SEIU 775 BENEFITS GROUP

KAISER PERMANENTE®

# Your 2018-19 Health Plan Highlights

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

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

Thank you for trusting us with your health benefits!

### Agency Providers: Open Enrollment Period – July 1–20, 2018

July is your month to make these optional plan changes:

1. Add or remove child dependents from your plan
   (caregiver pays full premium through automatic payroll deduction)
2. Change your dental plan
   (plan summaries and Dental Change Form attached)

JULY 20

**Important Dates:**

- **July 20, 2018**: Mail, email or fax your child dependent or 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. to 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 Free 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.

Make an appointment online at healthy.kaiserpermanente.org/oregon-washington or call: 1-800-813-2000.

## 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 an in-network pharmacy.

| Rx Co-pay (In-network) for 30 day supply | At the Pharmacy | Mail Order |
|---|---|---|
| Generic Drugs | $5 | $40 for up to 90 day supply |
| Formulary Brand Name Drugs | $25 | $80 for up to 90 day supply |
| Non-Formulary Brand Name Drugs | $50 | $120 for up to 90 day supply |

# Health Plan Benefit Summary

## Kaiser Permanente Northwest HMO Plan Summary

KAISER PERMANENTE®

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

**NOTE:** This is a benefit summary, only, and is not intended to replace the specifics of the plan's Certificate of Coverage, Contract, or Evidence of Insurance. If there is a contradiction, the Certificate of Coverage, Contract, or Evidence of Insurance will take precedence.

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.

| **Out-of-Pocket Maximum** (Note: All Co-payment and Coinsurance amounts count toward the Out-of-Pocket Maximum, unless otherwise noted.) | |
|---|---|
| For one Member | $1,250 |
| For an entire Family | $2,500 |
| **Office visits** | |
| Routine preventative physical exam | $0 |
| Primary Care | $15 |
| Specialty Care | $15 |
| Urgent Care | $30 |
| **Tests (outpatient)** | |
| Preventive Tests | $0 |
| Laboratory | $0 |
| X-ray, imaging, and special diagnostic procedures | $0 |
| CT, MRI, PET scans | $50 per department visit |
| **Medications (outpatient)** | |
| Prescription drugs (up to a 30 day supply) | $5 generic/$20 preferred brand/$50 non-preferred brand |
| Mail Order Prescription drugs (up to a 90 day supply) | $10 generic/$40 preferred brand/$100 non-preferred brand |
| Administered medications, including injections (all outpatient settings) | $0 |
| Nurse treatment room visits to receive injections | $5 |
| **Maternity Care** | |
| Scheduled prenatal care and first postpartum visit | $0 |
| Laboratory | $0 |
| X-ray, imaging, and special diagnostic procedures | $0 |
| Inpatient Hospital Services | $100 per admission |
| **Hospital Services** | |
| Ambulance Services (per transport) | $75 |
| Emergency department visit | $200 (Waived if admitted) |
| Inpatient Hospital Services | $100 per admission |
| **Services** | |
| Outpatient surgery visit | $50 |
| Chemotherapy/radiation therapy visit | $15 |

| Services Continued | |
|---|---|
| Durable medical equipment, external prosthetic devices, and orthotic devices | 20% Coinsurance |
| Physical, speech, and occupational therapies (up to 20 visits per therapy per Calendar Year) | $15 |
| **Skilled Nursing Facility Services** | |
| Inpatient skilled nursing Services (up to 100 days per Calendar Year) | $0 |
| **Chemical Dependency Services** | |
| Outpatient Services (Group visit ½ co-pay) | $0 |
| Inpatient hospital & residential Services | $100 per admission |
| **Mental Health Services** | |
| Outpatient Services (Group visit ½ co-pay) | $0 |
| Inpatient hospital & residential Services | $100 per admission |
| **Alternative Care** | |
| Alternative care (self-referred) | $15 per chiropractor visit |
| **Vision Services** | |
| Routine eye exam (through first month of age 19) | $0 |
| Vision hardware and optical Services (through first month of age 19) | No charge for eyeglass lenses or frames or contact lenses every 12 months. |
| Routine eye exam (age 19 and older) | $10 |
| Vision hardware and optical Services (ages 19 years and older)* | Balance after $200 allowance, once every two calendar years |

* Any amount you pay for covered Services does not count toward the Out-of-Pocket Maximum.

