

Dora P.
Caregiver, Tacoma

2025-2026

Healthcare Coverage Guide



Call 1-877-606-6705 if you have questions
about coverage or need help applying.

Get healthcare coverage information in
your language.

احصل على معلومات تغطية الرعاية
الصحية بلغتك.

获取以您使用的语言提供的健康保险信息。

ទទួលបានព័ត៌មានអំពីការបានរៀបចំនូវភាពជាប្រជាជាតិ។

한국어로 된 의료 보험 정보를 확인하
십시오.

અપણી ભાષા વિંચ હૈલ્યક્સેઅર કર્વરેઝ બારે
જાણવારી પ્રાપ્ત કરો।

Получите информацию о медицинском
страховом покрытии на вашем языке.

Ku hel macluumadaad ceymiska daryeelka
caafimaadka luqaddaada.

Obtenga información sobre la cobertura
de atención médica en su idioma.

Отримайте інформацію про покриття
медичної страховки своєю мовою.

Nhận thông tin về bảo hiểm chăm sóc
sức khỏe bằng ngôn ngữ của bạn.

myseiu.be/oe

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Easily apply, update coverage or manage benefits online.

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Deborah needed open-heart surgery that would have cost hundreds of thousands of dollars without coverage. Worrying less about the costs, she says "I was able to focus on myself and my healing".

Deborah M.
Caregiver, Vancouver



Wellness Benefits



In addition to access to high-quality healthcare coverage, you have other benefits available at no cost to you—designed to help you reduce stress, be safe at work and improve your quality of life.



Caregiver Kicks: Free Shoes for Caregivers

Get a free pair every year! Available in 90+ styles from Reebok to Sketchers, Caregiver Kicks are slip-resistant shoes designed to keep you safer and more comfortable on the job. myseiu.be/kicks



Self-care Benefits

Caregivers often put others first, but self-care matters too. There are many free and low-cost benefits for caregivers that can help address stress, anxiety and depression. myseiu.be/self-care

More Caregiver Benefits



Learn more about caregiver retirement, learning and job-matching benefits and how to access them at seiu775benefitsgroup.com.

Step-by-Step Guide to Applying for Coverage

The enrollment process was fairly easy. I just went through the booklet and highlighted things that were important to me. Being able to do it online was simple.”

Acacia V., Caregiver

1 Learn about your coverage

- Explore your coverage options and benefit highlights in this guide.
- Check eligibility details on page 8 to see if you qualify.
- Review the Plan Details Booklet to understand your plan's out-of-pocket costs for prescriptions, treatments and services.
- Select a coverage option and dental plan.

Health Benefits Customer Service: 1-877-606-6705

Get help with questions about coverage, eligibility and applying.

2 Prepare to apply

- Gather your information. You will need your Social Security number and employer name to apply.
- **Coverage for Kids:** Gather your Dependent Verification documents. See a list of accepted documents and instructions at myseiu.be/cfk.

3 Create a health benefits account

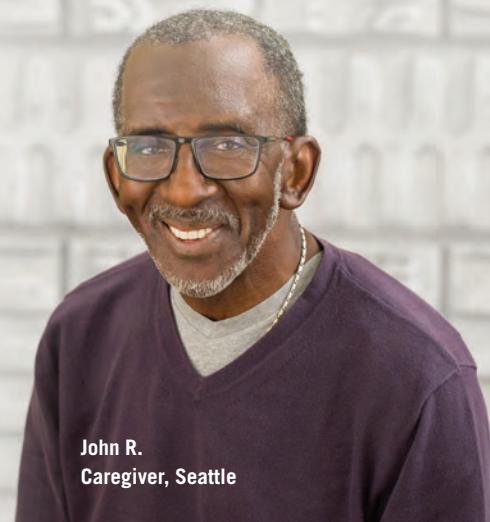
- Visit myseiu.be/hba to learn how to create an account. Once you have an account, you can log in anytime at myseiu.be/magnacare.

4 Submit your application

- Complete an application before the deadline at myseiu.be/magnacare. Learn more about deadlines and how to submit by mail on page 8.
- **Coverage for Kids:** Submit Dependent Verification documents when you apply. Learn how to submit your documents at myseiu.be/cfk.

5 Receive application notifications

- You'll receive an application receipt by email or through your health benefits account within 1 day and a coverage decision by letter or email within 30 days. If not, call 1-877-606-6705.



John R.
Caregiver, Seattle

Healthcare Coverage Plan Options

Get high-quality healthcare coverage starting at just \$25 a month. You can choose to cover just yourself or add Coverage for Kids for your dependent children.



After her second child, Dani enrolled both kids in Coverage for Kids, praising the "great rates" that help her family save monthly.

Dani R.
Caregiver, Asotin



Individual Coverage Medical and Dental

\$25/mo.

Monthly Co-premium

Get medical and dental coverage for yourself for just \$25 a month.

Monthly Co-premium: the amount you pay each month for your health coverage, see page 9 for details.

Eligibility

Work 80 hours or more a month.

Option 2



Individual Coverage + Coverage for Kids Medical and Dental

\$125/mo.

Monthly Co-premium

Get medical and dental coverage for yourself, plus your kids, for just \$125 a month.

Option 3



Individual Coverage + Coverage for Kids Dental-Only

\$35/mo.

Monthly Co-premium

Get medical and dental coverage for yourself, plus dental coverage for your kids, for just \$35 a month.

It's the same cost, no matter how many kids you add!

You can add eligible dependent children up to their 26th birthday, including biological, adopted, stepchildren and domestic partners' children.

KPWA POS members must switch plans to add Coverage for Kids.

Eligibility

Work 120 hours or more a month.

2025
**New and
Improved
Benefits**

Coverage Benefit Highlights

Coverage Reliability

Caregivers now receive 2 Coverage Reliability Credits per year. Each credit extends healthcare coverage for 1 month if you don't meet required work hours—providing continuous coverage for you and your dependents.

Progyny Adoption Benefit

Get up to \$15,000 for adoption-related expenses (lifetime benefit¹).

¹The maximum amount covered for adoption-related expenses for as long as you're enrolled in the plan.

Lowered Prescription Costs

Reduced costs for non-preferred brand inhalers, EpiPens and HIV post-exposure drugs and therapies.

Gender-Affirming Care Benefits

All plans now cover a variety of procedures and therapies.

