Health Plan Highlights

High-quality Health & Dental Coverage

Your coverage includes the following benefits:

- Free Primary Doctor Visits
- Medical
- Dental
- Orthodontia
- Emotional Health
- Vision
- Hearing
- Infertility
- Gender-Affirming Care
- Prescription Drug
- Alternative Care
- Chiropractic Care

Get the Most Out Of Your Coverage

Find a doctor you love

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.

If you have coverage through **Kaiser Permanente of Washington**, you can choose a primary care doctor though their website. Login or register your account at **myseiu.be/kp-login**, then you can choose a doctor.

If you have coverage through **Kaiser Foundation Health Plan of the Northwest**, you can choose a primary care doctor through their website. Login or register your account at **myseiu.be/kpnw-login**, then you can choose a doctor.

If you have coverage through **Aetna**, you can choose a primary care doctor through their website. Login or register your account at **myseiu.be/aetna-login** then you can choose your doctor.

EPIC HEARING HEALTHCARE

Hearing Benefits with No Co-pay!

Through EPIC hearing you can get up to $1,200 worth of hearing hardware for each ear with no co-pay as well as in-person or online visits. Get started at **myseiu.be/eic**.

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. If you are feeling stressed or overwhelmed try Ginger. With Ginger, you can chat with a coach through a secure smartphone app 24/7, as well as get secure and confidential video visits with a licensed therapist.

Your family members over the age of 18 can also get Ginger for free. Contact your health insurance provider to learn about the specific benefits available to you.

NEW THIS YEAR!

Changes to your coverage this year (across all plans):

- $0 co-pay for preferred generic and preferred brand insulin.
- $25 co-pay for non-preferred brand insulin.
- Increased alternative care (such as acupuncture and chiropractic care) is now covered for up to 20 visits per year. -Unlimited naturopathic care.
- An improved infertility benefit, including a new pharmacy benefit for fertility needs.

SEIU 775 BENEFITS GROUP

Alternatives to Using the Emergency Room

If you are in need of immediate care, look for your closest urgent care center or make a same-day appointment with your doctor. Doing so can save you money.

Save 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.

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.

Manage Your Prescriptions Wisely

Prescription drug coverage is a big part of your health benefits. Make the most of it by understanding your choices when it comes to prescriptions.

See Your Doctor for Free

With your Kaiser Permanente or Aetna coverage there is no co-pay when you see your primary care doctor (also called a primary care provider, or PCP). You can see your PCP for wellness check-ups, when you are sick or if you need a referral to a specialist.

- If you have coverage through Kaiser Permanente of Washington, learn more at **myseiu.be/kaiser-online**.
- If you have coverage through Aetna, learn more at **myseiu.be/aetna-online**.

KPWA

Save with Urgent Care	
Emergency Room $200 Co-pay, then 20% co-insurance	Urgent Care / Doctor Visit $0 Co-pay, deductible does not apply

Rx Co-pay (In-network)	At Pharmacy (up to a 30-day supply)	Mail Order (up to a 90-day supply)
Generic Contraceptives	$0	Some medications qualify for a discount when ordered through prescription mail order services.
Value-Based Drugs	$4	
Generic Drugs	$8	
Formulary Brand Name Drugs	$25	

Aetna

Save with Urgent Care	
Emergency Room $200 co-pay, then 20% co-insurance	Urgent Care / Doctor Visit $25 co-pay, deductible does not apply

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

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

KAISER PERMANENTE®

KPWA Elect HMO Plan Summary

Effective Date 8/1/2023

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: Dependent children are eligible to enroll in this plan through their 26th birthday.

Benefits	Inside Network
Plan deductible	**Individual:** $1,500 per calendar year **Family:** $3,000 per calendar year
Individual deductible carryover	4th quarter carryover does not apply
Plan coinsurance	The Plan pays 80%, you pay 20%
Out-of-pocket limit	**Individual:** $6,250 **Family:** $12,500
Pre-existing condition (PEC) waiting period	No PEC waiting period
Lifetime maximum	Unlimited
Outpatient services (Office visits)	No co-pay primary/$25 co-pay specialty, deductible and co-insurance do not apply
Hospital services	**Inpatient services:** $100 co-pay, per day for up to 5 days per admit. Pre-authorization required or will not be covered. **Outpatient surgery:** $50, deductible and co-insurance apply
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 Insulin/preferred generic (Tier 1): $0 co-pay
Prescription mail order (up to 90-day supply)	Some medications qualify for a discount when ordered through prescription mail order services
Acupuncture	$0 co-pay Covered up to 20 visits per medical diagnosis per calendar year without prior authorization; additional visits when approved by the plan - covered in full.
Ambulance services	Plan pays 80%, you pay 20%
Chemical dependency	**Inpatient:** $100 co-pay per day, up to 5 days per admit. Pre-authorization required or will not be covered. **Outpatient:** $0 co-pay
Devices, equipment and supplies	Covered at 50%. Pre-authorization required or will not be covered. • Durable medical equipment • Orthopedic appliances • Post-mastectomy bras limited to two (2) every six (6) months • Ostomy supplies • Prosthetic devices
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 Deductible and co-insurance apply.