## Additional Features

### Online Access anytime, anywhere at no additional charge: kp.org

- Access medical records
- Refill Prescriptions
- Email doctor
- Check lab results
- Schedule appointments
- Health Risk Assessments – personal online tool for members

### Facilities and Services: kp.org/facilities

- 37 Medical offices
- 8 Urgent Care locations
- 17 Dental offices
- The Portland Clinic (7 locations)
- 24-hour advice nurses
- Health coach services

### Member Discounts: kp.org/choosehealthy

- CHP Active and Healthy
- Fitness club discounts
- Vitamins & supplements
- Alternative and chiropractic care

**Exclusions and Limitations**

The Services listed below are either completely excluded from coverage or partially limited. This applies to all Services that would otherwise be covered and is in addition to the exclusions and limitations that apply only to a particular Service as listed in the description of that Service in the Evidence of Coverage (EOC). For a complete list and description of Exclusions and Limitations please refer to EOC. Acupuncture unless your employer Group has purchased the "Alternative Care Services Rider". Chiropractic unless your employer Group has purchased the "Alternative Care Services Rider" or the "Chiropractic Services Rider" (for self-referred chiropractic care). Cosmetic Services; This exclusion does not apply to Services that are covered under "Reconstructive Surgery Services" in the "Benefits" section of the EOC. Custodial Services. Dental Services. Designated Blood Donations. Employer Responsibility; We do not reimburse the employer for any Services that the law requires an employer to provide. Experimental or Investigational Services. Eye Surgery; Radial keratotomy, photorefractive keratectomy, and refractive surgery, including evaluations for the procedures. Family Services; Services provided by a member of your immediate family. Genetic Testing. Hearing Aids unless your Group has purchased the "Hearing Aid Rider." Hypnotherapy. Infertility Services unless your group has purchased the "Infertility Treatment Services Rider." Intermediate Services; Services in an intermediate care facility are excluded. Low-Vision Aids. Massage Therapy Services unless your employer Group has purchased the "Alternative Care Services Rider". Naturopathy Services unless your employer Group has purchased the "Alternative Care Services Rider". Non-Medically Necessary Services. Services Related to a Non-Covered Service. Services That are Not Health Care Services, Supplies, or Items. Supportive Care and Other Services. Surrogacy. Services for anyone in connection with a Surrogacy Arrangement, except for otherwise-covered Services provided to a Member who is a surrogate. Travel and Lodging. Travel Services. All travel-related Services including travel-only immunizations (such as yellow fever, typhoid, and Japanese encephalitis), unless your Group has purchased the "Travel Services Rider." Vision Hardware and Optical Services unless your Group has purchased an "Adult Vision Hardware and Optical Services Rider" and/or "Pediatric Vision Hardware and Optical Services Rider." Vision Therapy and Orthoptics or Eye Exercises. This is not a contract. This benefit summary does not fully describe your benefit coverage with Kaiser Foundation Health Plan of the Northwest. For more details on benefit coverage, claims review, and adjudication procedures, please see your EOC or call Membership Services. In the case of conflict between this summary and the EOC, the EOC will prevail.

