July 8, 2016

Dear Individual Provider,

SEIU 775 Benefits Group is pleased to continue to provide Home Care Workers with high quality, affordable health care benefits. We hope this document helps explain your plan benefits and changes for the 2016-2017 plan year.

A Quick Look at Changes

Office visit copay is waived for outpatient mental health and chemical dependency visits (in-network only).

The $25 monthly payroll deduction will not change.

For newly eligible Individual Providers (IPs), the waiting period will reduce from 3 months to 2 months. You will need to work 80 hours per month for two months in a row and allow one month for processing.

Changes are effective 8/1/2016.

How to schedule a mental health visit

New this year, mental health and chemical dependency visits have no copay. You can start either by talking with your Primary Care Provider or calling the numbers below for your health provider. Making this call can be the hardest step. But know that it is the first step on your road to a happier, healthy life.

Group Health members:

- First time appointments: Call 1-888-287-2680 or 206-901-6300
- Urgent or crisis care, call 1-888-287-2680

Kaiser Permanente members:

- Call 855-632-8280 to schedule therapy and counseling services.
- Emergency psychiatric services (24 hours), call 1-866-453-3932 (toll free)

Benefit Summary

SEIU Healthcare NW Health Benefits Trust- Plan B for IP's
Group Number: 6356800

GroupHealth

Effective Date 8/1/2016	**Health Plan** Options PPO	**Ref** RQ-105661

This is a brief summary of benefits. THIS IS NOT A CONTRACT OR CERTIFICATE OF COVERAGE. All benefit descriptions, including alternative care, are for medically necessary services. The Member will be charged the lesser of the cost share for the covered service or the actual charge for that service. For full coverage provisions, including limitations, please refer to your certificate of coverage.

In accordance with the Patient Protection and Affordable Care Act of 2010,

- The lifetime maximum on the dollar value of covered essential health benefits no longer applies. Members whose coverage ended by reason of reaching a lifetime limit under this plan are eligible to enroll in this plan, and
- Dependent children who are under the age of twenty-six (26) are eligible to enroll in this plan.

Benefits	**Preferred Provider Network (PPN)**	**Non-Preferred Provider Network**
Plan deductible	No annual deductible	Individual deductible: $500 per calendar year
Individual deductible carryover	Not applicable	4th quarter carryover applies
Plan coinsurance	No plan coinsurance	Plan pays 80%, you pay 20% of the Allowed Amount.
Out-of-pocket limit	Individual out-of-pocket limit: $1,200 Out-of-pocket expenses for the following covered services are included in the out-of-pocket limit: All cost shares for covered services	Shared with in-network
Pre-existing condition (PEC) **waiting period**	No PEC	Same as preferred provider network
Lifetime maximum	Unlimited	Same as preferred provider maximum
Outpatient services (Office visits)	$15 copay	$15 copay, deductible and coinsurance apply
Hospital services	**Inpatient services:** $100 copay, per day for up to 5 days per admit **Outpatient surgery:** $50 copay	**Inpatient services:** $100 copay, per day for up to 5 days per admit Deductible and coinsurance apply **Outpatient surgery:** $50 copay, deductible and coinsurance apply
Prescription drugs (some injectable drugs may be covered under Outpatient services)	Preferred generic (Tier 1)/preferred brand (Tier 2)/non-preferred (Tier 3) $4/$8/$25/$50 copay	Preferred generic/preferred brand/non-preferred $13/$30/$55 copay
Prescription mail order	2 x prescription cost share per 90 day supply	Not covered
Acupuncture	12 visits per calendar year $15 copay	Shared with preferred provider visit limit $15 copay, deductible and coinsurance apply
Ambulance services	Plan pays 80%, you pay 20%	Same as preferred provider benefit
Chemical dependency	**Inpatient:** $100 copay, per day for up to 5 days per admit **Outpatient:** $0 copay	**Inpatient:** $100 copay, per day for up to 5 days per admit Deductible and coinsurance apply **Outpatient:** $15 copay, deductible and coinsurance apply
Devices, equipment and supplies • Durable medical equipment • Orthopedic appliances • Post-mastectomy bras limited to two (2) every six (6) months • Ostomy supplies • Prosthetic devices	Covered at 50%	Covered at 50%, deductible applies

