2021 Open Enrollment

July 1-20 for Agency Providers

This packet includes information for:
✓ Caregivers already enrolled in health coverage.*
✓ Caregivers who are eligible and can apply for coverage.

*Currently enrolled Aetna members will receive new ID cards by mail in August 2021.

During Open Enrollment you can:
✓ Apply for health insurance (if you are not already enrolled).
✓ Make optional changes to your dental plan (if you are enrolled).
✓ Learn how to get the most value from your health benefits.

Complete and return your Health Benefits Application online or by mail on or before July 20.
New enrollees will receive coverage starting August 1. If you are currently enrolled, you will continue to receive the same coverage you have now if no action is taken.

If you do not have health insurance yet and would like to apply:
✓ Complete and submit the Health Benefits Application.
✓ Pay $25 a month.
✓ Continue working 80 hours a month to remain eligible.**
✓ Enjoy your Aetna Health Plan and Sav-Rx prescription benefits!

**To get more information on eligibility criteria, please refer to the Open Enrollment webpage at myseiu.be/oe2021.
How to Enroll or Make Changes

**Online**
You can fill out an online form using *My Plan*. Visit myseiu.be/oe-myplan to learn more.

**Mail Or Fax**
Send your application to the address listed on the Health Benefits Application. U.S. postage is required. Or fax it to 516-723-7395.

For questions, call SEIU 775 Benefits Group Customer Service | 1-877-606-6705 | 8 a.m. - 6 p.m., Mon-Fri | myseiubenefits.org

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**Information and Instructions in Your Language**

Gói này cũng được cung cấp bằng ngôn ngữ của bạn tại địa chỉ myseiu.be/oe2021-vi. Nếu bạn có câu hỏi, hãy gọi theo số 1-877-606-6705, de lunes a viernes de 8 a. m. a 6 p. m., hora del Pacifico.

이 패킷은 myseiu.be/oe2021-ko에서 귀하의 모국어로 제공됩니다. 궁금한 사항은 대행장 표준시 기준으로 월요일부터 금요일까지, 오전 8시부터 오후 6시 사이에 1-877-606-6705로 전화하십시오.

Este paquete está disponible en su idioma en myseiu.be/oe2021-es pSi tiene alguna pregunta, llame al 1-877-606-6705, de lunes a viernes de 8 a. m. a 6 p. m., hora del Pacifico.

Пакет доступен на вашем языке на сайте: myseiu.be/oe2021-ru с понедельника по пятницу с 8:00 до 18:00 часов (по Тихоокеанскому времени).

1-877-606-6705

این پاکت در زبان شما در وبسایت myseiu.be/oe2021-ar، شروع به مطالعه آن می‌کند. اگر شما نیاز به کمک دارید، لطفاً با 1-877-606-6705 تماس بگیرید.

Xímnadan iyada oo luqadaada ah waxaa laga heli karaa bogga internetka ee myseiu.be/oe2021-so. Haddii aad wax su’aalo ah qabto, wac 1-877-606-6705, 8 a.m. ilaa 6 p.m. Pacific time, Isniin-Jimce.
Enroll or Make Changes With My Plan!

Create a login for My Plan

Go to myseiu.be/oe-myplan to register as a new user by following these steps:

Step 1: Select Register as a New User.
- Username/Email Address
- Password
- Next
- Cancel

Step 2: Enter Member ID or Social Security Number (SSN).
- Member ID on your health card or SSN
- Next
- Cancel

Step 3: Enter Zip Code and Date of Birth.
- Zip Code
- Date of Birth
- Next
- Cancel

Step 4: Review and Accept Terms & Conditions.
- Next
- Cancel

Step 5: Fill out username, password and security question.
- Username/Email Address
- Password
- Secret Question
- Answer
- Next
- Cancel

Step 6: Fill out contact info and Save Communication.
- Home Phone
- Mobile Phone
- Work Phone
- Extension
- Additional Email Address
- Additional Phone for Communication
- Preferred method of communication
- Next
- Cancel