Caregivers deserve access to high-quality, reliable healthcare that allows them to focus on delivering exceptional care—without the stress of managing their benefits. These latest enhancements reflect our continued commitment to offering coverage that truly supports the caregiver experience.

Merissa Clyde
CEO,
SEIU 775
Benefits Group



The health plan available to you is based on your home ZIP code. Your assigned plan offers many ways to support your health and well-being. Coverage includes the following benefits:

- ✓ Medical
- ✓ Preventive Care
- ✓ Dental & Orthodontia
- ✓ Prescription Drug
- ✓ Mental Health
- ✓ Vision
- ✓ Hearing
- ✓ Family-building & Reproductive Health Benefits
- ✓ Gender-Affirming Care
- ✓ Massage & Chiropractic
- ✓ Physical Therapy

Free Primary Care Visits

There is no cost* to see your primary care provider (PCP). You can see your PCP for wellness check-ups and when you're sick. Your coverage also includes virtual care options, so you can get care from the comfort of home.

*Visits with your PCP have no co-pay, however if your doctor orders tests or lab work, you may have to pay a co-pay on those services.

Urgent and Emergency Care

Your plan covers urgent care and emergency room visits. Urgent care is a low-cost option for non-emergency issues like minor injuries or flu symptoms when your doctor isn't available. Emergency room visits have a \$200 co-pay and should be used for serious conditions like chest pain, difficulty breathing or severe injuries.

A deductible or co-pay may apply.

Prescription Benefits

You have access to a wide range of prescription medication (Rx) at little-to-no cost, depending on the medication tier. Generic medications typically have the lowest co-pay, while brand name and specialty drugs may have higher costs. Mail-order options are also available, allowing you to receive a 90-day supply of medications delivered to your home.

Mental Health Benefits

Your emotional and mental health is as important as your physical health. Your coverage includes professional support, medication, group therapy and alternative care, as well as access to self-care apps and other programs and resources.

Vision Benefits

Your coverage provides comprehensive eye care. This includes 1 free eye exam every 12 months, and \$600 every 12 months for vision hardware (like lenses, frames and contacts).

Hearing Benefits

Through EPIC Hearing, you and your kids can get a no-cost annual hearing exam with consultation from an in-network provider. Plus up to \$3,000 of hearing hardware with extended warranty per ear every 36 months.



"One time, I was really sick and was in the hospital for 45 days. Because I have health coverage, I only paid a little bit and insurance paid most of it. That's why it's really important to have coverage."

Amy L.
Caregiver, Seattle

Wellness Coaching & Programs

Wellness benefits and coaching can help you address chronic conditions like diabetes or high blood pressure, as well as improve your physical health. Your plan includes:

- One-on-one wellness coaching for personalized guidance to reach your goals.
- Support from a care team to help manage your condition.
- Programs and apps for easy management and tracking.

Massage & Chiropractic

Muscle and joint pain can be treated and prevented with low-cost physical therapy, massage, chiropractic, acupuncture and virtual wellness programs.

Check your plan details for visit limits or referral requirements and confirm with your provider that they accept your insurance when scheduling an appointment.

Family-building & Reproductive Health Benefits

Get benefits for every stage of life, from fertility and family-building to pregnancy, postpartum and menopause. Get coverage for the latest treatments, personalized support from dedicated Patient Care Advocates (PCAs) and in-person or virtual care. And now you can get up to \$15,000 for adoption-related expenses (lifetime benefit).



See the Plan Details Booklet for a Full List of Benefits.

The Plan Details Booklet provides a full breakdown of your medical and dental plans, including out-of-pocket costs, and coverage for prescriptions, visits and treatments.

Dental Plan

**Dental is included in your healthcare coverage.
Select the plan that's right for you.**

Use the chart to compare plans and review your potential out-of-pocket costs for common services in the Plan Details Booklet.

If you're already enrolled in coverage and would like to switch your dental plan, you can do so during Open Enrollment.



	 DELTA DENTAL®	 Willamette Dental
Annual Maximum Benefit	\$5,000	None
Deductible	\$0	\$0
Routine Exams	Covered In Full	Covered In Full
Orthodontia Benefits	Yes	Yes
Provider Network	Delta Dental has a broad network of providers, including in rural areas. You'll want to find a Delta Dental PPO dentist to maximize your benefit.	Willamette Dental has many convenient locations in western Washington, making it easy to find a Willamette dentist if you live along the I-5 corridor.
Find a Dentist Near You	Visit deltadentalwa.com/fad/search and select 'Delta Dental PPO' to filter your search results.	Visit locations.willametedental.com and enter your ZIP code into the search bar.
For Questions or More Information	1-800-554-1907 DeltaDentalWA.com	1-855-433-6825 myseiu.be/willamette



Apply for Coverage Online



Learn how to create an account at myseiu.be/hba

Accounts are currently available in English. If you need help making an account or language support call **1-877-606-6705**.

Your online account is managed by MagnaCare, the administrator of your health benefits.

In addition to being able to apply for healthcare coverage or make changes, you can pay co-premiums, view payment history, access plan documents and sign up for email communications.



Check Your Eligibility

View your work hours and eligibility for coverage and other wellness benefits like Caregiver Kicks.