Diabetic supplies	Insulin, needles, syringes and lancets-see Prescription drugs. External insulin pumps, blood glucose monitors, testing reagents and supplies-see Devices, equipment and supplies. When Devices, equipment and supplies or Prescription drugs are covered and have benefit limits, diabetic supplies are not subject to these limits.	Insulin, needles, syringes and lancets-see Prescription drugs. External insulin pumps, blood glucose monitors, testing reagents and supplies-see Devices, equipment and supplies. When Devices, equipment and supplies or Prescription drugs are covered and have benefit limits, diabetic supplies are not subject to these limits.
Diagnostic lab and X-ray services	**Inpatient:** Covered under Hospital services **Outpatient:** Covered in full	**Inpatient:** Covered under Hospital services **Outpatient:** Deductible and coinsurance apply
Emergency services (copay waived if admitted)	$200 copay	$200 copay
Hearing exams (routine)	$15 copay	$15 copay, deductible and coinsurance apply
Hearing hardware	Not covered	Not covered
Home health services	Covered in full up to 130 visits total per calendar year	Shared with preferred provider visit limit Deductible and coinsurance apply
Hospice services	Covered in full	Deductible and coinsurance apply
Infertility services	Not covered	Not covered
Manipulative therapy	Covered up to 12 visits per calendar year without prior authorization $15 copay	Shared with preferred provider visit limit $15 copay, deductible and coinsurance apply
Massage services	12 visits per calendar year $15 copay	Shared with preferred provider visit limit $15 copay, deductible and coinsurance apply
Maternity services	**Inpatient:** $100 copay, per day for up to 5 days per admit **Outpatient:** $15 copay. Routine care not subject to outpatient services copay.	**Inpatient:** $100 copay, per day for up to 5 days per admit Deductible and coinsurance apply **Outpatient:** $15 copay, deductible and coinsurance apply. Routine care not subject to outpatient services copay.
Mental Health	**Inpatient:** $100 copay, per day for up to 5 days per admit **Outpatient:** $0 copay	**Inpatient:** $100 copay, per day for up to 5 days per admit Deductible and coinsurance apply **Outpatient:** $15 copay, deductible and coinsurance apply
Naturopathy	12 visits per calendar year $15 copay	Shared with preferred provider visit limit $15 copay, deductible and coinsurance apply
Newborn Services	Initial hospital stay: See Hospital Services; Office visits: See Outpatient Services; Routine well care: See Preventive care. Any applicable cost share for newborn services is separate from that of the mother.	Initial hospital stay: See Hospital Services; Office visits: See Outpatient Services; Routine well care: See Preventive care. Any applicable cost share for newborn services is separate from that of the mother.
Obesity-related surgery (bariatric)	Not covered	Not covered
Organ transplants	Unlimited, no waiting period **Inpatient:** $100 copay, per day for up to 5 days per admit **Outpatient:** $15 copay	Not covered
Preventive care Well-care physicals, immunizations, Pap smear exams, mammograms	Covered in full Women's preventive care services (including contraceptive drugs and devices and sterilization) are covered in full.	Not covered Women's preventive care services (including contraceptive drugs and devices and sterilization) are subject to the applicable Preventive Care cost share and benefit maximums. Routine mammograms: Deductible and coinsurance apply
Rehabilitation services Rehabilitation visits are a total of combined therapy visits per calendar year	**Inpatient:** 60 days per calendar year. Services with mental health diagnoses are covered with no limit. $100 copay, per day for up to 5 days per admit **Outpatient:**60 visits per calendar year. Services with mental health diagnoses are covered with no limit. $15 copay	**Inpatient:** Day limits shared with preferred provider benefit limit $100 copay, per day for up to 5 days per admit Deductible and coinsurance apply **Outpatient:** Visit limits shared with preferred provider benefit limit $15 copay, deductible and coinsurance apply
Skilled nursing facility	Covered in full up to 60 days per calendar year	Day limits shared with preferred provider benefit, deductible and coinsurance apply