Step 7: Save Acknowledgements.
- SEIU 775 Benefits Group
- Next
- Cancel

Enroll in coverage

Step 1: Log in and view your health coverage information or enroll in coverage.
- If you are eligible to enroll, you will have the option to click on Start Enrollment.
- Step 2: Go through enrollment with My Plan
  - Select your Home Employer. This is the employer who will deduct your $25 monthly co-premium from your paycheck. Your home employer may be reassigned in the future to a secondary employer, based on your number of monthly hours worked.
  - For each benefit you will see eligibility information for both Agency Providers (APs) and Individual Providers (IPs).
- Step 3: Edit your preferences, such as:
  - How you want to be reached – by email, phone or mail.
  - Your preferred language.
- Step 4: Enroll in health coverage:
  - Medical plan – Your plan is chosen based on where you live.
  - Dental plan – Compare the plans and choose from the available dental plan options.
  - Other health resources available to you, such as Caregiver Kicks, EPIC Hearing and Ginger.
- Step 5: Review your selections.
- Step 6: Sign your name using your mouse or touchscreen to complete enrollment.
  - You will see a confirmation screen and be sent a confirmation email and letter.

View and make changes to your plan

Step 1: Log into My Plan to view or make changes to your coverage.
- Step 2: Use the menu icon on the upper left corner to:
  - Find your Coverage Summary.
  - View your eligibility and benefit information.
  - Change your dental plan.
  - View your work hours.
  - Make self-payments and more!

Questions? Call 1-877-606-6705, 8 a.m. to 6 p.m. Pacific time, Monday to Friday, or email SEIU775BG-caregiver@magnacare.com.

Download the MyCreateHealth mobile app on your smartphone to easily use My Plan.

The MyCreateHealth mobile app is available in the App Store on your iPhone, or in the Google Play Store on your Android phone.
Alternatives to Using the Emergency Room

Save $185 with Urgent Care.
If you are in need of immediate care, look for your closest urgent care center or make a same-day appointment with your doctor. You can save up to $185.

Immediate care is not the same as emergency care.
If you are suffering a life-threatening condition, such as heart attack or stroke, you should go to the emergency room. If you have a minor physical injury, like a sprained ankle, visit urgent care.

Health Plan Highlights

Get High-quality Health and Dental Coverage for Just $25 Per Month

Your coverage includes the following benefits:

- Free Doctor Visits
- Medical
- Orthodontia
- Dental
- Vision
- Hearing
- Infertility
- Prescription Drug
- Emotional Support

Get the Most Out of Your Coverage

Find a Doctor You Love
Care begins with you. Build a relationship with a doctor you trust by choosing a primary care doctor, who you can then see with no co-pay. You can see this doctor for wellness visits, if you get sick or if you need a referral to a specialist.

You can designate a primary care doctor through the Aetna website. Choosing and designating a primary care doctor is quick and easy. For help creating an account or finding a doctor, visit myseiu.be/oe-doctor.

Healthcare Anywhere
With your health coverage you get convenient, free or low-cost healthcare anywhere – by phone, tablet or computer – in addition to in-person visits. You can enjoy high-quality personalized care, safe and convenient visits and a choice of technology options. See myseiu.be/ha-2021 for more information.

More Benefits Designed Just For You

Self-care matters: Emotional Health Benefits
Emotional health is just as important as physical health. Coverage includes psychotherapy, medication, group therapy and complementary and alternative medicines, as well as:

- The Ginger app, which makes it easy to connect with an expert coach who can give advice and support through free, secure text messaging. Learn more at myseiu.be/oe-ginger.
- AbleTo Support, provided by Aetna, to get real help that fits your schedule with a convenient, 8-week phone/video counseling and coaching program. Call 1-855-773-2354 to learn more.
- Personal life help with Resource Finder*. Through Resource Finder, you can get access to emotional health resources, childcare, legal help and more. Visit myseiu.be/oe-resource to learn more.

Manage Your Prescriptions Wisely

Make the most of your prescription benefits by understanding all your choices and how much they cost.

*If you work for a religious-based organization, your health plan excludes contraceptive coverage, as permitted under the religious exemption of the Affordable Care Act. However, you will receive those at no cost to you (and without taking any additional action) from SavRx, as long as you are enrolled in a health plan.

**These value-based drugs are generic medications for treating various health conditions.

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

2x prescription co-pay per 90-day supply (in-network only)

New!
Visits to your Primary Care Doctor (also called a Primary Care Provider) are free with your coverage.

Alternatives to Using the Emergency Room

NEW!
Visits to your Primary Care Doctor (also called a Primary Care Provider) are free with your coverage.

