SEIU 775 BENEFITS GROUP

aetna

# Your 2018-19 Health Plan Highlights

## Welcome to your summary of 2018 health and dental benefits!

In this packet you will find your Aetna health plan and dental plan summaries.

Thank you for trusting us with your health benefits!

### Open Enrollment Period – July 1-20, 2018

July is your month to make these optional plan changes:

- Change your dental plan
  (plan summaries and Dental Change Form attached)


**Important Dates:**

- **July 20, 2018**: Mail, email or fax your dental plan changes by this date for coverage starting in August.

For questions, call the Member Resource Center | 1-866-371-3200

8 a.m. - 6 p.m., Mon-Fri | www.myseiubenefits.org

## Your Choice of Dental Plans:

| | Willamette Dental Group | DELTA DENTAL® |
|---|---|---|
| Annual Maximum | No Annual Maximum | $2,000 |
| Deductible | $0 | $0 |
| Co-pay for routine exams | Covered in Full | Covered in Full |

Your dental plan is included in your $25 monthly co-premium.

**Want to switch your dental plan?** Complete and send the attached Dental Change Form by:

- **July 20, 2018:** Last day to return form for dental coverage changes for the year.

## Plan Enhancements

These enhancements to your benefits have been made for the 2018–19 Plan Year:

- New Benefit – Hearing Aid Coverage through EPIC Hearing
  - * There is no co-pay for a hearing assessment through EPIC Hearing. You also get up to $1,200 per ear every three years toward the cost of a hearing aid. To take advantage of this benefit, you must go through EPIC Hearing. Prior to accessing your benefits, call EPIC at 1-866-956-5400.
- New Benefit – Orthodontic coverage with Delta Dental
  - * Orthodontic coverage, now available with Delta Dental, covers 50% of the cost of treatment, up to a $2,000 lifetime maximum.
- Preventative Dental – No co-pay required for preventative care on all plans.
- Delta Dental – Posterior composite ("white") fillings are covered.

These changes are effective 8/1/2018.

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

When you need immediate care, look for your closest Urgent Care center or make a same-day appointment with your Primary Care Provider.

| Emergency Room | Urgent Care / Doctor Visit |
|---|---|
| $200 Co-pay | $15 Co-pay |

## How to Schedule Your Mental Health Visits

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

To find providers in your area, visit www.aetna.com or call: 1-855-736-9469

## Prescription Cost Comparison Chart

Prescription drug coverage through Sav-Rx 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 an in-network pharmacy.

To contact Sav-Rx, visit www.savrx.com or call 1-800-228-3108

| Rx Co-pay (In-network) for 30 day supply | At the Pharmacy | Mail Order |
|---|---|---|
| Formulary Contraceptives* | $0 | 2x prescription co-pay per 90-day supply |
| Value-Based Drugs** | $4 | |
| Generic Drugs | $8 | |
| Formulary Brand Name Drugs | $25 | |
| Non-Formulary Brand Name Drugs | $50 | |

* Catholic Community Services Employees: Your employer does not pay for contraceptive and sterilization services.

Instead, Aetna 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.

# Health Plan Benefit Summary

Aetna PPO
Group 6356800

aetna

**Effective Date: 8/1/2018**

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 | Preferred Provider Network | 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<br><br>Out-of-pocket expenses for the following covered services are included in the out-of-pocket limit.<br><br>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 co-pay | $15 co-pay, deductible and coinsurance apply |
| **Hospital services** | Inpatient services: $100 co-pay, per day for up to 5 days per admit<br><br>Outpatient surgery: $50 co-pay | Inpatient services: $100 co-pay, per day for up to 5 days per admit<br><br>Deductible and coinsurance apply<br><br>Outpatient surgery: $50 co-pay, deductible and coinsurance apply |
| **Prescription drugs** (some injectable drugs may be covered under Outpatient services) | Preferred generic (Tier 1)/preferred brand (Tier 2)/nonpreferred (Tier 3)<br>$4/$8/$25/$50 co-pay | Preferred generic/preferred brand/non-preferred $13/$30/$55 co-pay |
| **Prescription mail order** | 2 x prescription cost share per 90 day supply | Not covered |
| **Acupuncture** | 12 visits per calendar year $15 co-pay | Shared with preferred provider visit limit $15 co-pay, deductible and coinsurance apply |

