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!

Individual Providers: 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 Date:

- 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. 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 a CareClinic inside Bartell Drugs, or 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 Co-pay	$15 Co-pay	Free

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, 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."

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 www.kp.org/wa or call: 1-888-901-4636.

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
Formulary Contraceptives*	$0	$0
Value-Based Drugs**	$4	$0 per 30 day supply
Generic Drugs	$8	$3 per 30 day supply
Formulary Brand Name Drugs	$25	$20 per 30 day supply
Non-Formulary Brand Name Drugs	$50	$45 per 30 day supply

*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.

Health Plan Benefit Summary

Kaiser Permanente of Washington HMO Plan Summary

KAISER PERMANENTE®

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	Inside Network
Plan deductible	No annual deductible
Individual deductible carryover	Not applicable
Plan coinsurance	No plan coinsurance
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
Pre-existing condition (PEC) waiting period	No PEC
Lifetime maximum	Unlimited
Outpatient services (Office visits)	$15 co-pay
Hospital services	Inpatient services: $100 co-pay, per day for up to 5 days per admit Outpatient surgery: $50 co-pay
Prescription drugs (some injectable drugs may be covered under Outpatient services)	Value based/preferred generic (Tier 1)/preferred brand (Tier 2) $4/$8/$25 co-pay per 30 day supply
Prescription mail order	$5 discount per 30 day supply
Acupuncture	Covered up to 8 visits per medical diagnosis per calendar year without prior authorization; additional visits when approved by the plan - $15 co-pay
Ambulance services	Plan pays 80%, you pay 20%
Chemical dependency	Inpatient: $100 co-pay, per day for up to 5 days per admit Outpatient: $0 co-pay
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

Benefits	Inside Network
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.
Diagnostic lab and X-ray services	Inpatient: Covered under Hospital services Outpatient: Covered in full, MRI/PET/CT $50 co-pay 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 (co-pay waived if admitted)	$200 co-pay at a designated facility $200 co-pay at a non designated facility
Hearing exams (routine)	$15 co-pay
Hearing hardware	Not covered
Home health services	Covered in full. No visit limit.
Hospice services	Covered in full
Infertility services	Not covered
Manipulative therapy	Covered up to 10 visits per calendar year without prior authorization $15 co-pay
Massage services	See Rehabilitation services
Maternity services	Inpatient: $100 co-pay, per day for up to 5 days per admit Outpatient: $15 co-pay. Routine care not subject to outpatient services co-pay.
Mental Health	Inpatient: $100 co-pay, per day for up to 5 days per admit Outpatient: $0 co-pay
Naturopathy	Covered up to 3 visits per medical diagnosis per calendar year without prior authorization; additional visits when approved by the plan $15 co-pay
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.
Obesity Related Services	Covered at cost shares when medical criteria is met
Organ transplants	Unlimited, no waiting period Inpatient: $100 co-pay, per day for up to 5 days per admit Outpatient: $15 co-pay
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.
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 co-pay, 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 co-pay
Skilled nursing facility	Covered in full up to 60 days per calendar year
Sterilization (vasectomy, tubal ligation)	Inpatient: $100 co-pay, per day for up to 5 days per admit Outpatient: $15 co-pay Women's sterilization procedures are covered in full.
Temporomandibular Joint (TMJ) services	Inpatient: $100 co-pay, per day for up to 5 days per admit Outpatient: $15 co-pay
Tobacco cessation counseling	Quit for Life Program - covered in full
Routine vision care (1 visit every 12 months)	$15 co-pay
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

*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 Lifetime Maximum (Per Person)	50% $2,000

	Provider 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%
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