Save $185 with Urgent Care.
If you are in need of immediate care, look for your closest urgent care center or make a same-day appointment with your doctor. You can save up to $185.

Immediate care is not the same as emergency care.
If you are suffering a life-threatening condition, such as heart attack or stroke, you should go to the emergency room. If you have a minor physical injury, like a sprained ankle, visit urgent care.

Caregiver Kicks
Get your free pair of Caregiver Kicks — slip-resistant shoes — every year! They are comfortable, keep you safer on the job and look great. Available over 70 styles, from popular brands like Reebok and Skechers. Get your Caregiver Kicks at myseiu.be/oe-kicks.

The Employee Assistance Program through Health Advocate will no longer be available to caregivers starting August 1, 2021.

*These value-based drugs are generic medications for treating various health conditions.
Aetna Health Plan Benefit Summary, continued.

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Preferred Provider Network</th>
<th>Non-Preferred Provider Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chemical dependency</td>
<td>Inpatient: $100 co-pay, per day for up to 5 days per admit</td>
<td>Inpatient: $100 co-pay, per day for up to 5 days per admit, deductible and coinsurance apply</td>
</tr>
<tr>
<td></td>
<td>Outpatient: $0 co-pay</td>
<td>Penalty of $400 for failure to obtain pre-authorization for out-of-network care.</td>
</tr>
<tr>
<td>Devices, equipment and supplies</td>
<td>Covered at 50%</td>
<td>Covered at 50%, deductible applies</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orthopedic appliances</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post-mastectomy bras</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Limited to two (2) every six (6) months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ostomy supplies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prosthetic devices</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetic supplies</td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>Diagnostic lab and X-ray services</td>
<td>Inpatient: Covered under hospital services</td>
<td>Inpatient: Covered under hospital services</td>
</tr>
<tr>
<td>Emergency services (co-pay waived if admitted)</td>
<td>Outpatient: Covered in full</td>
<td>Outpatient: Deductible and coinsurance apply</td>
</tr>
<tr>
<td>Hearing exams (routine)</td>
<td>$200 co-pay</td>
<td>$200 co-pay</td>
</tr>
<tr>
<td>Hearing hardware</td>
<td>$15 co-pay</td>
<td>$15 co-pay, deductible and coinsurance apply</td>
</tr>
<tr>
<td>Home health services</td>
<td>Covered in full up to 130 visits total per calendar year</td>
<td>Covered through a separate benefit. EPIC Hearing. No co-pay, up to $1,200 per every 3 years toward the cost of a hearing aid. Learn more at myseiu.be/hearing</td>
</tr>
<tr>
<td>Hospice services</td>
<td>Covered in full</td>
<td>Covered through a separate benefit. EPIC Hearing. No co-pay, up to $1,200 per every 3 years toward the cost of a hearing aid. Learn more at myseiu.be/hearing</td>
</tr>
<tr>
<td>Infertility services</td>
<td>Medical and surgical services for the treatment of sterility and infertility and all related services, including artificial insemination, in-vitro fertilization and drug therapy are covered subject to the applicable outpatient services cost shares, limited to $50,000 per lifetime maximum. Fertility drugs are covered subject to deductible and 20% plan coinsurance, limited to a lifetime maximum of $5,000.</td>
<td></td>
</tr>
<tr>
<td>Manipulative therapy</td>
<td>Covered up to 12 visits per calendar year without prior authorization</td>
<td>Not covered</td>
</tr>
<tr>
<td>Massage services</td>
<td>$15 co-pay (12 visits per calendar year)</td>
<td>Visit limits shared with in-network</td>
</tr>
<tr>
<td>Maternity services</td>
<td>Inpatient: $100 co-pay, per day for up to 5 days per admit</td>
<td>Inpatient: $100 co-pay, per day for up to 5 days per admit, deductible and coinsurance apply</td>
</tr>
<tr>
<td></td>
<td>Outpatient: $15 co-pay</td>
<td>Penalty of $400 for failure to obtain pre-authorization for out-of-network care.</td>
</tr>
</tbody>
</table>

**Medical Plan Benefit Summary**

Effective Date: 08/01/2021

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.

