UnitedHealthcare®

SEANC SEIU LOCAL 2008

Dental Plan Enrollment Form

Effective Date: _____

1. Check the appropriate box for coverage desired:

	Basic Plan	Core Plan	Premium Plan
Member Only	☐ $22.53	☐ $28.33	☐ $53.59
Member + 1 Child	☐ $43.61	☐ $54.84	☐ $106.82
Member + Spouse	☐ $45.44	☐ $57.13	☐ $107.50
Member + Child(ren)	☐ $55.56	☐ $69.84	☐ $139.41
Member + 1 Family	☐ $77.79	☐ $97.79	☐ $198.22

Applications received in the SEANC home office by the 10th of the month will be effective the first of the following month.

These rates are effective until 12/31/2020.

For more information on becoming a member, call 800-222-2758. visit www.seanc.org. or www.welcometouhc.com/SEANC. After enrolling, visit www.myuhc.com for provider search, benefits and claims information.

You must be a member of SEANC to enroll.

Send forms to SEANC office:

Fax: 1-919-792-3321

Mail: ATTN: Insurance Department
1621 Midtown Place
Raleigh, NC 27609

2. Employee Information (please print clearly):

Social Security Number: - -			SEANC#
Your Name:	First Name	Middle Initial	Last Name
Birth Date: / /	Gender: ☐ M ☐ F	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partnership	
Address:			
Home Phone: ( ) -		Work Phone: ( ) -	
Cell Phone: ( ) -		Personal email address:	

3. List all eligible family members below (if electing dependent coverage): Note: Adult dependent children up to age 26

	First Name	Last Name	Birth Date	Gender
Spouse			/ /	☐ M ☐ F
Child			/ /	☐ M ☐ F
Child			/ /	☐ M ☐ F
Child			/ /	☐ M ☐ F
Child			/ /	☐ M ☐ F

I agree to continue enrollment in the dental plan for a period of 12 months

☐ I authorize payroll/pension deduction for this insurance ☐ I authorize bank draft

☐ I prefer to have my premiums invoiced

I, the undersigned, hereby authorize my employer to deduct premiums for the SEANC Insurance identified above from my wages/pension or bank draft on a monthly basis, in such amounts as are currently established pursuant to the SEANC insurance contract with the provider, or in such adjusted amounts as may be established by SEANC and the provider by contract subsequent to the date of this authorization. This authorization shall continue until cancelled by me by written notice to the SEANC Central Office.

Your Signature Date

State Employees Association of North Carolina

NEW! The Prenatal Dental Care (not available in WA) and Oral Cancer Screening programs are covered under all plans.