Sterilization (vasectomy, tubal ligation)	**Inpatient:** $100 copay, per day for up to 5 days per admit **Outpatient:** $15 copay Women's sterilization procedures are covered in full.	**Inpatient:** $100 copay, per day for up to 5 days per admit Deductible and coinsurance apply **Outpatient:** $15 copay, deductible and coinsurance apply Women's sterilization procedures are covered subject to the applicable Preventive Care cost share and benefit maximums.
Temporomandibular Joint (TMJ) **services**	**Inpatient:** $100 copay, per day for up to 5 days per admit **Outpatient:** $15 copay	**Inpatient:** $100 copay, per day for up to 5 days per admit Deductible and coinsurance apply **Outpatient:** $15 copay, deductible and coinsurance apply
Tobacco cessation counseling	Quit for Life Program - covered in full	Applicable cost shares apply
Routine vision care (1 visit every 12 months)	$15 copay	$15 copay, deductible and coinsurance apply
Optical hardware Lenses, including contact lenses and frames	**Members under 19:** 1 pair of frames and lenses per year or contact lenses covered at 50% coinsurance **Members age 19 and over:** $200 per 24 months	Shared with preferred provider benefit

DELTA DENTAL Delta Dental of Washington

SEIU – Individual Providers
Group #00018

Delta Dental PPO℠ Plan
Benefit Summary

Effective Date	August 1, 2016
Benefit Period	January 1, 2017 – December 31, 2017
Benefit Period Maximum (Per Person)	$2,000

	Dental Network		
	Delta Dental PPO℠ Dentist	Delta Dental Premier® Dentist	Non-Participating Dentist
Benefit Period Deductible			
Does Not Apply to Class I **In Network – no deductible** **Out of Network - $50 per benefit period**	**$0/$0**	$50	$50
Class I – Diagnostic & Preventive			
Exams	**100%**	80%	80%
Cleaning			
Fluoride			
X-Rays			
Sealants			
Class II – Restorative			
Restorations	**100%**	60%	60%
Endodontics (Root Canal)			
Periodontics			
Oral Surgery			
Class III – Major			
Dentures	**80%**	40%	40%
Partial Dentures			
Implants			
Bridges			
Crowns			

Please Note: This is a brief summary of available benefits for comparison purposes only and does not constitute a contract. Once enrolled in a plan, you will have access to your benefits booklet which provides more details of your Delta Dental PPO plan. Please feel free to call our customer service department or visit our website at **DeltaDentalWA.com** if you have any questions.

You will likely experience the greatest out-of-pocket savings when you see a Delta Dental PPO dentist.

Here's some important information to help you use your benefits:

Finding a participating dentist

Under your plan, you can choose dentists from two networks: Delta Dental PPO℠ or Delta Dental Premier®. You can find a participating, in-network, dentist in your area by visiting DeltaDentalWA.com and using our Find a Dentist tool. We recommend you select the Delta Dental PPO network to filter your search results.

The advantages of seeing a Delta Dental PPO or Delta Dental Premier dentist

We encourage you to see a Delta Dental network dentist because they provide services at discounted rates and file all claims paperwork for you. We will pay our portion and you're only responsible for your stated deductibles, coinsurance and/or amounts in excess of the plan maximums. In most cases, you will experience the greatest out-of pocket savings if you choose a dentist from the Delta Dental PPO network.

Visiting your participating, in-network, dentist

Be sure to tell your dentist you're covered by Delta Dental of Washington and give them your member identification number, plan name and group number.

Visiting a non-participating, out-of-network, dentist

You are not limited to using a Delta Dental network dentist. You may use any licensed dentist. If you choose a non-participating dentist, you will be responsible to have the dentist complete your claim forms and to ensure that the claims are sent to us. Claim payments will be based on actual charges or our maximum allowable fees for non-participating dentists, whichever is less. You're then responsible for any balance remaining after we pay. Unlike our participating dentists, we have no control over non-participating dentists' charges or billing procedures.