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Preferred Provider Network</th>
<th>Non-Preferred Provider Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan deductible</td>
<td>No annual deductible</td>
<td>Individual deductible: $500 per calendar year</td>
</tr>
<tr>
<td>Individual deductible carryover</td>
<td>Not applicable</td>
<td>4th quarter carryover applies</td>
</tr>
<tr>
<td>Plan coinsurance</td>
<td>No plan coinsurance</td>
<td>Plan pays 80%, you pay 20% of the Allowed Amount.</td>
</tr>
<tr>
<td>Out-of-pocket limit</td>
<td>Out-of-pocket expenses for the following covered services are included in the out-of-pocket limit. All cost shares for covered services are shared with in-network.</td>
<td></td>
</tr>
<tr>
<td>Pre-existing condition (PEC)</td>
<td>No PEC</td>
<td>Same as preferred provider network</td>
</tr>
<tr>
<td>Lifetime maximum</td>
<td>Unlimited</td>
<td>Same as preferred provider maximum</td>
</tr>
<tr>
<td>Outpatient services (Office visits)</td>
<td>$15 co-pay. If you designate a primary care doctor on the Aetna website, all visits with this doctor will have a $0 co-pay</td>
<td>$15 co-pay, deductible and coinsurance apply</td>
</tr>
<tr>
<td>Hospital services</td>
<td>Inpatient services: $100 co-pay, per day for up to 5 days per admit</td>
<td>Inpatient services: $100 co-pay, per day for up to 5 days per admit, deductible and coinsurance apply</td>
</tr>
<tr>
<td></td>
<td>Outpatient surgery: $50 co-pay</td>
<td>Outpatient surgery: $50 co-pay, deductible and coinsurance apply</td>
</tr>
<tr>
<td>Prescription drugs (some injectable drugs may be covered under Outpatient services)</td>
<td>Preferred generic (Tier 1) preferred brand (Tier 2)</td>
<td>Preferred generic/preferred brand/non-preferred</td>
</tr>
<tr>
<td>Prescription mail order</td>
<td>2 x prescription cost share per 90 day supply</td>
<td>$13/$30/$55 co-pay</td>
</tr>
<tr>
<td>Acupuncture</td>
<td>12 visits per calendar year $15 co-pay</td>
<td>Not covered</td>
</tr>
<tr>
<td>Ambulance services</td>
<td>Plan pays 80%, you pay 20%</td>
<td>Same as preferred provider benefit</td>
</tr>
</tbody>
</table>
Preferred Provider Network

Applicable cost shares apply shared with preferred provider visit limit $15 co-pay, Quit for Life Program—covered in full.

- $15 co-pay
- Covered in full up to 60 days per calendar year.
- 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.

- Covered at cost shares when medical criteria is met.
- Not covered

- Unlimited, no waiting period
- Women’s preventive care services (including contraceptive drugs and devices and sterilization) are subject to the applicable Preventive Care cost share and benefit maximums.

- 60 days per calendar year. Services with mental health diagnoses are covered with no limit. $15 co-pay
- Day limits shared with preferred provider benefit limit. $100 co-pay, per day for up to 5 days per admits. Deductible and coinsurance apply

- Covered in full
- Not covered
- Not covered

- Covered in full up to 60 days per calendar year

- $100 co-pay, per day for up to 5 days per admit
- $15 co-pay
- Women’s sterilization procedures are covered subject to the applicable Preventive Care cost share and benefit maximums.

- $100 co-pay, per day for up to 5 days per admit
- $15 co-pay
- Applicable cost shares apply

- $100 co-pay, per day for up to 5 days per admit
- $15 co-pay

- $15 co-pay

- Quit for Life Program—covered in full
- $15 co-pay

- Members under 19-1 pair of frames and lenses per year or contact lenses covered at $150 coinsurance. Members age 19 and over: $300 per 12 months
- Shared with preferred provider benefit

- Medicaid

- Optical hardware

- $100 co-pay, per day for up to 5 days per admit
- $15 co-pay

- Routine vision care (1 visit every 12 months)

- Tobacco cessation counseling

- Preventive care (Well-care physicals, immunizations, Pap smear exams, mammograms)

- Rehabilitation services

- Skilled nursing facility

- Sterilization (vasectomy, tubal ligation)

- Temporomandibular Joint (TMJ) services

- Your Choice of Dental Plans

- Your dental plan is included in your $25 monthly co-premium. Both dental plans offer orthodontia benefits.

