do not need to provide documentation.

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 the end of the month of their 26th birthdate.
- **Your disabled adult child**—Disabled children older than age 26 may be covered if the disability occurred prior to age 19.

Acceptable Types Of Dependent Documentation

Eligible Dependents	OPTION 1	OPTION 2 (Provide all documents noted)				
	Copy of 1040 Income Tax Return (page 1 only)	Marriage Certificate	Domestic Partner Certificate	Birth Certificate	Adoption or Legal Guardianship Papers	Social Security Disability Award Letter
Legal Spouse	X	X				
Domestic Partner	X		X			
Child—Biological	X			X		
Child—Stepchild	X			X		
Child—Adopted or Placed for Adoption	X				X	
Child—Legal Guardianship	X				X	
Child—Disable	X			X		X

FAX required documentation by September 16, 2016 to: (202) 379-3404 or scan to: info@wtulocal6.net

Please be sure to include your name and your relationship to the dependent. Feel free to email the Membership Office at: info@wtulocal6.net or call us at: (202) 517-1477 with any questions.

DENTAL PLAN SUMMARY

You have a choice between two dental plans, the comprehensive In-Network Only or a PPO Plan. There will be no payroll deductions for either plan, no matter whether you opt for single or family coverage.

Please be sure WTU membership matches DCPS PeopleSoft.

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 2,000 regional providers and more than 180,000 national providers. You must receive services from providers who accept this In-Network plan, to receive coverage for procedures.

There are no out of network benefits with this plan. This plan has a larger annual max and has no deductibles. You will pay less out of your pocket with this plan design.

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, and a deductible and less coverage. This plan will pay Out of Network benefits that are deemed Reasonable and Customary (R&C). Any amounts over the R&C will be your responsibility.

Plan Comparison

	In Network Only Plan	PPO Plan
Coverage for in-network providers	YES	YES
Coverage for out-of-network providers	NO	YES
Access to National PPO Providers	YES	YES
Deductible	\$0	\$50 single/\$150 family
Annual maximum	\$3,500	\$1,000
Orthodontia coverage	Yes, covered at 50% coinsurance, with a \$2,000 maximum, for both children and adults	Yes, covered at 50% coinsurance, with a \$1,000 maximum, for children only
Referrals needed for specialty services	NO	NO
Additional benefits:	<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 co-pay options (you'll know the out-of-pocket costs up front) 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.myuhc.com to estimate out-of-pocket costs for treatment.

To find a provider call:
1-800-445-9090

DENTAL IN-NETWORK PLAN DETAILS

	NON-ORTHODONTICS		ORTHODONTICS	
	NETWORK	NON-NETWORK	NETWORK	NON-NETWORK
Individual Annual Deductible	None		None	
Family Annual Deductible	None		None	
Annual Maximum Benefit <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.

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

DENTAL IN-NETWORK PLAN DETAILS

GENERAL LIMITATIONS

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

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

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

EXTRAORAL RADIOGRAPHS Limited to 2 films per calendar year.

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

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

RESTORATIONS Multiple restorations on one surface will be treated as a single filling. **PIN RETENTION** Limited to 2 pins per tooth; not covered in addition to cast restoration.

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

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

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

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

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

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

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

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

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

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

GENERAL ANESTHESIA Covered only where clinically necessary.

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

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

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

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

GENERAL EXCLUSIONS

The following are not covered:

1. Dental Services that are not necessary.
2. Hospitalization or other facility charges.
3. Any dental procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
4. Reconstructive Surgery regardless of whether or not the surgery which is incidental to a dental disease, injury, or Congenital Anomaly when the primary purpose is to improve physiological functioning of the involved part of the body.
5. Any dental procedure not directly associated with dental disease.
6. Any procedure not performed in a dental setting.
7. Procedures that are considered to be Experimental, Investigational or Unproven. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.
8. Services for injuries or conditions covered by Worker's Compensation or employer liability laws, and services that are provided without cost to the covered person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.
9. Expenses for dental procedures begun prior to the covered person becoming enrolled under the Policy.
10. Dental services otherwise covered under the Policy, but rendered after the date individual coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual coverage under the Policy terminates.
11. Services rendered by a provider with the same legal residence as a covered person or who is a member of a covered person's family, including spouse, brother, sister, parent or child.
12. Foreign Services are not covered unless required as an Emergency.
13. Replacement of crowns, bridges, and fixed or removable prosthetic appliances inserted prior to plan coverage unless the patient has been eligible under the plan for 12 continuous months. If loss of a tooth requires the addition of a clasp, pontic, and/or abutment(s) within this 12 month period, the plan is responsible only for the procedures associated with the addition.
14. Replacement of missing natural teeth lost prior to the onset of plan coverage until the patient has been covered under the Policy for 12 continuous months.
15. Replacement of complete dentures, fixed and removable partial dentures, or crowns, if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dentist. If replacement is necessary because of patient non-compliance, the patient is liable for the cost of replacement.
16. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
17. Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial over dentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.
18. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
19. Placement of dental implants, implant-supported abutments and prostheses
20. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
21. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.
22. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
23. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). No coverage is provided for 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 malocclusion, or replacement of lost or broken retainers and/or habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the plan.

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

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

DENTAL PPO PLAN DETAILS

	NON-ORTHODONTICS		ORTHODONTICS	
	NETWORK	NON-NETWORK	NETWORK	NON-NETWORK
Individual Annual Deductible	\$50	\$50	\$0	\$0
Family Annual Deductible	\$150	\$150	\$0	\$0
Maximum (the sum of all Network and Non-Network benefits will not exceed annual maximum)	\$1000 per person per Calendar	\$1000 per person per Calendar	\$1000 per person per Lifetime	\$1000 per person per Lifetime
New enrollee's waiting period:				
Annual deductible applies to preventive and diagnostic services			No	
Annual deductible applies to orthodontic services			No	
Orthodontic eligibility requirement			Child (up to age 19)	
COVERED SERVICES	NETWORK LAN PAYS*	NON-NETWORK PLAN PAYS**	BENEFIT GUIDELINES	
PREVENTIVE & DIAGNOSTIC				
Oral Evaluations (Diagnostic)	100%	80%	Covered as a separate benefit only if no other service was done during the visit other than X-rays. Limited to 2 times per consecutive 12 months.	
X Rays (Diagnostic)	100%	80%	Bite-wing: Limited to 1 series of film per calendar year. Complete/Panorex: Limited to one time per consecutive 36 months.	
Lab and Other Diagnostic Tests	100%	80%		
Prophylaxis (Preventive)	100%	80%	Limited to 2 times per consecutive 12 months.	
Fluoride Treatment (Preventive)	100%	80%	Limited to Covered Persons under the age of 16 years, and limited to 2 times per consecutive 12 months. Treatment should be done in conjunction with dental prophylaxis.	
Sealants	100%	80%	Limited to Covered Persons under the age of 16 years and once per first or second permanent molar every consecutive 36 months.	
BASIC SERVICES				
Restorations (Amalgams and Resin Based Only)	80%	60%	Multiple restorations on one surface will be treated as a single filling. Composite: for anterior teeth only.	
General Services (incl. Emergency Treatment)	80%	60%	Covered as a separate benefit only if no other service was done during the visit other than X-rays. General Anesthesia: when clinically necessary.	
Space Maintainers	80%	60%	Limited to Covered Persons under the age of 16 years, once per lifetime. Benefit includes all adjustment within 6 months of installation.	
Simple Extractions	80%	60%		
Oral Surgery (includes surgical extractions)	50%	40%		
Periodontics	50%	40%	Perio Surgery: Limited to once every consecutive 36 months per surgical area. Root Planning: Limited to one time per quadrant per consecutive 24 months. Perio Maintenance: Limited to 2 times per consecutive 12 months period following active and adjunctive periodontal therapy, within the prior 24 months, exclusive of gross debridement.	
Endodontics	50%	40%		
MAJOR SERVICES				
Inlays/Onlays/Crowns	50%	40%	Limited to one time per tooth per consecutive 60 months. Covered only when silver fillings cannot restore the tooth.	
Dentures and other Removable Prosthetics	50%	40%	Once every 60 months. No additional allowances for overdentures or customized dentures.	
Fixed Prosthetics	50%	40%	Limited to one time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.(alternate benefits for a partial denture may be applied)	
ORTHODONTIC SERVICES				
Orthodontia	50%	50%	Preauthorization required	

