



**Kandie L.  
Caregiver, Kent**

# 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.

## **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 Kaiser Foundation Health Plan of the Northwest health insurance coverage!

\*To get more information on eligibility criteria, please refer to the Open Enrollment webpage at [myseiu.be/oe2021](https://myseiu.be/oe2021).

# 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 Pacífico.

此套文档可提供您的语言版本, 网址: **myseiu.be/oe2021-zh**。如有任何疑问, 请致电 **1-877-606-6705** 太平洋时间周一至周五早上 8 点至下午 6 点)。

이 패킷은 **myseiu.be/oe2021-ko** 에서 귀하의 모국어로 제공됩니다. 궁금한 사항은 태평양 표준시 기준으로 월요일부터 금요일까지, 오전 8시부터 오후 6 시 사이에 **1-877-606-6705** 로 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 Pacífico.

Пакет доступен на вашем языке на сайте: **myseiu.be/oe2021-ru** ля получения дополнительной информации звоните по телефону **1-877-606-6705** с понедельника по пятницу с 8:00 до 18:00 часов (по Тихоокеанскому времени).

**1-877-606-6705** myseiu.be/oe2021-ar, تيقوتبءاسم 6 ىتح اءابص 8 ةعاسلا نم ،ىلع لئتغلب قرفوتم ةعرجلا هذه 6705 .ةعرجلا ىلا نينثإلا نم ،ىداعلا طيحل

ይህ ፖኪት በእርስዎ ቋንቋ **myseiu.be/oe2021-am** ሊገኝ ይችላል። ጥያቄዎች ካልዎት ወደ **1-877-606-6705**፣ ከ 8 a.m. እስከ 6 p.m. በፓሲፊክ ሰዓት አቆጣጠር ከሰኞ እስከ ዓርብ መደወል ይችላሉ።

Xirmadan iyada oo luuqadaada 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 iyo 6 p.m. Pacific time, Isniin-Jimce.

# Table of Contents

Your packet includes highlights about your health plan, medical and dental plan summaries and common health insurance terms. You will also get the forms you need to enroll yourself if you are not enrolled or make optional changes to your plan if you are enrolled already.

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# 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.

# Enroll or Make Changes With *My Plan*!

## Create a login for *My Plan*

Go to [myseiu.be/oe-myplan](https://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

SIGN IN

REGISTER AS A NEW USER

### 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.

Member ID or SSN:

Name:

Zip Code:

Date of Birth:

NEXT

CANCEL

### Step 4: Review and Accept Terms & Conditions.

Please read and accept Terms & Conditions

CREATE will occasionally update this Privacy Policy to reflect changes in the law or feedback. CREATE encourages you to periodically review this Statement to be informed of how CREATE is protecting your information. Your continued use of this web portal and/or mobile app after we make changes is deemed to be acceptance of those changes, so please check the policy periodically for updates.

CONTACT INFORMATION

CREATE welcomes your comments regarding this Statement of Privacy. If you believe that CREATE has not adhered to this Statement, please contact CREATE at [CREATE@compliance.tcgbrighthouse.com](mailto:CREATE@compliance.tcgbrighthouse.com). We will use commercially reasonable efforts to promptly determine and remedy the problem.

View full screen

☒ I accept Terms & Conditions

☐ I do not accept Terms & Conditions

NEXT

CANCEL

### Step 5: Fill out username, password and security question.

Username or Email Address:

Confirm Username or Email Address:

Password (at least 8 characters)

Confirm Password:

Secret Question:

Answer:

NEXT

CANCEL

### Step 6: Fill out contact info and Save Communication.

\* At least one phone number and email address is required.

