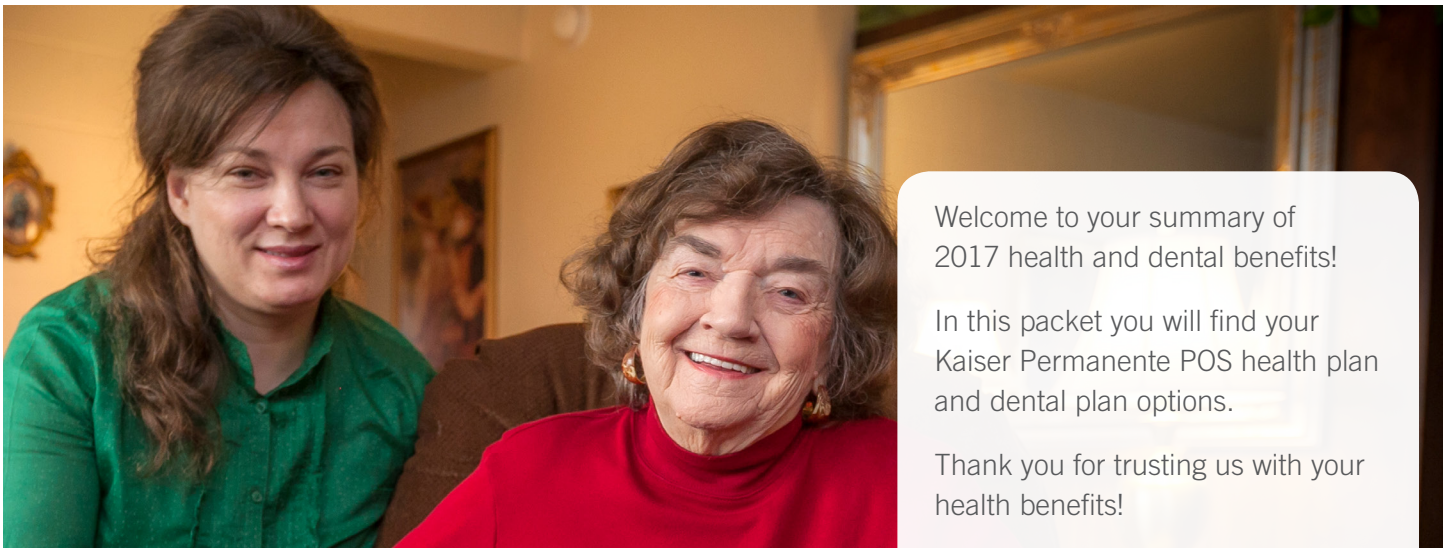
SEIU 775 BENEFITS GROUP

Your 2017-18 Health Plan Highlights



Welcome to your summary of 2017 health and dental benefits!

In this packet you will find your Kaiser Permanente POS health plan and dental plan options.

Thank you for trusting us with your health benefits!

Group Health is Now Kaiser Permanente

The biggest change to your health plan this year is that Group Health was bought by Kaiser Permanente. What does this mean for you:

- **You should have received a new medical card in the mail.** Your member number is the same and you can continue using your current card if you did not receive the new one.
- **Your plan is exactly the same under Kaiser Permanente.** Your premium, benefits and costs are exactly the same from last year.
- **You can keep your current doctors.** You will continue to receive care from the doctors and care teams you count on.
- **You can visit the same locations.**

New Benefit: Obesity Related Services

Your Kaiser medical insurance now includes Obesity Related Services. With approval from your doctor, Kaiser offers a holistic program with surgery options, support groups and nutrition counseling.

Get Free, Quick Care with Online Visits

You can now chat with your doctor online for no cost about common conditions like cold/flu symptoms, cough, sore throat, female bladder symptoms and yeast infections. You can even get a prescription if needed. Go to www.kp.org/wa and under "Need Care Now?" click "Care Options," then "Online Visit."