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

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

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

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

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

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

DENTAL PPO PLAN DETAILS

United Healthcare/ Dental Exclusions and Limitation

General Limitations

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

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

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

EXTRAORAL RADIOGRAPHS Limited to 2 films per calendar year.

DENTAL PROPHYLAXIS Limited to 2 times per consecutive 12 months.

DIAGNOSTIC CASTS Limited to one time per consecutive 24 months.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PALLIATIVE TREATMENT Covered as a separate benefit only

if no other service, other than exam and radiographs, were done during the visit.

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

General Exclusions

The following are not covered:

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



To find a provider call:
1-800-445-9090

VISION PLAN SUMMARY

Your vision coverage for 2016 - 2017 will be provided by United Healthcare Vision. Your coverage will include eye exams, frames and lenses or contact lenses. You may choose to see In-Network or Out-of Network providers. **However, coverage will be highest—and your out-of-pocket costs will be lowest— when you use an In-Network provider.** 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 eyeglasses)	(Fully covered contacts or \$150 allowance, not all brands apply)	
Elective	Up to 6 boxes or \$150 allowance	Up to \$70
Medically Necessary	Up to 6 boxes	Up to \$100
Benefit Frequency	12 months	12 months
Submitting a Claim	You do not need to submit a claim for this plan. Your doctor should submit one for you on your behalf to United Healthcare	You must submit a claim to United Healthcare for benefit reimbursement: P.O. 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 are: Standard Scratch Resistant Coating, Polycarbonates, Basic and High End Progressives, Tints/UV and Transition, Lenses, Standard Anti-Reflective Coating.

Contact Lens Benefit

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

Laser Vision Benefit

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

Additional Materials Discount Program

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

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 United Healthcare Vision and confirm reimbursement before you purchase such contacts.

VISION PLAN DETAILS

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

In-network, covered-in-full benefits (after applicable copay) include a comprehensive exam, eye glasses with standard single vision, lined bifocal, or lined trifocal lenses, standard scratch-resistant coating¹ and the frame, or contact lenses in lieu of eye glasses.

Copays for in-network services	
Exam	\$0.00
Materials	\$0.00
Benefit frequency	
Comprehensive Exam	Once every 12 months
Spectacle Lenses	Once every 12 months
Frames	Once every 12 months
Contact Lenses in Lieu of Eye Glasses	Once every 12 months
Frame benefit	
Private Practice Provider	\$130.00 retail frame allowance
Retail Chain Provider	\$130.00 retail frame allowance
Lens options	
Standard scratch-resistant coating, Standard, Deluxe progressive lenses, Standard anti-reflective coating, Photochromic lenses, Polycarbonate lenses, Ultraviolet coating, Tints -- covered in full. Other optional lens upgrades may be offered at a discount. (Discount varies by provider.)	
Contact lens benefit	
<p>Covered-in-full elective contact lenses⁴ The fitting/evaluation fees, contact lenses, and up to two follow-up visits are covered in full (after copay). If you choose disposable contacts, up to 6 boxes are included when obtained from a network provider.</p> <p>All other elective contact lenses A \$150.00 allowance is applied toward the fitting/evaluation fees and purchase of contact lenses outside the covered selection (materials copay does not apply). Toric, gas permeable and bifocal contact lenses are examples of contact lenses that are outside of our covered contacts.</p> <p>Necessary contact lenses³ Covered in full after applicable copay.</p>	
Out-of-network reimbursements up to (Copays do not apply)	
Exam	\$25.00
Frames	\$15.00
Single Vision Lenses	\$25.00
Bifocal Lenses	\$30.00
Trifocal Lenses	\$70.00
Lenticular Lenses	\$70.00
Elective Contacts in Lieu of Eye Glasses ²	\$70.00
Necessary Contacts in Lieu of Eye Glasses ³	\$100.00
Laser vision benefit	
United Healthcare Vision has partnered with the Laser Vision Network of America (LVNA) to provide our members with access to discounted laser vision correction providers. Members receive 15% off usual and customary pricing, 5% off promotional pricing at over 500 network provider locations and even greater discounts through set pricing at Lasik Plus locations. For more information, call 1-888-563-4497 or visit us at www.uhclasik.com .	