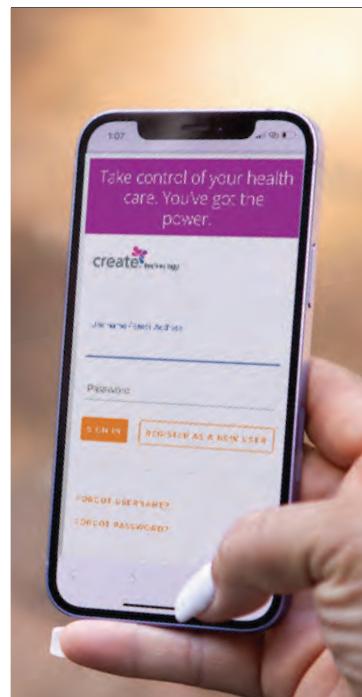
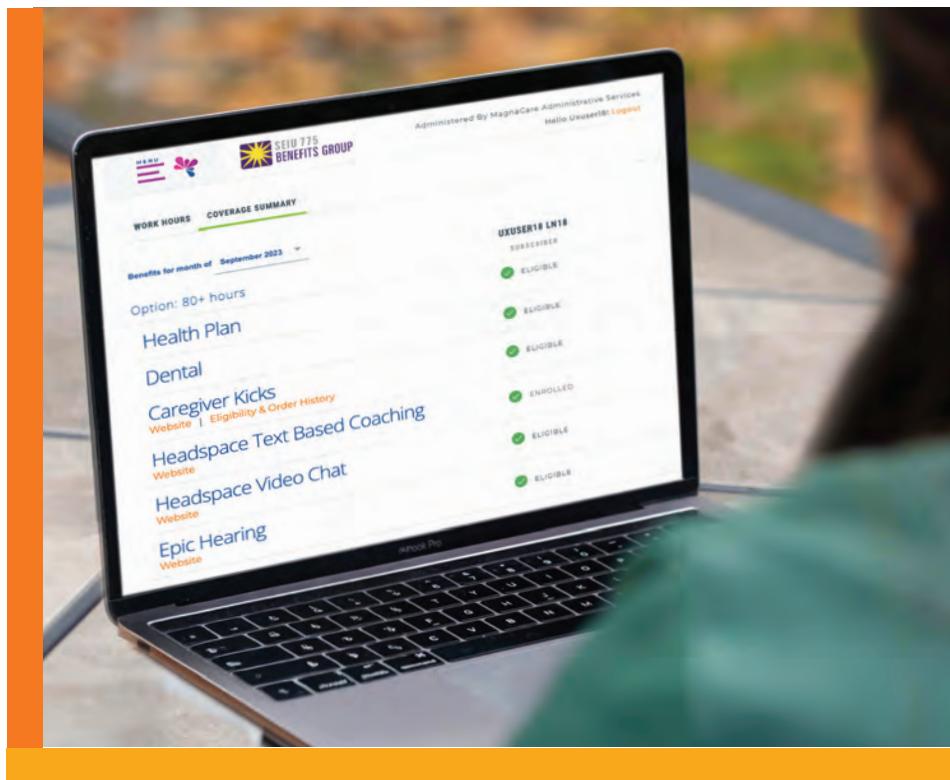
Apply or Update Coverage

Access your account to easily apply online or make changes to existing coverage.



Get Live Chat Support

Get help with questions about applying, eligibility and more from Health Benefits Customer Service.



Healthcare Coverage FAQ

How do I become eligible for individual coverage?

You must work **80 paid hours or more a month** for 2 months in a row to become eligible for individual coverage.

How do I apply?

Apply or make changes online at myseiu.be/magnacare.

If you receive a Health Benefits Application you can mail or fax the completed application to the address or fax number listed on the application. U.S. postage is required.

You'll receive an application receipt by email or through your health benefits account within 1 day and a coverage decision by letter or email within 30 days. If not, call 1-877-606-6705.

When can I apply?

There are 3 times when you can apply for coverage:

1. Initial Eligibility: Within 60 days of the date on your newly eligible enrollment materials. Initial eligibility is when you become eligible for the first time.

2. Open Enrollment: July 1-20 each year.

If you're already enrolled your coverage renews automatically, no action is needed unless you want to make changes.

3. Qualifying Life Event (QLE): Within 30 days of a QLE that changes your health insurance needs. Examples of QLEs include adopting a baby, losing other healthcare coverage or getting a divorce. For more information, visit myseiu.be/qle.

Not Eligible Yet? You can still apply during Open Enrollment, July 1-20.

Complete a Health Benefits Application* and your individual coverage will start when you work 80+ hours a month. If you want to add Coverage for Kids, dependent coverage begins when you work 120+ hours a month.

*If you don't currently work 80+ a month, you can't complete an application online. Email SEIU775BG-caregiver@magnacare.com to request a copy of the application form.

How do I become eligible for Coverage for Kids?

You must work **120 paid hours or more a month** to become eligible for Coverage for Kids.

Who can I add to Coverage for Kids?

You can add eligible children through their 26th birthday. Eligible dependent children include biological, adopted, stepchildren and children of your domestic partner.

Children are enrolled in the same plan as you and can only be enrolled under one caregiver. Coverage can coordinate with outside plans. For more information, call 1-877-606-6705.

How do I add Coverage for Kids?

1. Complete the Coverage for Kids section of the application.

2. Choose a coverage option, medical and dental or dental-only.

3. Submit your Dependent Verification document(s) with your application or within 60 days of applying**. Examples of accepted documents include copies of government-issued birth certificates and tax returns listing the dependents you want to add to your coverage.

**Dependent Verification is needed when enrolling children for the first time. You don't need to resubmit previously verified documents, unless requested.

Visit myseiu.be/cfk for detailed information on:

- How to apply for Coverage for Kids.
- Who you can add to coverage.
- A list of accepted verification documents.
- How to submit your documents.



When will coverage begin?

Open Enrollment: Submit applications or changes by July 20 for coverage starting August 1.

Initial Eligibility and Qualifying Life Events: Coverage begins on the 1st of the month after your application is received and processed, which takes about 2 weeks. For example, if your completed application is received:

- by March 15, coverage will begin April 1.
- between March 16 - 31, coverage will begin May 1.

Coverage for Kids can't begin until after your dependent verification is received and processed.

What if I want to end coverage?

To end coverage for yourself or your children, submit a Waive Coverage form. Waiver received:

- by the 15th ends coverage on the 1st of the next month.
- after the 15th ends coverage on the 1st of the second month.

Important: You can only re-enroll during Open Enrollment or after a Qualifying Life Event. Waivers received before July 1 of the current year reset during Open Enrollment. If you had coverage in the past 12 months, you will be automatically re-enrolled unless you submit a new Waive Coverage form.

How do I pay my monthly co-premium?

Your employer will automatically deduct your monthly co-premium (the amount you pay each month) from your wages. If your employer is not able to make the deduction, you will receive a self-pay letter in the mail and by email directing you to pay your co-premium. You can pay by check, or using your online health benefits account.

If you're an individual provider (IP) with CDWA, your first monthly payment will be a self-pay.

What happens if I lose coverage?

You'll receive information about COBRA (Consolidated Omnibus Budget Reconciliation Act), administered by Ameriflex (1-877-606-6705). COBRA allows caregivers and their children to maintain coverage for a monthly payment.

If you stop caregiving and need long-term coverage, check eligibility for free Washington Apple Health or explore other options at wahealthplanfinder.org.

How do the hours I work affect my coverage?