Confirmation of Treatment and Cost (Formerly called Predeterminations)

If you are considering extensive treatments such as crowns, oral surgery, periodontics or prosthodontics, we recommend you ask your dentist to request a predetermination from us. We will process the request and provide you and your dentist with a Confirmation of Treatment and Cost (Confirmation). The Confirmation will show you what procedures will be covered, an estimate of what Delta Dental of Washington will pay and your expected financial responsibility. Confirmations are based on the treatment plan submitted by your dentist and the covered dental benefits available to you at the time the Confirmation is issued. Confirmations are estimates, not guarantees of payment.

Have a question?

Give us a call at 800.554.1907, Monday – Friday from 7 am to 5 pm, Pacific Time. We're happy to help.

Summary of Benefits

Group Number: WA172
Effective Date: 8/1/2016

Willamette Dental Group

SEIU Healthcare NW / Health Benefits Trust – IP Plan

BENEFITS	COPAYS
Annual Maximum	No Annual Maximum*
Deductible	No Deductible
General & Orthodontic Office Visit	You pay a $15 Copay per Visit
DIAGNOSTIC AND PREVENTIVE SERVICES	
Routine and Emergency Exams	Covered with the Office Visit Copay
X-rays	Covered with the Office Visit Copay
Teeth Cleaning	Covered with the Office Visit Copay
Fluoride Treatment	Covered with the Office Visit Copay
Sealants (per Tooth)	Covered with the Office Visit Copay
Head and Neck Cancer Screening	Covered with the Office Visit Copay
Oral Hygiene Instruction	Covered with the Office Visit Copay
Periodontal Charting	Covered with the Office Visit Copay
Periodontal Evaluation	Covered with the Office Visit Copay
RESTORATIVE DENTISTRY	
Fillings (Amalgam)	Covered with the Office Visit Copay
Porcelain-Metal Crown	You pay a $250 Copay
PROSTHODONTICS	
Complete Upper or Lower Denture	You pay a $400 Copay
Bridge (per Tooth)	You pay a $250 Copay
ENDODONTICS AND PERIODONTICS	
Root Canal Therapy – Anterior	You pay a $85 Copay
Root Canal Therapy – Bicuspid	You pay a $105 Copay
Root Canal Therapy – Molar	You pay a $130 Copay
Osseous Surgery (per Quadrant)	You pay a $150 Copay
Root Planning (per Quadrant)	You pay a $75 Copay
ORAL SURGERY	
Routine Extraction (Single Tooth)	Covered with the Office Visit Copay
Surgical Extraction	You pay a $100 Copay
ORTHODONTIA TREATMENT	
Pre-Orthodontia Treatment	Not Covered
Comprehensive Orthodontia Treatment	Not Covered
MISCELLANEOUS	
Local Anesthesia	Covered with the Office Visit Copay
Dental Lab Fees	Covered with the Office Visit Copay
Nitrous Oxide	You pay a $40 Copay
Specialty Office Visit	You pay a $30 Copay per Visit
Out of Area Emergency Care Reimbursement	You pay charges in excess of $250

*TMJ has a $1000 annual maximum/ $5000 lifetime maximum
**Copay credited towards the Comprehensive Orthodontia Treatment copay if patient accepts treatment plan.

Underwritten by Willamette Dental of Washington, Inc.
This plan provides extensive coverage of services to prevent, diagnose, and treat diseases or conditions of the teeth and supporting tissues. Presented are just some of the most common procedures covered in your plan. Please see the Certificate of Coverage for a complete plan description, limitations, and exclusions.

Form No. 015-WA(5/15)
Contract No. 001L-WA(5/15), 001S-WA(5/15)

Exclusions and Limitations

Willamette Dental Group

Exclusions

Bridges, crowns, dentures, or prosthetic devices requiring multiple treatment dates or fittings if the prosthetic item is installed or delivered more than 60 days after termination of coverage.

The completion or delivery of treatments or services initiated prior to the effective date of coverage

Dental implants, including attachment devices, maintenance, and dental implant-related services.

Endodontic services, prosthetic services, and implants that were provided prior to the effective date of coverage.

Endodontic therapy completed more than 60 days after termination of coverage.

Exams or consultations needed solely in connection with a service that is not covered.

Experimental or investigational services and related exams or consultations.