VISION PLAN DETAILS

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

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

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

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

Important to Remember:

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

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

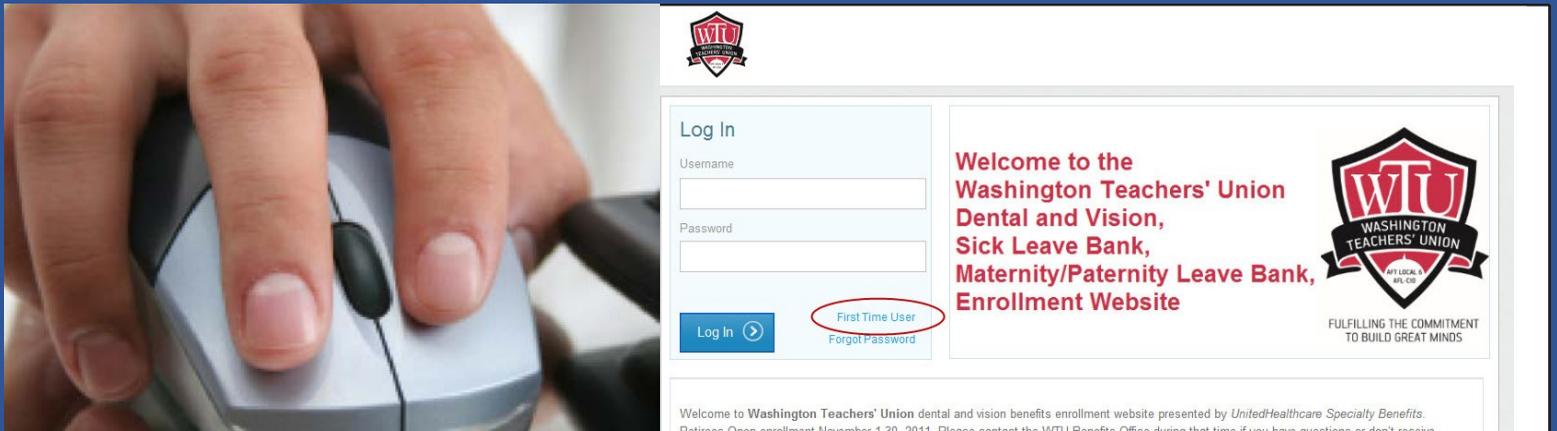
The following services and materials are excluded from coverage under the Policy: Post cataract lenses; Non-prescription items; Medical or surgical treatment for eye disease that requires the services of a physician; Worker's Compensation services or materials; Services or materials that the patient,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

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



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

HOW TO ENROLL



Follow these 6 steps to enroll in your 2016 - 2017 Vision and Dental benefits:

**You may also enroll in the Sick Leave Bank and Maternity/Paternity Leave Bank online*

1. Log on to www.wtulocal6.org.
2. Click on “**Benefits Enrollment**” in the upper navigation at the top of the page to be directed to the enrollment page.
3. If you are a **new hire**, click on “First Time User” and **Enter the Company code: WTU-82405**.
4. All other enrollees must simply enter their username and password.
5. Fill out the required fields (noted in bold) to complete your profile. Then, click “Save” at the bottom of the page.
6. Click on “**Enroll Now**” and follow the prompts to enrollment. Remember to save often!