Once you're enrolled in coverage, the hours you work in one month determine your coverage status 2 months later. Example: January's hours determine coverage in March.

Work Month	Coverage Month
JANUARY	→ MARCH
FEBRUARY	→ APRIL
MARCH	→ MAY
APRIL	→ JUNE
MAY	→ JULY
JUNE	→ AUGUST
JULY	→ SEPTEMBER
AUGUST	→ OCTOBER
SEPTEMBER	→ NOVEMBER
OCTOBER	→ DECEMBER
NOVEMBER	→ JANUARY
DECEMBER	→ FEBRUARY

The paid hours you work this month:
Determine coverage this month:

Get more hours to maintain your coverage.

If you're an Individual Provider (IP) and need more hours to get or keep coverage, try Carina, a free job-matching website that helps you find more clients. Learn more at myseiu.be/carina.





Maintain Your Healthcare Coverage

Once you have coverage, you must do the following to maintain continuous healthcare coverage.

!✓ Work your required hours.

Individual coverage: You must work 80 paid hours or more per month to keep your coverage. **Coverage for Kids:** You must work 120 paid hours or more per month to keep dependent coverage. If your hours fall below 120, but remain above 80, you will lose Coverage for Kids but keep your own coverage.

!✓ Report your hours on time.

You'll lose coverage if you don't report your work hours on time. You must submit late hours or adjustments with your employer within 60 days of the worked month.

!✓ Pay your full monthly co-premium.

See the previous page for more information.

Learn more about maintaining your coverage at myseiu.be/maintain

See examples of what happens when you can't work your required hours with and without Coverage Reliability credits.

Coverage Reliability

Unpredictable schedules can make it difficult to meet required work hours. The Coverage Reliability benefit helps ensure continuous healthcare coverage, even when you're unable to work as planned.

How Coverage Reliability Works:

- You get **2 credits per coverage year** (August–July).
- Each credit **extends coverage for 1 month** if you don't meet the required work hours. A credit covers both you and your dependents' coverage.
- **Credits apply automatically**—no action is needed.
- You can **check your credit balance** anytime by logging into your health benefits account.

Frequently Asked Questions:

When do my credits reset?

Your 2 credits reset on August 1 of each year. They are available as soon as you're enrolled.

Do unused credits carry over to the next year?

No. Each year on August 1, you receive 2 new credits. Unused credits don't roll over.

Can I use my credits for consecutive months?

No, you cannot use credits 2 months in a row.

What if I work enough hours for individual coverage, but not enough for Coverage for Kids?

In this case 1 credit will be applied to extend your children's coverage for that month.

If I use a credit, do I still pay my monthly co-premium?

Yes, you are still responsible for your co-premium that month. See page 9 for more information on co-premiums.

HEALTH BENEFITS



Customer Service

Get help with questions about coverage, eligibility, applying and more.

Customer service is available Monday-Friday, 8 a.m. to 6 p.m.

1-877-606-6705

In-language support available.

Live Chat Support

Log in to myseiu.be/magnacare for chat support.

SEIU775BG-caregiver@magnacare.com

Can't contact customer service during business hours?

Email and get a response within 2 business days.



Additional Resources

Common Insurance Terms

Better understand your coverage by learning the definitions of common health insurance terms.

myseiu.be/hc-terms

Coverage for Kids

Learn how to apply for Coverage for Kids and what documents are needed to complete your application.

myseiu.be/cfk

Use Your Coverage

Get tips on making the most of your benefits to support your well-being once you're covered.

myseiu.be/covered



2025-2026 HEALTHCARE COVERAGE

Plan Details Booklet

This booklet includes important documents to help you understand your healthcare coverage:

Summary of Material Modifications (SMM):

Lists any updates or changes to your plan starting August 1, 2025.

Medical & Dental Plan Snapshot:

A quick, easy-to-read overview of your benefits for your medical plan and dental options, created by SEIU 775 Benefits Group.

Summary of Benefits and Coverage (SBC):

A detailed explanation of your plan, including:

- How common medical needs and prescriptions (like doctor visits, labs, diabetes care, etc.) are covered.
- What you pay and what the plan pays (deductibles, co-pays, coinsurance).
- What's included—and what's not (limitations or exclusions to coverage).

Plan Resources:

Contact numbers and websites to use once you're enrolled.

You're eligible for the Kaiser Permanente of Washington POS medical plan. This plan is effective from August 1, 2025, to July 31, 2026.

For more information about the SBC, SMM or other coverage questions, please contact Health Benefits Customer Service at:

1-877-606-6705

Monday – Friday, 8:00am – 6:00pm PST

SEIU775BG-caregiver@magnacare.com

Maila C.
Caregiver, Seattle



Summary of Material Modifications

**to Health Insurance Coverage provided through
the SEIU Healthcare NW Health Benefits Trust for
Consumer Direct of Washington (CDWA) Individual
Providers (IPs) and Agency Providers (APs)**

This Summary of Material Modifications (“SMM”) modifies some of the information contained in the Summary Plan Description (“SPD”) for the Core Plan health insurance coverage (the “Plan”) that describes the Plan as of August 1, 2025.

Effective August 1, 2025, plan benefits and the eligibility rules for healthcare coverage will change. APs and IPs should be aware of the following benefit enhancements:

Coverage Reliability provides caregivers with 2 credits per year. Each credit extends healthcare coverage for 1 month if you don't meet required work hours—providing continuous coverage for you and your dependents.

A \$15,000 lifetime adoption benefit offered by Progyny.

Reduced prescription cost shares for:

- Inhalers and EPI pens.
- 1 regimen of HIV post-exposure drugs and therapies will be reduced to \$0.

If you are enrolled in Aetna coverage, you can now access expanded Gender-Affirming Care:

- Second-tier medical necessity documentation requirements are removed.
- Voice modification therapy and body contouring procedures now available.

For further information regarding these changes, please contact Customer Service at 1-877-606-6705 Monday through Friday, 8:00am – 6:00pm PST or email SEIU775BG-caregiver@magnacare.com.



2025-2026 HEALTHCARE COVERAGE

Medical & Dental Plan Snapshot

A quick, easy-to-read overview of your medical plan and dental options, created by SEIU 775 Benefits Group.



Alyssa E.
Caregiver, Mount Vernon



Self-Insured Options POS Plan Snapshot

Effective Date 8/1/2025

This is a brief summary of benefits provided by SEIU 775 Benefits Group. 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.