Agency Providers Only: Open Enrollment Period - July 2017

For Agency Providers, July is your month to make these optional plan changes:

1. Add or remove dependents from your plan (Call us at 1-866-371-3200 for an enrollment form.)
2. Change your dental health plan (plan summaries and Dental Change Form attached)

Important Dates:

- **July 20, 2017:** Mail or fax your plan changes by this date for coverage starting in August.
- **July 31, 2017:** Last day to make plan changes for the 2017-2018 plan year.

For questions, call the Member Resource Center - 1-866-371-3200 - Mon-Fri, 8am-6pm
www.myseiubenefits.org

More Plan Details

Your Choice of Dental Plans:

	Willamette Dental Group	DELTA DENTAL
Annual Maximum	No Annual Maximum	$2,000
Deductible	$0	$0
Copay for routine exams	$15 Copay	Covered in full

Your dental plan is included in your $25 monthly co-premium and there are no plan changes from 2016.
Want to switch your dental plan? Complete and mail the attached Dental Change Form.
If you are an Agency Provider, send the attached Dental Change form by:

- **July 20, 2017:** for coverage starting in August.
- **July 31, 2017:** Last day to mail form for dental coverage for the year.

How to Schedule Your Free Mental Health Visits

When you think about staying healthy, is your mental health part of the equation? Mental healthcare and treatment can include psychotherapy, medication, group therapy, and complimentary and alternative medicines.

The first step is talking to your Primary Care Provider. Let them know you would like to access your mental health benefits. With your input, they can help guide you to the care that is best for you.

Make an appointment online at www.kp.org/wa or call:
1-888-287-2680

Prescription Cost Comparison Chart

Prescription drug coverage is a big part of your health benefits. Make the most of them by managing your prescriptions wisely. Your cost for prescriptions will be less if you use a Kaiser Permanente pharmacy.

Rx Copay (In-network) for 30 day supply	At the Pharmacy	Mail order
Formulary Contraceptives*	$0	$0
Value Based Drugs**	$4	$0
Generic Drugs	$8	$3
Formulary Brand Name Drugs	$25	$20
Non-Formulary Brand Name Drugs	$50	$45

**Catholic Community Services Employees:* *Your employer does not pay for contraceptive and sterilization services. Instead, Kaiser Permanente will provide separate payments for contraceptive services that you use, at no other cost to you, as long you are enrolled in your group's health plan.*

***The value based drugs are generic brands that treat: Diabetes, High Blood Pressure, High Cholesterol, and Heart Failure.*

Save $185 by Using Urgent Care instead of the Emergency Room

When you need immediate care, look for your closest Urgent Care center or a CareClinic inside Bartell drugs, make a same-day appointment or free online visit with your Primary Care Provider.

Emergency Room	Urgent Care / Doctor Visit / Bartell CareClinic	Online Doctor Visit
$200 Copay	$15 Copay	Free

Health Plan Benefit Summary

Kaiser Permanente of Washington

(Formerly Group Health)

POS Plan Summary

KAISER PERMANENTE

Effective Date: 8/1/2017 **Health Plan:** Kaiser Permanente Options

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
- Agency Providers only: Dependent children who are under the age of twenty-six (26) are eligible to enroll in this plan. You will be responsible for paying the full cost of the premium for your dependents. Contact your employer for premium rates.

Benefits	Inside Network	Outside 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	Out-of-pocket limit is shared with in-network Out-of-pocket expenses for the following covered services are included in the out-of-pocket limit: All cost shares for covered services
Pre-existing condition (PEC) waiting period	No PEC	Same as in-network
Lifetime maximum	Unlimited	Same as in-network 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)	Value based/preferred generic (Tier 1)/preferred brand (Tier 2)/non-preferred (Tier 3) $4/$8/$25/$50 copay per 30 day supply	Preferred generic/preferred brand/non-preferred $13/$30/$55 copay per 30 day supply
Prescription mail order	$5 discount per 30 day supply	Not covered
Acupuncture	Covered up to 8 visits per medical diagnosis per calendar year without prior authorization; additional visits when approved by the plan - $15 copay	$15 copay, deductible and coinsurance apply
Ambulance services	Plan pays 80%, you pay 20%	Same as in-network
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