Benefits	Inside Network
Hearing exams (1 routine exam per 12 months)	$0 co-pay, deductible and co-insurance do not apply
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 myseiu.be/epic.
Home health services	Covered in full. No visit limit. Pre-Authorization required or will not be covered.
Hospice services	Covered in full. Pre-authorization required or will not be covered.
Infertility services	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 $35,000
Manipulative therapy	Covered up to 20 visits per calendar year without prior authorization - $0 co-pay.
Massage services	See Rehabilitation services
Maternity services	**Inpatient:** $100 co-pay, per day for up to 5 days per admit **Outpatient:** $0 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. Pre-authorization required or will not be covered. **Outpatient:** $0 co-pay
Naturopathy	$0 co-pay, deductible and co-insurance do not apply. Unlimited visits per calendar year without preauthorization. Covered in full.
Newborn Services	**Initial hospital stay:** See Hospital Services; Office visits: See Outpatient Services; Routine wellness 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. Deductible and co-insurance apply **Outpatient:** $0 copay, deductible and co-insurance do not apply
Preventive care: Well-care physicals, immunizations, Pap smear exams, mammograms	Covered in full Contraceptive drugs and devices 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. Pre-authorization required or will not be covered. **Outpatient:** 60 visits per calendar year. Services with mental health diagnoses are covered with no limit. No co-pay primary/$25 co-pay specialty, deductible and co-insurance do not apply
Skilled nursing facility	Deductible and co-insurance apply. Covered up to 60 days per calendar year. Prior authorization required or will not be covered.
Sterilization (vasectomy, tubal ligation)	Covered in full.
Temporomandibular Joint (TMJ) services	**Inpatient:** $100 co-pay, per day for up to 5 days per admit. Deductible and co-insurance apply. **Outpatient:** $0 copay, deductible and co-insurance do not apply
Tobacco cessation counseling	Quit for Life Program - covered in full
Routine vision care (1 visit every 12 months)	$0 co-pay, deductible and co-insurance do not apply
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:** $300 per 12 months

aetna[SM]

Aetna PPO Plan Summary

Effective Date 8/1/2023

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: Dependent children are eligible to enroll in this plan through their 26th birthday.

Benefits	In-Network	Out-of-Network
Plan deductible	**Individual deductible:** $1,500 per calendar year **Family deductible:** $3,000 per calendar year	**Individual deductible:** $3,000 per calendar year **Family deductible:** $6,000 per calendar year
Plan coinsurance	The Plan pays 80%, you pay 20%	The Plan pays 50%, you pay 50%
Out-of-pocket limit	**Medical services:** **Individual:** $5,250 **Family:** $10,500 **Prescription drugs:** **Individual:** $1,000 **Family:** $2,000	**Medical Services:** None **Prescription drugs:** None
Pre-existing condition (PEC) waiting period	No PEC waiting period	Same as in-network
Lifetime maximum	Unlimited	Same as in-network
Outpatient services (Office visits)	$25 co-pay, deductible waived. All visits with your designated primary care provider (PCP) will have a $0 co-pay.	$25 co-pay, co-insurance applies. Deductible waived.
Hospital services	**Inpatient services:** Deductible and co-insurance apply **Outpatient surgery:** $25 co-pay, co-insurance applies. Deductible waived	**Inpatient services:** Deductible and co-insurance apply **Outpatient surgery:** $25 co-pay, deductible and co-insurance apply
Prescription drugs (some injectable drugs may be covered under Outpatient services)	Value-based Tier: Preferred generic (Tier 1)/preferred brand (Tier 2)/nonpreferred (Tier 3) $0/$0/$35 co-pay Insulin: Preferred generic (Tier 1)/preferred brand (Tier 2)/non-preferred (Tier 3) $0/$0/$25 co-pay	Value-based Tier: Preferred generic/preferred brand/non-preferred $13/$30/$55 co-pay Insulin: Preferred generic (Tier 1)/preferred brand (Tier 2)/non-preferred (Tier 3) $13/$30/$35 co-pay
Prescription mail order	2 x prescription cost share per 90 day supply	Not covered
Acupuncture	20 visits per calendar year $0 co-pay	Shared with preferred provider visit limit $15 co-pay, deductible and coinsurance apply
Ambulance services	Plan pays 80%, you pay 20%	Same as preferred provider benefit
Chemical dependency	**Inpatient:** $100 co-pay, per day for up to 5 days per admit. Co-insurance applies, deductible waived. **Outpatient:** Fully covered, deductible waived	**Inpatient:** $100 co-pay per day, up to 5 days per admit. Deductible and co-insurance apply. Penalty of $400 for failure to obtain pre-authorization for out-of-network care. **Outpatient:** $25 co-pay, deductible and coinsurance apply