Username: The first letter of your first name followed by your last name plus the MMDD of your birthday. For example, Joan Smith who was born on September 15, 1970 would have a username Of “jsmith0915.”

Password: The last four digits of your social security number.

For login help, call 202-517-1477 or email info@wtulocal6.net.

IMPORTANT REMINDERS

- Open enrollment begins July 15, 2016 and ends September 16, 2016. **Your benefit choice is in effect on October 1, 2016.**
- **Your PeopleSoft account must show Self and Family coverage in order to have dependents on your Union Dental and Vision plans or your dependents will not be covered.**
- ID Cards—You’ll receive a dental ID card in the mail if you are newly enrolled or changing your Dental Plan for October 1, 2016. You will not receive a Vision ID card, but you can print one at www.myuhcvision.com after October 1st. However, **vision ID cards are not needed** to use your vision benefit (just tell your provider you’re a Member of the United Healthcare Vision Plan). Dental ID cards can be printed online after October 1st.
- Coverage Changes—You can only make coverage changes after open enrollment if you experience a life event for family status changes, such as a divorce or the birth of a baby. **Any changes in benefit elections must be made within 30 days of this life change.**

BENEFITS ENROLLMENT CHECKLIST

Step 1: Review

- Review this guide, and be sure to read the contents carefully. Decide which benefits will be best for you and your family. Remember, your new benefit choices will take effect **October 1, 2016**.

Step 2: Enroll

- Log on to www.wtulocal6.org and complete your enrollment between July 15, 2016 and 5:00 p.m. on September 16, 2016. Be sure to have all individual and family Social Security numbers and Date of Births ready before beginning the process.

Step 3: Submit and Confirm

- Review your selections and click save to successfully enroll. Provide an email address to receive a confirmation stating that your choices have been submitted.

Step 4: Send in Documentation

- Email all required documentation for your spouse or dependent(s) by **September 16, 2016**, to: info@wtulocal6.net or fax to: **202-379-3404**.

For a list of documents needed, refer to page 7.

Don't Forget:

*You must enroll online and submit dependent documents by **September 16, 2016**. **If you do not do so, your plans will be selected for you, your dependents may no longer be covered, and you will not be able to make changes until the next enrollment period.**

***After September 16, 2016**, changes to vision and dental benefits cannot be made until the following enrollment period, unless there's a qualifying life event or family life change within 30 days of the change.

BENEFITS GLOSSARY

Annual Maximum:

The highest amount of money your insurance plan will pay out to you in one year.

Coinsurance:

The percentage that your insurance company will pay after you've 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 that have an agreement with your insurance company to offer a reduced rate for quality care. Your coverage is often 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 an Out-of-Network Provider.

PPO (Preferred Provider Organization):

A health care organization that has an agreement with your insurance company to offer a reduced rate for quality care.

FREQUENTLY ASKED QUESTIONS

1. How do I enroll?

- Please refer to page 16

2. 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 web site 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

3. 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 referrals for specialty care
- No claim forms for In-Network services

The INO also has the following features:

- No waiting periods
- \$3,500 annual benefit 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, \$2,000 maximum
- Non-Network Emergency Palliative Care covered at In Network rates

4. 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 means you will know out of pocket costs up front
- Orthodontics covered at 50% coinsurance, \$2,000 maximum
- No need to select a primary care dentist
- No referrals for specialty care
- No deductibles
- No waiting periods
- \$3,500 annual maximum
- No claim forms for Network services
- www.myuhc.com has a provider look up for members or you can call Customer Service to find a provider near you - look for PPO20 networks providers on the web site

5. Are there waiting periods for Major services?

There is no waiting periods for Major services.

6. How do I find a provider?

To find a dentist or an eye doctor, simply do a search for one near you, give them a call and ask if they accept United Healthcare and if they accept your specific plan. You can also log on to www.myuhc.com or www.myuhcvision.com and do a search. Lastly, you can call UHC Dental at 800-445-9090 or UHC Vision at 800-839-3242.



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