Home Phone

Mobile Phone

Work Phone

Extension

Preferred Phone Number for Communication:

☐ HOME ☐ MOBILE ☐ WORK

Personal Email Address

Work Email Address

Preferred Email for Communication:

☐ PERSONAL ☐ WORK

Preferred Method of Communication:

-Select-

English

SAVE COMMUNICATION

CONTINUE LATER

### Step 7: Save Acknowledgements.

create technology

SEIU 775 Benefits Group

☒ YOU MAY RECEIVE ELECTRONIC COMMUNICATIONS FROM US

SAVE ACKNOWLEDGEMENTS

CONTINUE LATER

## 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**.

MENU

SEIU 775 BENEFITS GROUP Administered by MAGNACARE

Start Enrollment

Hi! Hi! Logout

Home Employer

Your current employer is:

CHANGE HOME EMPLOYER | EMPLOYER HISTORY

I NEED HELP NOW  
(If this is a life-threatening emergency, please call 911.)

QUICK LINKS

### 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!

### 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.



**Questions?** Call **1-877-606-6705**, 8 a.m. to 6 p.m. Pacific time, Monday to Friday, or email [SEIU775BG-caregiver@magnacare.com](mailto:SEIU775BG-caregiver@magnacare.com).



# 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 choose a primary care doctor though the Kaiser Foundation Health Plan of the Northwest website. Choosing 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](#).
- Call Kaiser Foundation Health Plan of the Northwest Mental Health Services at **1-855-632-8280** or visit [myseiu.be/kpnw-bh](#).
- 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.



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.

John R.  
Caregiver, Seattle



## Manage Your Prescriptions Wisely

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

| Rx Co-pay (In-network) for 30 day supply | At the Pharmacy | Mail Order                    |
|--|-----------------|-------------------------------|
| Generic Contraceptives*                  | \$0             | \$0                           |
| Preferred Generic                        | \$5             | \$10 for up to 90 day supply  |
| Preferred Brand                          | \$25            | \$50 for up to 90 day supply  |
| Non-Preferred                            | \$50            | \$100 for up to 90 day supply |

\*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 these at no cost to you (and without taking any additional action) from Sav-Rx, as long as you are enrolled in a health plan.

## NEW!

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

## Alternatives to Using the Emergency Room

| Emergency Room<br>\$200 Co-pay | Urgent Care<br>\$30 Co-pay | Primary Doctor / Online Visits<br>Free |
|--------------------------------|----------------------------|--|
|--------------------------------|----------------------------|--|

### Save \$170 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 \$170.

### 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.

# Medical Plan Benefit Summary



Kaiser Foundation Health Plan of the Northwest 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.

| In-Network Coverage   |   |
|---|---|
| Out-of-Pocket Maxmium   |   |
| For one Member  | \$1,250   |
| For an entire Family  | \$2,500   |
| Deductible  | \$0   |
| Office Visits   |   |
| Routine preventative physical exam  | \$0   |
| Primary Care  | \$0   |
| Specialty Care  | \$15  |
| Urgent Care   | \$30  |
| Tests   |   |
| Preventive Tests  | \$0   |
| Laboratory  | \$0   |
| X-ray, imaging, and special diagnostic procedures   | \$0   |
| CT, MRI, PET scans  | \$50 per department visit. Some services may require prior authorization.   |
| 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/\$50 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   |
| Infertility   |   |
| Medical and surgical services for the treatment of sterility and infertility and all related services | Covered subject to the applicable outpatient services cost shares, limited to \$30,000 per lifetime maximum. Includes artificial insemination, in-vitro fertilization, and assisted reproduction, including gamete intrafallopian transfer (GIFT) and zygote intrafallopian transfer (ZIFT).<br><b>Fertility drugs:</b> Covered subject to 50% plan coinsurance, limited to a lifetime maximum of \$5,000 |

## Kaiser Foundation Health Plan of the Northwest Benefit Summary, continued.

| Services Ctd.  |  |
|--|--|
| Hospital Services  |  |
| Ambulance Services (per transport)   | \$75   |
| Emergency department visit   | \$200 (Waived if admitted)   |
| Inpatient Hospital Services  | \$100 per admission  |
| Chemotherapy/radiation therapy visit   | \$15   |
| 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  | \$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 up to 12 visits, additional visits require pre-authorization   |
| 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)  | \$0  |
| Vision hardware and optical Services (ages 19 years and older)*                              | Initial allowance of up to \$300 for eyeglasses or contact lenses, not more than once in a one year period.  |
| Hearing Services   |  |
| Hearing hardware   | Covered through a separate benefit: EPIC Hearing. No co-pay, up to \$1,200 per ear every 3 years toward the cost of a hearing aid. Learn more at <a href="https://myseiu.be/hearing">myseiu.be/hearing</a> |