# 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

# Enrollment Application

Administered by: Zenith American Solutions Inc. 201 Queen Anne Ave. N. Suite 100 Seattle, WA 98109-4896 Phone: 1 (866) 770-1917

**B**

## 1. EMPLOYER INFORMATION

Agency Name: Branch:

Address: City: State: Zip:

**Status Changes** **Effective Date of Coverage** ____/ ____/ _____

Change Requested

❑ Name Change ❑ Address Change ❑ New Employee ❑ Open Enrollment ❑ Add Dependent(s) ❑ Drop Dependent(s) ❑ Cancel Employee ❑ Reinstate Employee

Reason _____

## 2. COMPLETE SECTIONS 2 THROUGH 5 (if applicable) AND SIGN THIS FORM.

| Social Security Number | Last Name | First Name | MI |
|---|---|---|---|
| | | | |

❑ Male ❑ Female ❑ Single ❑ Married Date of Birth Mo. Day Yr.

Home Mailing Address

City State Zip

**Phone Number**

Home ( ) _____

Work ( ) _____

Email _____

## 3. HEALTH PLAN ASSIGNED BASED ON ZIP CODE:

**Medical:**

**Kaiser Foundation Health Plan of the Northwest-HMO**

**Dental:**

❑ **Delta Dental of Washington** ❑ **Willamette Dental Group**

❑ **Waive Medical / Dental**

## 4. DEPENDENT ENROLLMENT INFORMATION -

*Use additional forms to list additional dependents. Please Print Clearly*

***Please provide the Social Security number of each dependent you enroll.***

***Federal regulations require health plans to report the names, and Social Security numbers of every covered individual to the IRS***

| Relationship to Employee | Gender | Name (Last, First, Middle Initial) | Social Security Number | Date of Birth (mm/dd/yyyy) | Medical / Dental | Medical / Dental Rates |
|---|---|---|---|---|---|---|
| ❑ Child | ❑ Male ❑ Female | | | | ❑ Add ❑ Drop | **KPNW-HMO w/ Delta $715.38** |
| ❑ Child | ❑ Male ❑ Female | | | | ❑ Add ❑ Drop | |
| ❑ Child | ❑ Male ❑ Female | | | | ❑ Add ❑ Drop | **KPNW-HMO w/WDG $674.79** |
| ❑ Child | ❑ Male ❑ Female | | | | ❑ Add ❑ Drop | |

**Carrier Addresses:**

**Kaiser Foundation Health Plan of Washington**
320 Westlake Ave., N. Suite 100
Seattle, Wa 98109

**Kaiser Foundation Health Plan of NW**
500 NE Multnomah St., Ste. 100
Portland, OR 97232

**Aetna**
601 Union Street
Seattle, WA 98101

**Washington Dental Service**
PO Box 75688 NG Station
Seattle, WA 98175

**Willamette Dental of Washington Inc**
6950 NE Campus Way
Hillsboro, OR 97124

***VERY IMPORTANT: YOU MUST READ AND SIGN THIS FORM FOR COVERAGE TO TAKE EFFECT***

I hereby apply for enrollment or change of enrollment as indicated on this application. I understand that the SEIU Healthcare NW Health Benefits Trust and the Insurers may collect, use and disclose protected health information about each individual enrolled under this application in order to carry out their routine business functions, including but not limited to, determining eligibility for benefits, paying claims, coordinating benefits with other insurance carriers or payer, underwriting and conducting case management, care management and quality reviews. The SEIU Healthcare NW Health Benefits Trust and the Insurers may also disclose protected health information to state and federal agencies, or other third parties, as required by law. The undersigned understands that it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purposes of defrauding the company. Penalties may include imprisonment, fines and denial of insurance benefits. By signing below, I agree to the required monthly payroll deduction for my health insurance. In the event of an involuntary loss of HBT coverage, if minimum hour eligibility requirements are met again within 12 months from the date of coverage loss, coverage will be automatically reinstated. I understand if my hours drop below 80 through my primary employer, HBT may combine my hours from other home care agencies or the state to meet the 80 hour requirement and keep me enrolled in my health plan.

_____ Employee Signature

_____ Employee Name (please print)

_____ Date

_____ Group Administrator Signature

_____ Date

**APPLICATION DUE DATE: 15TH**

**Please Return Your Completed and Signed Form to the Health Benefits Trust.**

**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**

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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