Benefits	Inside Network	Outside Network
Plan deductible	No annual deductible	Individual deductible: \$500 per calendar year
Individual deductible carryover	Not applicable	4th quarter carryover applies
Plan coinsurance	No plan coinsurance	Plan pays 80%, you pay 20% of the Allowed Amount.
Out-of-pocket limit	Individual out-of-pocket limit: \$1,200 Out-of-pocket expenses for the following covered services are included in the out-of-pocket limit: All cost shares for covered services	Out-of-pocket limit is shared with in-network Out-of-pocket expenses for the following covered services are included in the out-of-pocket limit: All cost shares for covered services
Pre-existing condition (PEC) waiting period	No PEC	Same as in-network
Lifetime maximum	Unlimited	Same as in-network maximum
Outpatient services (Office visits)	No co-pay primary/\$15 co-pay specialty	\$15 co-pay, deductible and coinsurance apply
Urgent Care	Network Urgent Care Center: No co-pay primary/\$15 co-pay specialty	\$15 co-pay, deductible and coinsurance apply
Hospital services	Inpatient services: \$100 co-pay, per day for up to 5 days per admit Outpatient surgery: \$50 co-pay	Inpatient services: \$100 co-pay, per day for up to 5 days per admit. Deductible and coinsurance apply Outpatient surgery: \$50 co-pay, deductible and coinsurance apply
Prescription drugs* (some injectable drugs may be covered under Outpatient services)	Value based**/preferred generic (Tier 1)/preferred brand (Tier 2)/non-preferred (Tier 3) \$4/\$8/\$25/\$50 co-pay per 30 day supply Insulin: Preferred generic (Tier 1)/preferred brand (Tier 2)/non-preferred (Tier 3) \$0/\$0/\$25 Inhalers & EPI Pens: preferred generic (Tier 1)/preferred brand (Tier 2)/non-preferred (Tier 3) \$8/\$25/\$35 co-pay	Preferred generic/preferred brand/non-preferred \$13/\$30/\$55 co-pay per 30 day supply Insulin: Preferred generic (Tier 1)/preferred brand (Tier 2)/non-preferred (Tier 3) \$0/\$0/\$25 Inhalers & EPI Pens: preferred generic (Tier 1)/preferred brand (Tier 2)/non-preferred (Tier 3) \$8/\$25/\$35 co-pay
Prescription mail order	\$5 discount per 30 day supply	Not covered
Acupuncture	Covered up to 20 visits per medical diagnosis per calendar year without prior authorization; additional visits when approved by the plan - \$0 co-pay	\$15 co-pay, deductible and coinsurance apply
Ambulance services	Plan pays 80%, you pay 20%	Same as in-network

*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 Kaiser Permanente, if you're enrolled in a health plan. **Value-based drugs are generic medications for treating various health conditions.

Benefits	Inside Network	Outside Network
Chemical dependency	Inpatient: \$100 co-pay, per day for up to 5 days per admit Outpatient: \$0 co-pay	Inpatient: \$100 co-pay, per day for up to 5 days per admit, deductible and coinsurance apply Outpatient: \$15 co-pay, deductible and coinsurance apply
Devices, equipment and supplies <ul style="list-style-type: none"> • Devices, equipment and supplies • Durable medical equipment • Orthopedic appliances • Post-mastectomy bras limited to two (2) every six (6) months • Ostomy supplies • Prosthetic devices 	Covered at 100%. Pre-authorization required or will not be covered.	Covered at 50%, deductible applies
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.	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 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.	Inpatient: Covered under Hospital services Outpatient: Deductible and coinsurance apply 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	\$200 co-pay
Hearing exams (routine)	\$0 co-pay	\$15 co-pay, deductible and coinsurance apply
Hearing hardware	Covered through a separate benefit: EPIC Hearing. No co-pay, up to \$3,000 per ear every 3 years toward the cost of a hearing aid. Learn more at myseiu.be/epic	Covered through a separate benefit: EPIC Hearing. No co-pay, up to \$3,000 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.	No visit limit Deductible and coinsurance apply
Hospice services	Covered in full	Deductible and coinsurance apply
Infertility services	Covered through a separate benefit: Progyny Fertility and Family Building. 2+1 Smart Cycles to help members through their Fertility and Family Building journey. Learn more at myseiu.be/progyny	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	See Rehabilitation 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.	Inpatient: \$100 co-pay, per day for up to 5 days per admit, deductible and coinsurance apply Outpatient: \$15 co-pay, deductible and coinsurance apply. Routine care not subject to outpatient services co-pay.