\*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: <a href="https://kp.org">kp.org</a> | Schedule appointments                                      | 17 Dental offices   | Fitness club discounts            |
| Access medical records   | Health Risk Assessments – personal online tool for members | The Portland Clinic (7 locations)   | Vitamins & supplements            |
| Refill Prescriptions   | Facilities and Services:                                   | 24-hour advice nurses   | Alternative and chiropractic care |
| Email doctor   | <a href="https://kp.org/facilities">kp.org/facilities</a>  | Health coach services   |                                   |
| Check lab results  | 37 Medical offices   | Member Discounts: <a href="https://kp.org/choosehealthy">kp.org/choosehealthy</a> |                                   |
|  | 8 Urgent Care locations                                    | CHP Active and Healthy  |                                   |

**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.

# Your Choice of Dental Plans



| Providers   | Annual Maximum | Deductible | Co-pay for routine exams | Special Features  |
|---|----------------|------------|--------------------------|---|
|  | \$2,000        | \$0        | Covered in Full          | <ul style="list-style-type: none"><li>Broad network of providers, including rural areas</li></ul>   |
| Willamette Dental Group   | None           | \$0        | Covered in Full          | <ul style="list-style-type: none"><li>Convenient for caregivers who live on the I-5 corridor</li><li>No annual maximum for caregivers with high dental expenses</li></ul> |

## 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.



**PPO Plan**

Effective Date 8/1/2021

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 |
|--|--------------------------|------------------------------|---------------------------|
| Benefit Period Deductible  |                          |                              |                           |
| Does not apply to class 1 in network—no deductible out of network—\$50 per benefit period                | \$0/\$50                 | \$50                         | \$50                      |
| Class 1- Diagnostic & Preventative   |                          |                              |                           |
| Exams<br>Cleaning<br>Fluoride<br>X-Rays<br>Sealants  | 100%                     | 80%                          | 80%                       |
| Class II - Restorative   |                          |                              |                           |
| Restorations<br>Posterior Composite Fillings<br>Endodontics (Root Canal)<br>Periodontics<br>Oral Surgery | 100%                     | 60%                          | 60%                       |
| Class III - Major  |                          |                              |                           |
| Dentures<br>Partial Dentures<br>Implants<br>Bridges<br>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.

|   | PPO | Premier | Out-of-network |
|---|-----|---------|----------------|
| Your plan's dental network                                  | ✓   |         |                |
| Benefits go farthest which means least out-of-pocket costs  | ✓   |         |                |
| Files claims forms for you                                  | ✓   | ✓       |                |
| 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 helps you and your dentist plan treatments to maximize your benefits.

**MySmile Cost Genie<sup>SM</sup>** 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.

| Benefits  | Co-pays  |
|---|--|
| Annual Maximum  | No Annual Maximum*                                   |
| Deductible  | No Deductible  |
| General & Orthodontic Office Visit  | No Co-pay per visit                                  |
| Diagnostic and Preventative Services  |  |
| 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 | Covered with the Office Visit Co-pay                 |
| Restorative Dentistry   |  |
| Filings (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 & 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   | You pay a \$150 Co-pay**                             |
| Comprehensive Orthodontia Treatment   | You pay a \$2,500 Co-pay                             |
| Dental Implant  |  |
| Dental Implant Surgery  | Implant benefit maximum of \$1,500 per calendar year |
| 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, maintenanceand dental implant-related services.

Endodontic services, prosthetic servicesand 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 plan treatments to maximize your 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.





SEIU 775  
BENEFITS GROUP

Learning – Health – Retirement – Jobs



Daniel M.  
Caregiver, Lynnwood

## Open Enrollment is July 1 – July 20

Enroll or make changes to your coverage  
online with *My Plan!*

[myseiu.be/oe-myplan](https://myseiu.be/oe-myplan)

Questions? Call 1-877-606-6705