	Premium Plan	Core Plan	Basic Plan
Annual Maximum Benefit*	**$5,000**	**In - $1,500 Out - $1,250**	**$1,250**
Orthodontia Lifetime Policy Maximum	**$5,000**	**Not Covered**	**Not Covered**
Deductible (Individual)	**$50**	**$25**	**$25**
Deductible (Family)	**$150**	**$75**	**$75**
Preventive and Diagnostic Services	**High Option Plan**	**Network Incentive Option**	**Standard Option Plan**
Preventive & Diagnostic Co-Insurance	**100%**	**In - 100% Out – 80%**	**100%**
Oral evaluation Exams (Routine Exam)	2 times per consecutive 12 months	2 times per consecutive 12 months	2 times per consecutive 12 months
Dental Prophylaxis (Teeth Cleaning)	2 times per consecutive 12 months	2 times per consecutive 12 months	2 times per consecutive 12 months
Fluoride Treatments	2 times per consecutive 12 months to age 16	2 times per consecutive 12 months to age 16	2 times per consecutive 12 months to age 16
Intraoral Radiographs (Full Mouth X-rays)	1 time per 36 months (complete series and Panorex)	1 time per 36 months (complete series and Panorex)	1 time per 36 months (complete series and Panorex)
Bitewing and Extraoral X-rays Adults and child(ren)	Bitewing: 1 series per calendar year Extraoral: 2 films per calendar year	Bitewing: 1 series per calendar year Extraoral: 2 films per calendar year	Bitewing: 1 series per calendar year Extraoral: 2 films per calendar year
Basic Services	**High Option Plan**	**Network Incentive Option**	**Standard Option Plan**
Basic Co-Insurance	**80%**	**In – 80% Out - 60%**	**70%**
Sealants	Once per first or second permanent molar every 36 months for dependent children to age 16.	Once per first or second permanent molar every 36 months for dependent children to age 16.	Once per first or second permanent molar every 36 months for dependent children to age 16.
Space maintainers	1 per consecutive 60 months for dependent children to age 16.	1 per consecutive 60 months for dependent children to age 16.	1 per consecutive 60 months for dependent children to age 16.
Simple Extractions	Covered	Covered	Covered
Restorations (Routine Fillings)	Covered	Covered	Covered
Therapeutic Pulputomy	Covered	Covered	Covered
Periodontal maintenance	2 times per consecutive 12 months following active or adjunctive periodontal therapy	2 times per consecutive 12 months following active or adjunctive periodontal therapy	2 times per consecutive 12 months following active or adjunctive periodontal therapy
Palliative Treatment	Covered	Covered	Covered
Major Services	**High Option Plan**	**Network Incentive Option**	**Standard Option Plan**
Major Co-Insurance	**50%**	**In – 50% Out – 20%**	**0% Not Covered**
Endodontics	Covered	Covered	Not Covered
Denture Repairs	12 months after initial insertion, 1 time per 6 months	12 months after initial insertion, 1 time per 6 months	Not Covered
Adjustment to Dentures	12 months after initial insertion, 1 time per 6 months	12 months after initial insertion, 1 time per 6 months	Not Covered
Oral Surgery	Covered	Covered	Not Covered
Periodontal Scaling and Root Planing	One time per quadrant per consecutive 24 months	One time per quadrant per consecutive 24 months	Not Covered
Root Canal Therapy	1 time per tooth per lifetime	1 time per tooth per lifetime	Not Covered
Periodontal Surgery	Once per quadrant or site every consecutive 36 months	Once per quadrant or site every consecutive 36 months	Not Covered
Oral Surgery – Other/Surgical	Covered	Covered	Not Covered
Anesthesia	Covered as a basic service	Covered as a basic service	Not Covered
Bridges/Dentures	Full Denture/Partial Denture: 1 per consecutive 60 months. Relining and Rebasing Dentures: 6 months after initial installation and 1 time per consecutive 12 months.	Full Denture/Partial Denture: 1 per consecutive 60 months. Relining and Rebasing Dentures: 6 months after initial installation and 1 time per consecutive 12 months.	Not Covered
Crowns/Inlays/Onlays	1 time per tooth per consecutive 60 months Crown replacement: 1 time per consecutive 60 months from initial or supplemental placement.	1 time per tooth per consecutive 60 months Crown replacement: 1 time per consecutive 60 months from initial or supplemental placement.	Not Covered
Implants Procedures	1 time per tooth per consecutive 60 months	1 time per tooth per consecutive 60 months	Not Covered
Relines and Rebases Dentures	Relining and Rebasing Dentures: 6 months after initial installation and 1 time per consecutive 12 months.	Relining and Rebasing Dentures: 6 months after initial installation and 1 time per consecutive 12 months.	Not Covered
Occlusal Guards	Covered if prescribed to control habitual grinding	Covered if prescribed to control habitual grinding	Not Covered
Orthodontia	**High Option Plan**	**Network Incentive Option**	**Standard Option Plan**
Orthodontia Co-Insurance	**50% (for dependent children only - up to age 25)**	**0% Not Covered**	**0% Not Covered**

*The Annual Maximum Benefit is the maximum amount the plan will pay each calendar year. It is a combined annual maximum for network and out-of- network benefit services.

Please refer to the UnitedHealthcare Dental Plan Certificate of Coverage for a detail description of the plan benefits. Note: The Core Plan is not available to residents in AL, LA, MS or TX.