| Benefits | Preferred Provider Network | Non-Preferred Provider Network |
|---|---|---|
| **Ambulance services** | Plan pays 80%, you pay 20% | Same as preferred provider benefit |
| **Chemical dependency** | Inpatient: $100 co-pay, per day for up to 5 days per admit<br><br>Outpatient: $0 co-pay | Inpatient: $100 co-pay, per day for up to 5 days per admit Deductible and coinsurance apply<br><br>Outpatient: $15 co-pay, deductible and coinsurance apply |
| **Devices, equipment and supplies**<br>• Durable medical equipment<br>• Orthopedic appliances<br>• Post-mastectomy bras limited to two (2) every six (6) months<br>• Ostomy supplies<br>• 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<br><br>Outpatient: Covered in full | Inpatient: Covered under Hospital services<br><br>Outpatient: Deductible and coinsurance apply |
| **Emergency services** (co-pay waived if admitted) | $200 co-pay | $200 co-pay |
| **Hearing exams** (routine) | $15 co-pay | $15 co-pay, 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<br><br>$15 co-pay | Shared with preferred provider visit limit<br>$15 co-pay, deductible and coinsurance apply |
| **Massage services** | 12 visits per calendar year $15 co-pay | Shared with preferred provider visit limit<br>$15 co-pay, deductible and coinsurance apply |
| **Maternity services** | Inpatient: $100 co-pay, per day for up to 5 days per admit<br><br>Outpatient: $15 co-pay. Routine care not subject to outpatient services co-pay. | Inpatient: $100 co-pay, per day for up to 5 days per admit Deductible and coinsurance apply<br><br>Outpatient: $15 co-pay, deductible and coinsurance apply. Routine care not subject to outpatient services co-pay. |
| **Mental Health** | Inpatient: $100 co-pay, per day for up to 5 days per admit<br><br>Outpatient: $0 co-pay | Inpatient: $100 co-pay, per day for up to 5 days per admit Deductible and coinsurance apply<br><br>Outpatient: $15 co-pay, deductible and coinsurance apply |
| **Naturopathy** | 12 visits per calendar year<br>$15 co-pay | Shared with preferred provider visit limit$15 co-pay, 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) | Covered at cost shares when medical criteria is met | Covered at cost shares when medical criteria is met |

| Benefits | Preferred Provider Network | Non-Preferred Provider Network |
|---|---|---|
| **Organ transplants** | Unlimited, no waiting period<br><br>Inpatient: $100 co-pay, per day for up to 5 days per admit<br><br>Outpatient: $15 co-pay | Not covered |
| **Preventive care**<br>Well-care physicals, immunizations, Pap smear exams, mammograms | Covered in full<br><br>Women's preventive care services (including contraceptive drugs and devices and sterilization) are covered in full. | Not covered<br><br>Women's preventive care services (including contraceptive drugs and devices and sterilization) are subject to the applicable Preventive Care cost share and benefit maximums.<br><br>Routine mammograms: Deductible and coinsurance apply |
| **Rehabilitation services**<br>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.<br>$100 co-pay, per day for up to 5 days per admit<br><br>Outpatient: 60 visits per calendar year. Services with mental health diagnoses are covered with no limit.<br>$15 co-pay | Inpatient: Day limits shared with preferred provider benefit limit<br>$100 co-pay, per day for up to 5 days per admit<br>Deductible and coinsurance apply<br>Outpatient: Visit limits shared with preferred provider benefit limit<br>$15 co-pay, 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**<br>(vasectomy, tubal ligation) | Inpatient: $100 co-pay, per day for up to 5 days per admit<br><br>Outpatient: $15 co-pay<br><br>Women's sterilization procedures are covered in full. | Inpatient: $100 co-pay, per day for up to 5 days per admit<br>Deductible and coinsurance apply<br><br>Outpatient: $15 co-pay, deductible and coinsurance apply<br><br>Women's sterilization procedures are covered subject to the applicable Preventive Care cost share and benefit maximums. |
| **Temporomandibular Joint (TMJ) services** | Inpatient: $100 co-pay, per day for up to 5 days per admit<br><br>Outpatient: $15 co-pay | Inpatient: $100 co-pay, per day for up to 5 days per admit<br>Deductible and coinsurance apply<br><br>Outpatient: $15 co-pay, 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 co-pay | $15 co-pay, deductible and coinsurance apply |
| **Optical hardware**<br>Lenses, including contact lenses and frames | Members under 19: 1 pair of frames and lenses per year or contact lenses covered at 50% coinsurance<br><br>Members age 19 and over: $200 per 24 months | Shared with preferred provider benefit |

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

# Delta Dental Benefit Summary

## Delta Dental PPO Plan

DELTA DENTAL®

| | |
|---|---|
| **Effective Date** | August 1, 2018 |
| **Benefit Period** | January 1, 2019 – December 31, 2019 |
| **Benefit Period Maximum** (Per Person) | $2,000 |
| **Orthodontia – Adults & Children**<br>Lifetime Maximum (Per Person) | 50%<br>$2,000 |

| | Provider Network | | |
|---|---|---|---|
| | Delta Dental PPO℠ Dentist | Delta Dental Premier® Dentist | Non-Participating Dentist |
| | **Benefit Period Deductible** | | |
| **Does Not Apply to Class I**<br>**In Network – no deductible**<br>**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% |
| Posterior Composite Fillings | | | |
| 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**.**

## Get the most from your benefits!

### Create a MySmile® account

It gives you secure, 24/7 access to your ID card, benefits information, out-of-pocket cost estimates, and more! Visit DeltaDentalWA.com to create your account.