Benefits	Inside Network	Outside Network
Mental Health	<p>Inpatient: \$100 co-pay, per day for up to 5 days per admit</p> <p>Outpatient: \$0 co-pay</p>	<p>Inpatient: \$100 co-pay, per day for up to 5 days per admit Deductible and coinsurance apply</p> <p>Outpatient: \$15 co-pay, deductible and coinsurance apply</p>
Naturopathy	\$0 co-pay. Unlimited visits per calendar year without preauthorization. Covered in full.	\$15 co-pay, deductible and coinsurance apply
Newborn Services	<p>Initial hospital stay: See Hospital Services; Office visits: See Outpatient Services; Routine well care: See Preventive care.</p> <p>Any applicable cost share for newborn services is separate from that of the mother.</p>	<p>Initial hospital stay: See Hospital Services; Office visits: See Outpatient Services; Routine well care: See Preventive care.</p> <p>Any applicable cost share for newborn services is separate from that of the mother.</p>
Obesity Related Services	Covered at cost shares when medical criteria is met	Covered at cost shares when medical criteria is met
Organ transplants	<p>Unlimited, no waiting period</p> <p>Inpatient: \$100 co-pay, per day for up to 5 days per admit</p> <p>Outpatient: \$0 co-pay</p>	<p>Shared with in-network</p> <p>Inpatient: \$100 co-pay, per day for up to 5 days per admit Deductible and coinsurance apply</p> <p>Outpatient: \$15 co-pay, deductible and coinsurance apply</p>
Preventive care Well-care physicals, immunizations, Pap smear exams, mammograms	<p>Covered in full</p> <p>Women's preventive care services (including contraceptive drugs and devices and sterilization) are covered in full.</p>	<p>Deductible and coinsurance apply</p> <p>Women's preventive care services (including contraceptive drugs and devices and sterilization) are subject to then applicable Preventive Care cost share and benefit maximums.</p> <p>Routine mammograms: Deductible and coinsurance apply</p>
Rehabilitation services Rehabilitation visits are a total of combined therapy visits per calendar year	<p>Inpatient: 60 days per calendar year. Services with mental health diagnoses are covered with no limit.</p> <p>\$100 co-pay, per day for up to 5 days per admit</p> <p>Outpatient: 60 visits per calendar year. Services with mental health diagnoses are covered with no limit.</p> <p>No co-pay primary/\$15 co-pay specialty</p>	<p>Inpatient: Day limits shared with in-network \$100 co-pay, per day for up to 5 days per admit Deductible and coinsurance apply</p> <p>Outpatient: Visit limits shared with in-network \$15 co-pay, deductible and coinsurance apply</p>
Skilled nursing facility	Covered in full up to 60 days per calendar year	Day limits shared with in-network benefit, deductible and coinsurance apply
Sterilization (vasectomy, tubal ligation)	Covered in full.	<p>Inpatient: \$100 co-pay, per day for up to 5 days per admit, deductible and coinsurance apply</p> <p>Deductible and coinsurance apply</p> <p>Outpatient: \$15 co-pay, deductible and coinsurance apply</p> <p>Women's sterilization procedures are covered subject to the applicable Preventive Care cost share and benefit maximums.</p>
Temporomandibular Joint (TMJ) services	<p>Inpatient: \$100 co-pay, per day for up to 5 days per admit</p> <p>Outpatient: \$0 co-pay</p>	<p>Inpatient: \$100 co-pay, per day for up to 5 days per admit, deductible and coinsurance apply</p> <p>Deductible and coinsurance apply</p> <p>Outpatient: \$15 co-pay, deductible and coinsurance apply</p>
Tobacco cessation counseling	Quit for Life Program - covered in full	Applicable cost shares apply
Routine vision care (1 visit every 12 months)	\$0 co-pay	\$15 co-pay, deductible and coinsurance apply
Optical hardware Lenses, including contact lenses and frames	<p>Members under 19: 1 pair of frames and lenses per year or contact lenses covered at 50% coinsurance</p> <p>Members age 19 and over: \$600 per 12 months</p>	Shared with in-network



PPO Dental Plan Snapshot
Effective Date 8/1/2025

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. Call the Delta Dental Customer Service department at **1-800-554-1907** or visit **DeltaDentalWA.com** if you have any questions.

Benefit Period:
1/1/2025-12/31/2025

Benefit Period Maximum*
(per person; does not apply to Class I):
\$5,000

Orthodontia—Adults & Children:
50% with a lifetime maximum
of \$5,000 per person

*Dental care received at a PDA dentists will be covered in full up to the \$2,000 maximum, with coinsurance waived with Class III - Major services.

Delta Dental Network
Your benefits go the furthest with the Delta Dental PPO network. You also get access to the Delta Dental Premier® network, which helps you expand your options.

Get a Free Sonicare Toothbrush

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

View the complete PDA provider list: myseiu.be/oe-pda.

	Delta Dental PPO	Delta Dental Premier	Out-of-Network
Benefit Period Deductible			
Does Not Apply to Class I & Orthodontia Out-of-Network (\$50 Per Person)	\$0	\$50	\$50
Class I- Diagnostic & Preventative			
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%
Features			
Least out-of-pocket costs	●		
Files claims forms for you	●	●	
Quality management and cost protection	●	●	

Dental Emergency: Participating Providers will provide treatment for Dental Emergencies during office hours. The Company will provide benefits for Covered Services provided by Participating Providers for treatment of a Dental Emergency. The Enrollee may see treatment for a Dental Emergency from a Non-Participating Provider if the Enrollee is more than 50 miles from any Participating Provider Office.

Underwritten by Willamette Dental of Washington, Inc., this plan provides extensive coverage. The below list gives information for some of the most common procedures covered in your plan. Call **1-855-433-6825** or visit myseiu.be/oe-willamette for more information. 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	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	
Fillings (Amalgam)	Covered with the Office Visit Co-pay
Porcelain-Metal Crown	You pay a \$250 Co-pay
Prosthodontics	
Complete Upper or Lower Denture	You pay a \$400 Co-pay
Bridge (per Tooth)	You pay a \$250 Co-pay
Endodontics & 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 \$1,500 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. **Dental Emergency:** Participating Providers will provide treatment for Dental Emergencies during office hours. The Company will provide benefits for Covered Services provided by Participating Providers for treatment of a Dental Emergency. The Enrollee may see treatment for a Dental Emergency from a Non-Participating Provider if the Enrollee is more than 50 miles from any Participating Provider Office.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. This is only a summary. For more information about your coverage, please contact your dedicated Progyny Pregnancy and Postpartum coach or your Progyny Patient Care Advocate (PCA) at (833) 233-0517.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Individual \$0 / Family \$0	There is no deductible with your Progyny plan.
Do I have a copayment?	No	There is no copayment with your Progyny Pregnancy and Postpartum plan.
Do I have coinsurance?	No	There is no coinsurance with your Progyny Pregnancy and Postpartum plan.
Are there services covered before you meet your deductible?	No	You will not pay an out-of-pocket for your Progyny Pregnancy and Postpartum services. All services provided under the plan are preventive care services and not subject to cost share.
Are there other deductibles for specific services?	No	There is no deductible required for the Progyny Pregnancy and Postpartum HRA plan. All services provided under the plan are preventive care services and not subject to cost share.
What is the out-of-pocket limit for this plan?	Individual \$0 / Family \$0	There is no out-of-pocket limit with your Progyny plan.
Will you pay less if you use a network provider?	Not applicable.	Progyny's Pregnancy and Postpartum coaches and care providers are all included in this plan. There are no benefits available for non-Progyny coaches.

Excluded Services & Other Covered Services:

Exclusions include home ovulation prediction kits, services and supplies furnished by an out-of-network provider, and treatments considered experimental by the American Society of Reproductive Medicine. All charges associated with services for a gestational carrier, including but not limited to fees for laboratory tests, are not covered. If your doctor requests services that are not listed in this guide, please check with your PCA to confirm coverage. There are some services that do not fall under Progyny's coverage; however, they may be provided through your medical plan.

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Healthcare.gov: www.HealthCare.gov or call 1-800-318-2596 or state health insurance marketplace or SHOP. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318- 2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, go to www.dol.gov/ebsa/healthreform and <http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants>.