- Want to switch your dental plan? Complete and return the Health Benefits Application by July 20, 2021.

- Benefit Period: 1/1/2022 - 12/31/2022
- Benefit Period Maximum* (per person; does not apply to Class I): $2,000
- Orthodontia—Adults & Children: 50%
- Lifetime Maximum (per person): $2,000

- Delta Dental PPO Dentist
- Delta Dental Premier Dentist
- Non-Participating Dentist

- Delta Dental PPO Dentist
- Delta Dental Premier Dentist
- Non-Participating Dentist

- Benefit Period Deductible

- Does not apply to class 1 in network—no deductible out of network—$50 per benefit period

- Class I - Diagnostic & Preventive

- Exams
- Cleaning
- Fluoride
- X-Rays
- Sealants

- 100% 80% 80%

- Class II - Restorative

- Restorations
- Posterior Composite Fillings
- Endodontics (Root Canal)
- Periodontics
- Oral Surgery

- 100% 60% 60%

- Class III - Major

- Dentures
- Partial Dentures
- Implants
- Bridges
- Crowns

- 80% 40% 40%

- *New this year! Your Annual Maximum is the maximum amount your insurance will cover per year. For dental work over this amount, you will have to pay out of pocket except for Class I costs.

- 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!
our “find your member id” tool makes registration easy. visit deltadentalwa.com to create your account.

choose an in-network dentist
your plan gives you access to the delta dental ppo network. however, benefits go farthest when you visit a delta dental po dentist. visit deltadentalwa.com to find a dentist in your network (learn how on the next page).

your plan also comes with access to the delta dental premier® network, which helps you find a ppo dentist outside of your area if needed. this means you can avoid higher out-of-network costs (see chart below).

more dental work is covered
class i costs do not count toward your annual maximum, which means more of your class ii and iii expenses are covered by insurance.

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 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 your mysmile account to get your personalized estimate.

when you need extensive treatment, like a crown, ask your dentist for a “predetermination.” you will get a confirmation of treatment and cost from your dentist. it details your treatment plan, what your benefits cover and how much you may owe your dentist for the treatment.

questions?
call delta dental.
1-800-554-1907
monday-friday, 7 a.m. to 5 p.m.
pacific time

willamette
dental group

dental plan effective date 8/1/2021

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.

<table>
<thead>
<tr>
<th>benefits</th>
<th>co-pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>annual maximum</td>
<td>no annual maximum*</td>
</tr>
<tr>
<td>deductible</td>
<td>no deductible</td>
</tr>
<tr>
<td>general &amp; orthodontic office visit</td>
<td>no co-pay per visit</td>
</tr>
<tr>
<td>diagnostic and preventative services</td>
<td></td>
</tr>
<tr>
<td>routine and emergency exams, x-rays, teeth cleaning, fluoride treatment, sealants (per tooth), head and neck cancer screening, oral hygiene instruction, periodontal charting, periodontal evaluation</td>
<td></td>
</tr>
<tr>
<td>restorative dentistry</td>
<td></td>
</tr>
<tr>
<td>fillings (amalgam)</td>
<td>you pay a $250 co-pay</td>
</tr>
<tr>
<td>porcelain-metal crown</td>
<td>you pay a $250 co-pay</td>
</tr>
<tr>
<td>prosthodontics</td>
<td></td>
</tr>
<tr>
<td>complete upper or lower denture</td>
<td>you pay a $400 co-pay</td>
</tr>
<tr>
<td>bridge (per tooth)</td>
<td>you pay a $250 co-pay</td>
</tr>
<tr>
<td>endodontics &amp; periodontics</td>
<td></td>
</tr>
<tr>
<td>root canal therapy – anterior</td>
<td>you pay a $85 co-pay</td>
</tr>
<tr>
<td>root canal therapy – bicuspids</td>
<td>you pay a $105 co-pay</td>
</tr>
<tr>
<td>root canal therapy – molar</td>
<td>you pay a $130 co-pay</td>
</tr>
<tr>
<td>osseous surgery (per quadrant)</td>
<td>you pay a $150 co-pay</td>
</tr>
<tr>
<td>root planning (per quadrant)</td>
<td>you pay a $75 co-pay</td>
</tr>
<tr>
<td>oral surgery</td>
<td></td>
</tr>
<tr>
<td>routine extraction (single tooth)</td>
<td>covered with the office visit co-pay</td>
</tr>
<tr>
<td>surgical extraction</td>
<td>you pay a $100 co-pay</td>
</tr>
<tr>
<td>orthodontia treatment</td>
<td></td>
</tr>
<tr>
<td>pre-orthodontia treatment</td>
<td>you pay a $150 co-pay**</td>
</tr>
<tr>
<td>comprehensive orthodontia treatment</td>
<td>you pay a $2,500 co-pay</td>
</tr>
<tr>
<td>dental implant</td>
<td></td>
</tr>
<tr>
<td>dental implant surgery</td>
<td>implant benefit maximum of $1,500 per calendar year</td>
</tr>
<tr>
<td>miscellaneous</td>
<td></td>
</tr>
<tr>
<td>local anesthesia</td>
<td>covered with the office visit co-pay</td>
</tr>
<tr>
<td>dental lab fees</td>
<td>covered with the office visit co-pay</td>
</tr>
<tr>
<td>nitrous oxide</td>
<td>you pay a $40 co-pay</td>
</tr>
<tr>
<td>specialty office visit</td>
<td>you pay a $30 co-pay per visit</td>
</tr>
<tr>
<td>out of area emergency care reimbursement</td>
<td>you pay charges in excess of $250</td>
</tr>
</tbody>
</table>