More Plan Details

Devices, equipment and supplies	Covered at 50% • Durable medical equipment • Orthopedic appliances • Post-mastectomy bras limited to two (2) every six (6) months • Ostomy supplies • Prosthetic devices	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 High end radiology imaging services such as CT, MR and PET must be determined Medically Necessary and require prior authorization except when associated with Emergency care or inpatient services.	Inpatient: Covered under Hospital services Outpatient: Deductible and coinsurance apply High end radiology imaging services such as CT, MR and PET must be determined Medically Necessary and require prior authorization except when associated with Emergency care or inpatient services.
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. No visit limit.	No 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 10 visits per calendar year without prior authorization $15 copay	Visit limits shared with in-network $15 copay, deductible and coinsurance apply
Massage services	See Rehabilitation services	See Rehabilitation services
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	Covered up to 3 visits per medical diagnosis per calendar year without prior authorization; additional visits when approved by the plan $15 copay	$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 Services	Covered at cost shares when medical criteria is met	Covered at cost shares when medical criteria is met
Organ transplants	Unlimited, no waiting period Inpatient: $100 copay, per day for up to 5 days per admit Outpatient: $15 copay	Shared with in-network Inpatient: $100 copay, per day for up to 5 days per admit Deductible and coinsurance apply Outpatient: $15 copay, deductible and coinsurance apply
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.	Deductible and coinsurance apply 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 in-network $100 copay, per day for up to 5 days per admit Deductible and coinsurance apply Outpatient: Visit limits shared with in-network $15 copay, deductible and coinsurance apply
Skilled nursing facility	Covered in full up to 60 days per calendar year	Day limits shared with in-network 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 in-network

*Catholic Community Services does not pay for contraceptive and sterilization services

Delta Dental Benefit Summary

Delta Dental PPO Plan

DELTA DENTAL®

Effective Date: 8/1/2017 **Benefit Period Maximum (Per Person)** $2,000

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.

	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			

More Plan Details

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.

Willamette Dental Benefit Summary

Willamette Dental Group

Willamette Dental Group

Effective Date: 8/1/2017

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.

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	
Teeth Cleaning	
Fluoride Treatment	
Sealants (per Tooth)	
Head and Neck Cancer Screening	
Oral Hygiene Instruction	
Periodontal Charting	
Periodontal Evaluation	
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	Surgical Extraction
ORTHODONTIA TREATMENT	
Pre-Orthodontia Treatment	Not Covered
Comprehensive Orthodontia Treatment	Not Covered

More Plan Details

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.

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 premedications.
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.

SEIU 775
BENEFITS GROUP

Dental Change Form

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.

If you are an Agency Provider, mail this form by:

- **July 20, 2017:** for coverage starting in August.
- **July 31, 2017:** Last day to mail form for dental coverage for the year.

PERSONAL INFORMATION

First Name:		Last Name:	
Street Address:			
City:	State:	ZIP:	
Phone:	Date of Birth: / /	Social Security: - -	Gender: ☐ Female ☐ Male
Agency / Payee Number:			

I want to change my dental insurance carrier to: (check one) ☐ Delta Dental OR ☐ Willamette Dental

Your dental change will take place the first of the month following the date your change form is received by the Trust Office. You will not be able to change your dental carrier again until 12 months after your change has taken place.

Your Signature: Date:

Please mail, fax or email your form to Zenith American Solutions, your benefits administrator by July 20th for August coverage.
For Agency Providers, please mail by July 30th, for 2017-2018 coverage.
If you have any questions, please call the Member Resource Center at 1-866-371-3200.

Mail to:
Zenith American Solutions, Inc
201 Queen Anne Ave. N, Suite 100
Seattle, WA 98109-4896

Fax to:
(206) 298-3424

Email to:
SEIU-HBT@Zenith-American.com