Benefits	Preferred Provider Network	Non-Preferred Provider Network
Devices, equipment and supplies • Durable medical equipment • Orthopedic appliances • Post-mastectomy bras • limited to two (2) every • six (6) months • Ostomy supplies • Prosthetic devices	Co-insurance applies, deductible waived	Deductible and co-insurance apply
Diabetic supplies	See: Prescription Drugs	See: Prescription Drugs
Diagnostic lab and X-ray services	**Inpatient:** Covered under hospital services **Outpatient:** Deductible and co-insurance apply	**Inpatient:** Covered under hospital services **Outpatient:** Deductible and co-insurance apply
Emergency services (co-pay waived if admitted)	$200 co-pay. Co-insurance and deductible apply	Same as in-network
Hearing exams (routine)	Fully covered, deductible waived	Deductible and co-insurance apply
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 myseiu.be/hearing	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 myseiu.be/hearing
Home health services	Fully covered, up to 130 visits total per calendar year. Deductible waived	Shared with preferred provider visit limit, deductible and coinsurance apply. Penalty of $400 for failure to obtain pre-authorization for out-of-network care.
Hospice services	Fully covered, deductible waived	Deductible and coinsurance apply. Penalty of $400 for failure to obtain pre-authorization for out-of-network care.
Infertility services	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 $35,000	Not covered
Manipulative therapy	Covered up to 20 visits per calendar year without prior authorization $0 co-pay	Visit limits shared with in-network $15 co-pay, deductible and coinsurance apply
Massage services	$15 co-pay (20 visits per calendar year)	Shared with preferred provider visit limit $15 co-pay, deductible and coinsurance apply
Maternity services	**Inpatient:** $100 co-pay, per day for up to 5 days per admit. Co-insurance applies, deductible waived **Outpatient:** $25 co-pay, deductible waived. Routine care not subject to outpatient services co-pay.	Penalty of $400 for failure to obtain pre-authorization for out-of-network care. **Inpatient:** $100 co-pay, per day for up to 5 days per admit, deductible and coinsurance apply. **Outpatient:** $25 co-pay, deductible and coinsurance apply.
Mental Health	**Inpatient:** $100 co-pay per day, up to 5 days per admit. Co-insurance applies, deductible waived **Outpatient:** Fully covered, deductible waived	**Inpatient:** $100 co-pay per day, up to 5 days per admit. Deductible and co-insurance apply. Penalty of $400 for failure to obtain pre-authorization for out-of-network care. **Outpatient:** $25 co-pay, deductible and co-insurance apply
Naturopathy	Unlimited visits per calendar year without preauthorization. $0 Co-pay	$25 co-pay, deductible and coinsurance apply