Does this plan provide Minimum Essential Coverage? Not Applicable.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Not Applicable.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.



2025-2026 HEALTHCARE COVERAGE

Summary of Benefits and Coverage

A detailed explanation of your plan and examples to help you understand the costs you might pay for various services.



Patrick M.
Caregiver, Puyallup



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.kp.org/plandocuments or call 1-888-901-4636 (TTY: 711). For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other [underlined](#) terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-888-901-4636 (TTY: 711) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: \$0 Out-of-network provider : \$500 Individual / \$1,000 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible .
Are there services covered before you meet your deductible?	Yes. Preventive care and services indicated in chart starting on page 2.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network provider : \$1,200 Individual / \$2,400 Family Shared in and out-of-network	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums , balance-billing charges, health care this plan doesn't cover, and services indicated in chart starting on page 2.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider?	Yes. See www.kp.org or call 1-888-901-4636 (TTY: 711) for a list of network providers .	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes, but you may self-refer to certain specialists .	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist .



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge	\$15 / visit, then 20% coinsurance	None
	Specialist visit	\$15 / visit	\$15 / visit, then 20% coinsurance	None
	Preventive care/screening/ immunization	No charge	20% coinsurance , deductible does not apply.	You may have to pay for services that aren't preventive . Ask your provider if the services needed are preventive . Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% coinsurance	None
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance	Preauthorization required
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.kp.org/formulary	Value based drugs	\$4 (retail); \$8 (retail); \$5 discount from retail cost share (mail order) / prescription	\$13 (retail), deductible does not apply.	Up to a 30-day supply (retail); up to a 90-day supply (mail order). Subject to formulary guidelines. Contraceptive drugs and devices are not covered.
	Preferred brand drugs	\$25 (retail); \$5 discount from retail cost share (mail order) / prescription	\$30 (retail), deductible does not apply.	Up to a 30-day supply (retail); up to a 90-day supply (mail order). Subject to formulary guidelines. Contraceptive drugs and devices are not covered.
	Non-preferred drugs	\$50 (retail); \$5 discount from retail cost share (mail order) / prescription	\$55 (retail), deductible does not apply.	Up to a 30-day supply (retail); up to a 90-day supply (mail order). Subject to formulary guidelines. Contraceptive drugs and devices are not covered.
	Specialty drugs	Applicable Preferred generic, Preferred brand, or Non-Preferred cost shares apply.	Applicable Preferred generic, Preferred brand, or Non-Preferred cost shares apply.	Up to a 30-day supply (retail). Subject to formulary guidelines, when approved through the exception process.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$50 / visit	\$50 / visit, then 20% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	No charge	20% coinsurance	None
If you need immediate medical attention	Emergency room care	\$200 / visit	\$200 / visit, then No charge, deductible does not apply.	You must notify Kaiser Permanente within 24 hours if admitted to a out-of-network provider ; limited to initial emergency only. Copayment waived if admitted directly to the hospital as an inpatient.
	Emergency medical transportation	20% coinsurance .	20% coinsurance , deductible does not apply.	None
	Urgent care	No charge	\$15 / visit, then 20% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$100 / day up to \$500 / admission	\$100 / day up to \$500 / admission, then 20% coinsurance	Preauthorization required
	Physician/surgeon fees	No charge	20% coinsurance	Preauthorization required
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	\$15 / visit, then 20% coinsurance	None
	Inpatient services	\$100 / day up to \$500 / admission	\$100 / day up to \$500 / admission, then 20% coinsurance	Preauthorization required
If you are pregnant	Office visits	No charge	\$15 / visit, then 20% coinsurance	Depending on the type of services, a copayment , coinsurance , or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge	20% coinsurance	You must notify Kaiser Permanente within 24 hours of admission, or as soon thereafter as medically possible. Newborn services cost shares are separate from that of the mother.
	Childbirth/delivery facility services	\$100 / day up to \$500 / admission	\$100 / day up to \$500 / admission, then 20% coinsurance	You must notify Kaiser Permanente within 24 hours of admission, or as soon thereafter as medically possible. Newborn services cost shares are separate from that of the mother.
If you need help recovering or have other special health	Home health care	No charge	20% coinsurance	Preauthorization required
	Rehabilitation services	Outpatient: No charge Inpatient: \$100 / day up	Outpatient: \$15 / visit, then 20% coinsurance	Combined with Habilitation services : Outpatient: 60 visit limit / year. Inpatient: 60-

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
needs		to \$500 / admission	Inpatient: \$100 / day up to \$500 / admission, then 20% coinsurance	day limit / year, preauthorization required. Limits are combined with in and out-of-network provider networks .
	Habilitation services	Outpatient: No charge Inpatient: \$100 / day up to \$500 / admission	Outpatient: \$15 / visit, then 20% coinsurance Inpatient: \$100 / day up to \$500 / admission, then 20% coinsurance	Combined with Rehabilitation services : Outpatient: 60 visit limit / year. Inpatient: 60-day limit / year, preauthorization required. Limits are combined with in and out-of-network provider networks .
	Skilled nursing care	No charge	20% coinsurance	60-day limit / year. Limits are combined with in and out-of-network provider networks . Preauthorization required
	Durable medical equipment	No charge	50% coinsurance	Subject to formulary guidelines. Preauthorization required
	Hospice services	No charge	20% coinsurance	Preauthorization required
If your child needs dental or eye care	Children's eye exam	No charge for refractive exam, deductible does not apply.	\$15 / visit, then 20% coinsurance	Limited to 1 exam / 12 months
	Children's glasses	No charge	Shared with In- Network	Members age 19 and over limited to \$600 / 12 months; Members under age 19 limited to 1 pair of frames and lenses / year or contact lenses covered at 50% coinsurance
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

- Cosmetic surgery
- Dental care (Adult and child)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Acupuncture (20 visit limit / year)
- Bariatric surgery
- Children's glasses
- Chiropractic care (20 visit limit / year)
- Routine eye care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is shown in the chart below. Other coverage options may be available to you, too, including buying individual insurance coverage through the [Health](#)

[Insurance Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318- 2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact the agencies in the chart below.