*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 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 to complete these benefits.

Common Insurance Terms
Learn the definitions of some common insurance terms to better understand your insurance policy.

Co-insurance
Co-insurance is the percentage of costs you pay for medical services after you have met your deductible (if your plan has one).

Co-pay
A co-pay is the amount you pay for doctor’s visits, emergency room visits and often for prescriptions. Some plans require you to pay co-pays instead of meeting a deductible. Other plans may require you to do both. Your co-pays do not count toward the deductible amount, but do count toward your out-of-pocket limit.

Deductible
The deductible is the amount you pay during a coverage period (usually one year) for covered healthcare services before your plan begins to pay. The deductible may not apply to all services and not all plans have a deductible. For some plans, the deductible may only apply to out-of-network services.

Eligibility
You are eligible for health coverage with SEIU 775 Benefits Group after you work for a minimum of 80 paid hours per month for at least two months in a row. To stay eligible for your coverage, you must continue to work 80 hours per month.

In-Network vs Out-Of-Network
In-network services are services that your health plan covers that you can get at lower or no co-pay/co-insurance. Out-of-network services are those that are still covered by your plan, but may have a higher co-pay or co-insurance than in-network services.

Member ID
Your member ID is a unique number connected to you that allows healthcare providers and their staff to verify your coverage and arrange payment for services. It’s also the number health insurance companies use to look up specific members and answer questions you may have about your claims and benefits. Your member ID number can be found on your member ID card.

Network
Your health plan network is made up of the facilities, providers (doctors, nurses) and suppliers your health plan has contracts with to provide health care services.

Out-Of-Pocket Limit
The out-of-pocket limit is the total you must pay for before your plan begins paying 100% of covered health costs for the rest of the year. Generally, co-pays, your deductible, co-insurance and covered in-network payments count toward this limit.

Primary Care Provider or Provider (Doctor)
A primary care provider is a doctor or other healthcare provider that you can see for continued care. You can choose your primary care provider through your health plan’s website. Some plans may automatically assign one to you, but you can change it at any time.

Premium/Co-premium
A premium (or co-premium) is the amount you pay for health insurance coverage every month, whether or not you go to the doctor. For caregivers covered through SEIU 775 Benefits Group, their co-premium is just $25 a month.

Outpatient Services vs Inpatient Services
An inpatient service is one that requires you to stay at a hospital overnight. Some examples may be delivering a baby or some surgeries. An outpatient service is any service that does not require you to stay at a hospital.

Waiver or Waiving Coverage
If you do not want to enroll in health coverage or would like to end your coverage (if you are already enrolled), you can fill out an online form on My Plan or call Customer Service to request a paper form. If you choose to waive coverage, you may not be able to enroll again until Open Enrollment 2022.
Open Enrollment is July 1 – July 20
Enroll or make changes to your coverage online with My Plan!
myseiu.be/oe-myplan

Questions? Call 1-877-606-6705