Benefits	Preferred Provider Network	Non-Preferred Provider Network
Newborn Services	**Initial hospital stay:** See Hospital Services; Office visits: See Outpatient Services; Routine well care: See Preventive care. Any applicable cost share for newborn services is separate from that of the mother.	**Initial hospital stay:** See Hospital Services; Office visits: See Outpatient Services; Routine well care: See Preventive care. Any applicable cost share for newborn services is separate from that of the mother.
Obesity-related surgery (bariatric)	Covered at cost shares when medical criteria is met	Not covered
Organ transplants	Unlimited, no waiting period **Inpatient:** $100 co-pay, per day for up to 5 days per admit. Co-insurance applies **Outpatient:** $25 co-pay, deductible waived	Not covered Non-Preferred coverage is provided at a Non-IOE facility.
Preventive care (Well-care physicals, immunizations, Pap smear exams, mammograms)	Fully covered, deductible waived Women's preventive care services (including contraceptive drugs and devices and sterilization) are covered in full.	Deductible and co-insurance apply
Rehabilitation services (Rehabilitation visits are a total of combined therapy visits per calendar year)	$25 co-pay, deductible waived Covered up to 60 visits per year	$25 copay, deductible and co-insurance apply Visit limit shared with in-network
Skilled nursing facility	Deductible and co-insurance apply Covered up to 60 days per calendar year	Day limits shared with in-network limit, deductible and co-insurance apply. Penalty of $400 for failure to obtain pre-authorization for out-of-network care.
Sterilization (vasectomy, tubal ligation)	**Vasectomy:** Your cost sharing is based on the type of service and where it is performed **Tubal ligation:** Fully covered, deductible waived	**Vasectomy:** Your cost sharing is based on the type of service and where it is performed T**ubal ligation:** Not covered
Temporomandibular Joint (TMJ) services	Not covered	Not covered
Tobacco cessation counseling	Quit for Life Program - covered in full	Applicable cost shares apply
Routine vision care (1 visit every 12 months)	$15 co-pay	$15 co-pay, deductible and coinsurance apply
Optical hardware (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:** $300 per 12 months	Shared with preferred provider benefit

Your Choice of Dental Plans

Providers	Annual Maximum	Deductible	Routine Exams	Special Features
DELTA DENTAL®	$1,000	$0	Covered in Full	Broad network of providers, including rural areas
Willamette Dental Group	None	$0	Covered in Full	Convenient for members who live on the I-5 corridor

Your dental plan is included in your coverage.

Both dental plans offer orthodontia benefits.

Want to switch your dental plan? Complete and return the Health Benefits Application by July 20, 2023.

DELTA DENTAL®

PPO Plan

Effective Date 8/1/2023

Benefit Period: 1/1/2024 - 12/31/2024
Benefit Period Maximum (per person; does not apply to Class I): $1,000
Orthodontia—Adults & Children: 50%

	Delta Dental PPO Dentist	Delta Dental Premier Dentist	Non-Participating Dentist
Benefit Period Deductible			
Does Not Apply to Class I & Orthodontia Out of Network - $50 (Per Person)	None	$50	$50
Class 1- Diagnostic & Preventative			
Exams Cleaning Fluoride X-Rays Sealants	100%	80%	80%
Class II - Restorative			
Restorations Posterior Composite Fillings Endodontics (Root Canal) Periodontics Oral Surgery General Anesthesia/IV Sedation	100%	60%	60%
Class III - Major			
Dentures Partial Dentures Implants Bridges Crowns	80%	40%	40%

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℠ 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

For Delta Dental members who visit a Pacific Dental Alliance (PDA) provider as a new patient: you can receive a free Sonicare toothbrush.

Visit **myseiu.be/oe-pda** for the complete PDA provider list.

Willamette Dental Group

SEIU Healthcare NW/ Health Benefits Trust
Elect Plan - Employers
Effective Date 8/1/2023

Dental Benefit Summary Plan

Underwritten by Willamette Dental of Washington, Inc. 6950 NE Campus Way, Hillsboro, OR 97124
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. For a list of limitations and exclusions, visit **myseiu.be/willamette-exclusions**.

Benefits	Co-pays
Annual Maximum	No Annual Maximum*
Deductible	No Deductible
General & Orthodontic Office Visit	You pay $20 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)	You pay a $35 Copay
Porcelain-Metal Crown	You pay a $350 Copay**
Prosthodontics	
Complete Upper or Lower Denture	You pay a $500 Copay**
Bridge (per Tooth)	You pay a $350 Copay**
Endodontics & Periodontics	
Root Canal Therapy – Anterior	You pay a $150 Copay
Root Canal Therapy – Bicuspid	You pay a $250 Copay
Root Canal Therapy – Molar	You pay a $275 Copay
Osseous Surgery (per Quadrant)	You pay a $250 Copay
Root Planning (per Quadrant)	You pay a $115 Copay
Oral Surgery	
Routine Extraction (Single Tooth)	You pay a $40 Copay
Surgical Extraction	You pay a $175 Copay
Orthodontia Treatment	
Pre-Orthodontia Treatment	NOT COVERED
Comprehensive Orthodontia Treatment	NOT COVERED
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 per Visit
Out of Area Emergency Care Reimbursement	You pay charges in excess of $250

*Benefits for TMJ, implant surgery, and orthognathic surgery have a benefit maximum, if covered.
**Dental implant-supported prosthetics (crowns, bridges, and dentures) are not a covered benefit.
***Copay credited towards the Comprehensive Orthodontia Treatment copay if patient accepts treatment plan.