### Choose an in-network dentist

Your plan gives you access to the Delta Dental PPO℠ network. Your benefits go farthest when you visit a Delta Dental PPO dentist which gives you the most bang for your buck.

Your plan also comes with access to the Delta Dental Premier® network. It's kind of like a safety net in case you're unable to find a PPO dentist in your area. We want to make it as easy as possible for you to access a Delta Dental dentist.

| | Delta Dental PPO | Delta Dental Premier | Out-of-network |
|---|---|---|---|
| Your plans dental network | ✓ | | |
| Benefits go farthest which means least out-of-pocket costs | ✓ | | |
| Comes with our quality management and cost protection | ✓ | ✓ | |
| No cost protection which means greatest out-of-pocket costs | | | ✓ |

Find an in-network dentist near you:

1. Visit DeltaDentalWA.com
2. Click on 'Online Tools' and use our 'Find a Dentist' tool
3. Select 'Delta Dental PPO' to filter your search results

### Visit your dentist regularly

Your plan covers preventive care visits each year. Regular cleanings and check-ups are essential to keeping your smile healthy and preventing painful, expensive problems down the road.

### Get out-of-pocket cost estimates

Knowing your cost upfront helps you and your dentist plan treatments to maximize your benefits.

**MySmile Cost Genie℠** gives you instant, cost estimates. It's great for basic treatments like fillings. Simply sign in to MySmile account to get your personalized estimate.

When you need extensive treatment, like a crown, ask your dentist for a "Predetermination." You'll get a **Confirmation of Treatment and Cost** from us. It details your dentist's treatment plan, what your benefits cover, and how much you may owe your dentist for the treatment.

### Have a question?

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

# Willamette Dental Benefit Summary

## Willamette Dental Group

Willamette
Dental Group

**Effective Date:** 8/1/2018

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 | Co-payS |
|---|---|
| Annual Maximum | No Annual Maximum* |
| Deductible | No Deductible |
| General & Orthodontic Office Visit | No Co-pay per Visit |
| **DIAGNOSTIC AND PREVENTIVE SERVICES** | |
| Routine and Emergency Exams | Covered with the Office Visit Co-pay |
| 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 Co-pay |
| Porcelain-Metal Crown | You pay a $250 Co-pay |
| **PROSTHODONTICS** | |
| Complete Upper or Lower Denture | You pay a $400 Co-pay |
| Bridge (per Tooth) | You pay a $250 Co-pay |
| **ENDODONTICS AND PERIODONTICS** | |
| Root Canal Therapy – Anterior | You pay a $85 Co-pay |
| Root Canal Therapy – Bicuspid | You pay a $105 Co-pay |
| Root Canal Therapy – Molar | You pay a $130 Co-pay |
| Osseous Surgery (per Quadrant) | You pay a $150 Co-pay |
| Root Planning (per Quadrant) | You pay a $75 Co-pay |
| **ORAL SURGERY** | |
| Routine Extraction (Single Tooth) | Covered with the Office Visit Co-pay |
| Surgical Extraction | You pay a $100 Co-pay |
| **ORTHODONTIA TREATMENT** | |
| Pre-Orthodontia Treatment | Not Covered |
| Comprehensive Orthodontia Treatment | Not Covered |

| MISCELLANEOUS | |
|---|---|
| **Local Anesthesia** | Covered with the Office Visit Co-pay |
| **Dental Lab Fees** | Covered with the Office Visit Co-pay |
| **Nitrous Oxide** | You pay a $40 Co-pay |
| **Specialty Office Visit** | You pay a $30 Co-pay per Visit |
| **Out of Area Emergency Care Reimbursement** | You pay charges in excess of $250 |

*TMJ has a $1000 annual maximum/ $5000 lifetime maximum

**Co-pay credited towards the Comprehensive Orthodontia Treatment co-pay 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 co-payments.

General anesthesia is covered with the co-payments 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 co-payments 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.

All members who wish to make changes must mail, fax or email this form by:

- **July 20, 2018:** for coverage starting in August.

## 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 20 for August coverage.

If you have any questions, please call the Member Resource Center at 1-866-371-3200, 8 a.m. to 6 p.m., Mon - Fri.

**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