Contact Information for Your Rights to Continue Coverage & Your Grievance and Appeals Rights:

Kaiser Permanente Member Services	1-888-901-4636 (TTY: 711) or www.kp.org
Department of Labor's Employee Benefits Security Administration	1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform
Department of Health & Human Services, Center for Consumer Information & Insurance Oversight	1-877-267-2323 x61565 or www.cciio.cms.gov .
Washington Department of Insurance	1-800-562-6900 or www.insurance.wa.gov

Does this [plan](#) provide Minimum Essential Coverage? Yes

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this [plan](#) meet the Minimum Value Standards? Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-901-4636 (TTY: 711).

Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-888-901-4636 (TTY: 711).

Navajo (Dine): Dinek'ehgo shika a'ohwol ninisingo, kwijjigo holne' 1-888-901-4636 (TTY: 711).

Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-888-901-4636 (TTY: 711) uff.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-901-4636 (TTY: 711).

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-888-901-4636 (TTY: 711).

Carolinian (Kapatal Falawasch): ngere aukke ghut alillis reel kapatal Falawasch au fafaangi tilifon ye 1-888-901-4636 (TTY: 711).

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-888-901-4636 (TTY: 711).

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost-sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible	\$0
■ Specialist copayment	\$15
■ Hospital (facility) copayment	\$100
■ Other (blood work) copayment	\$0

This EXAMPLE event includes services like:
[Specialist](#) office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
[Diagnostic tests](#) (*ultrasounds and blood work*)
[Specialist](#) visit (*anesthesia*)

Total Example Cost **\$12,700**

In this example, Peg would pay:

Cost Sharing

Deductibles	\$0
Copayments	\$100
Coinsurance	\$0

What isn't covered

Limits or exclusions	\$20
The total Peg would pay is	\$120

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$0
■ Specialist copayment	\$15
■ Hospital (facility) copayment	\$100
■ Other (blood work) copayment	\$0

This EXAMPLE event includes services like:
[Primary care physician](#) office visits (*including disease education*)
[Diagnostic tests](#) (*blood work*)
[Prescription drugs](#)
[Durable medical equipment](#) (*glucose meter*)

Total Example Cost **\$5,600**

In this example, Joe would pay:

Cost Sharing

Deductibles	\$0
Copayments	\$600
Coinsurance	\$0

What isn't covered

Limits or exclusions	\$0
The total Joe would pay is	\$600

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$0
■ Specialist copayment	\$15
■ Hospital (facility) copayment	\$100
■ Other (x-ray) copayment	\$0

This EXAMPLE event includes services like:
[Emergency room care](#) (*including medical supplies*)
[Diagnostic test](#) (*x-ray*)
[Durable medical equipment](#) (*crutches*)
[Rehabilitation services](#) (*physical therapy*)

Total Example Cost **\$2,800**

In this example, Mia would pay:

Cost Sharing

Deductibles	\$0
Copayments	\$200
Coinsurance	\$200

What isn't covered

Limits or exclusions	\$0
The total Mia would pay is	\$400

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

Coverage Period: **08/01/2025 – 07/31/2026**

Coverage for: **SEIU Healthcare NW Health Benefit Trust - Progyny Fertility and Pregnancy & Postpartum Health Reimbursement Arrangement**

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. This is only a summary. For more information about your coverage, please contact your dedicated Progyny Pregnancy & Postpartum coach or your Progyny Fertility Patient Care Advocate (PCA) at (833) 233-0517.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Individual \$0 Family \$0	There is no deductible with your Progyny plans.
Do I have a copayment?	No.	There is no copayment with your Progyny Fertility and Pregnancy & Postpartum plans.
Do I have coinsurance	No.	There is no coinsurance with your Progyny Fertility and Pregnancy & Postpartum plans.
Are there services covered before you meet your deductible?	No.	You will not pay an out-of-pocket for your Progyny Fertility and Pregnancy & Postpartum services. All services provided under the plan are preventive care services and not subject to cost share.
Are there other deductibles for specific services?	No.	There is no deductible required for the Progyny Fertility and Pregnancy & Postpartum HRA plans. All services provided under the plan are preventive care services and not subject to cost share.
What is the out-of-pocket limit for this plan?	Individual \$0 / Family \$0	There is no out-of-pocket limit with your Progyny plans.
Will you pay less if you use a network provider?	Not applicable.	Progyny's Fertility and Pregnancy & Postpartum coaches and care providers are all included in this plan. There are no benefits available for non-Progyny coaches.

Excluded Services & Other Covered Services:

Exclusions include home ovulation prediction kits, services and supplies furnished by an out-of-network provider, and treatments considered experimental by the American Society of Reproductive Medicine. All charges associated with services for a gestational carrier, including but not limited to fees for laboratory tests, are not covered. If your doctor requests services that are not listed in this guide, please check with your PCA to confirm coverage. There are some services that do not fall under Progyny's coverage; however, they may be provided through your medical plan.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Healthcare.gov: www.HealthCare.gov or call 1-800-318-2596 or state health insurance marketplace or SHOP. Other coverage options may be available to you, too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318- 2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, go to www.dol.gov/ebsa/healthreform and <http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants>.

Does this plan provide Minimum Essential Coverage? Not Applicable.

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this plan meet the Minimum Value Standards? Not Applicable.

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Plan Resources

Health Benefits Customer Service

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Phone	1-877-606-6705 (8 a.m. to 6 p.m., Monday-Friday)
Email	SEIU775BG-caregiver@magnacare.com
Health Benefits Account	myseiu.be/magnacare

Kaiser Permanente of Washington



New Member Services	1-888-844-4607	myseiu.be/kp-new-member
Member Services	1-888-901-4636	myseiu.be/kp-member
Mental Health Services	1-888-287-2680	myseiu.be/kaiser-bh
Nurse Helpline	1-800-297-6877	myseiu.be/kp-nurse
Member Language Assistance	1-888-901-4636	myseiu.be/kp-language

Dental

Delta Dental	1-800-554-1907	deltadentalwa.com
Willamette Dental	1-855-433-6825	myseiu.be/oe-willamette

Other Benefits

EPIC Hearing	1-877-363-5638	myseiu.be/epic
Progyny (Fertility and Family-building)	1-833-233-0517	myseiu.be/progyny

Get Support in Your Language

Call Customer Service at 1-877-606-6705 or email SEIU775BG-caregiver@magnacare.com. You will be connected to a representative who speaks your language and can assist with questions about applying for and managing your benefits.

Once you have been enrolled in healthcare coverage, language support will be available through your health plan.