Full mouth reconstruction, including the extensive restoration of the mouth with crowns, bridges, or implants; and occlusal rehabilitation, including crowns, bridges, or implants used for the purpose of splinting, altering vertical dimension, restoring occlusions or correcting attrition, abrasion, or erosion.

Hospitalization care outside of a dental office for dental procedures, physician services, or facility fees.

Maxillofacial prosthetic services.

Nightguards.

Personalized restorations.

Plastic, reconstructive, or cosmetic surgery and other services or supplies, which are primarily intended to improve, alter, or enhance appearance.

Prescription and over-the-counter drugs and pre-medications.

Provider charges for a missed appointment or appointment cancelled without 24 hours prior notice.

Replacement of lost, missing, or stolen dental appliances; replacement of dental appliances that are damaged due to abuse, misuse, or neglect.

Replacement of sound restorations.

Services and related exams or consultations that are not within the prescribed treatment plan and/or are not recommended and approved by a Willamette Dental Group dentist.

Services and related exams or consultations to the extent they are not necessary for the diagnosis, care, or treatment of the condition involved.

Services by any person other than a licensed dentist, denturist, hygienist, or dental assistant.

Services for the treatment of injuries sustained while practicing for or competing in a professional athletic contest.

Services for the treatment of an injury or disease that is covered under workers' compensation or that are an employer's responsibility.

Services for the treatment of intentionally self-inflicted injuries.

Services for which coverage is available under any federal, state, or other governmental program, unless required by law.

Services not listed as covered in the contract.

Services where there is no evidence of pathology, dysfunction, or disease other than covered preventive services.

Limitations

If alternative services can be used to treat a condition, the service recommended by the Willamette Dental Group dentist is covered.

Services listed in the contract, which are provided to correct congenital or developmental malformations which impair functions of the teeth and supporting structures will be covered for dependent children if dental necessity has been established. Orthognathic surgery is covered as specified in the contract when the Willamette Dental Group dentist determines it is dentally necessary and authorizes the orthognathic surgery for treatment of an enrollee, under age 19, with congenital or developmental malformations.

Crowns, casts, or other indirect fabricated restorations are covered only if dentally necessary and if recommended by the Willamette Dental Group dentist.

When the initial root canal therapy was performed by a Willamette Dental Group dentist, the retreatment of the root canal therapy will be covered as part of the initial treatment for the first 24 months. When the initial root canal therapy was performed by a non-participating provider, the retreatment of such root canal therapy by a Willamette Dental Group dentist will be subject to the applicable copayments.

General anesthesia is covered with the copayments specified in the contract if it is performed in a dental office; provided in conjunction with a covered service; and dentally necessary because the enrollee is under the age of 7, developmentally disabled or physically handicapped.

The services provided by a dentist in a hospital setting are covered if medically necessary; pre-authorized in writing by a Willamette Dental Group dentist; the services provided are the same services that would be provided in a dental office; and applicable copayments are paid.

The replacement of an existing denture, crown, inlay, onlay, or other prosthetic appliance is covered if the appliance is more than 5 years old and replacement is dentally necessary.

Form No. 015-WA(5/15)
Contract No. 001L-WA(5/15), 001S-WA(5/15)

SEIU HEALTHCARE NW
HEALTH BENEFITS TRUST

DENTAL CHANGE FORM

DATE

_____
_____
_____
_____

Dental Change Form

If you would like to change your current dental carrier, please fill out and return the form below.
If you have any questions, please contact the Member Resource Center at 1-866-371-3200.

PERSONAL INFORMATION:	Please Print Clearly and in English		
Employee Name:	First Last		
Address:			
City:		State:	Zip:
( ) - Phone Number	/ / Date of Birth	- - Social Security Number	Gender ☐M ☐F
AGENCY / PAYEE NUMBER			

I want to change my dental insurance carrier to: (check one)

☐ Delta Dental -or- ☐ Willamette Dental

I understand that my dental change will take place the first of the month following the date my change form is received by the Trust Office and I will not be able to change my dental carrier again until12 months after my change has taken place.

Employee Signature _____ *Date* _____

Please return form to the Trust Administration Office at:
PO Box 6, Mukilteo, WA 98275

If you have any questions please call the Member Resource Center at 1-866-371-3200.

HBT-Dental Change-01