



SEIU 775
BENEFITS GROUP



Sonja T.
Caregiver, Renton

2026-2027

Healthcare Coverage Guide

Learn about your healthcare coverage benefits.

If you have questions about coverage, contact Human Resources.

Coverage Benefits



Make the most of your coverage.

Beyond preventive care, your coverage includes many ways to get care and support, like wellness coaching and personalized management programs for chronic conditions like diabetes, hypertension and back pain.

Once you're enrolled, your provider will send you a Member ID card by mail. With your Member ID card, you can make an account, manage your health and find a primary care provider.

If your Member card doesn't arrive within 10 business days of your coverage start date, call your carrier.

The plans available to you offer many ways to support your health and wellbeing. Coverage includes the following benefits:

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

We've added new and improved benefits to make it easier to access care.

New benefits begin August 1, 2026.

+ New Vision Coverage

VSP Vision Care is the new vision provider. Their expanded network makes it easier to find convenient care near you. Benefits include an annual eye exam, with up to \$150 toward glasses or \$300 toward contact lenses every 12 months.

+ Expanded Hearing Aid Coverage

The limit on EPIC hearing aid coverage has been removed. You can now get more support to help you hear clearly.

+ Extended Prescription Fulfillment

You'll be able to receive up to a 12-month supply of hormone therapy or contraceptive medications in a single fill, reducing pharmacy trips and making it easier to stay consistent with your treatment.

Medical Visits	KPWA		Aetna	
Primary Care Provider/Online Visits	\$0 Co-Pay		\$0 Co-Pay	
Urgent Care Visits	\$0 Co-Pay		\$25 Co-Pay	
Emergency Room Visits	\$200 Co-Pay		\$200 Co-Pay	
Rx Co-pay	Retail Pharmacy per 30-day supply	Mail Order up to 90-day supply	Retail Pharmacy per 30-day supply	Mail Order up to 90-day supply
Generic Contraceptives*	\$0	\$0	\$0	\$0
Value-Based Drugs**	\$4	\$10	\$4	\$8
Preferred Generic	\$8	\$3	\$8	\$16
Preferred Brand	\$25	\$20	\$25	\$50
Non-Preferred Brand	-	-	\$50	\$100

*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, as long as you are enrolled in a health plan. **Value-based drugs are generic medications for treating various health conditions.

Coverage Benefits



Free Primary Care Visits

There's no cost to see your primary care provider for wellness visits or when you're sick. Virtual care options are also available, so you can get care from home.

Tests or additional services may have a cost.

Urgent & Emergency Care

Your plan covers urgent care and emergency room visits. Urgent care is a convenient option for non-emergency issues when your doctor isn't available. Emergency care is for serious or life-threatening conditions.

Prescription

You have access to a wide range of prescription medications, including convenient mail-order options delivered to your home.

Mental Health

Your coverage includes professional mental health support, medication management, group therapy, alternative care and access to self-care tools and programs.

Wellness Coaching & Programs

Get personalized support to manage chronic conditions and improve your overall health. Your plan includes wellness coaching, care team guidance and tools to help you track your progress.

Massage & Chiropractic

Low-cost options are available for physical therapy, massage, chiropractic care, and acupuncture.

Vision

Vision coverage through VSP includes routine eye exams, an allowance for glasses or contact lenses and access to a large network of eye doctors.

Hearing

Through EPIC Hearing, you can access hearing exams and support for hearing devices through in-network providers.

Family-building, Reproductive & Midlife Care

With Progyny you 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 and in-person or virtual care.

See your plan details for a full list of benefits.

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

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



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.

Benefits	Inside Network
Plan deductible	Individual: \$1,500 per calendar year Family: \$3,000 per calendar year
Individual deductible carry-over	4th quarter carryover does not apply
Plan coinsurance	The Plan pays 80%, you pay 20%
Out-of-pocket limit	Individual out-of-pocket limit: \$6,250 Family out-of-pocket limit: \$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
Urgent Care	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)/Preferred brand (Tier 2) \$0/\$0 Co-pay Inhalers & EPI Pens: Preferred generic (Tier 1)/Preferred brand (Tier 2) \$8/\$25 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 100%. 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.

Benefits	Inside Network
Emergency services (co-pay waived if admitted)	\$200 co-pay at a designated facility Deductible and coinsurance apply \$200 co-pay at a non-designated facility
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, no limit 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	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
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 & optical hardware	Covered through a separate benefit: VSP Vision Care. Learn more at myseiu.be/vspvision

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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.
Urgent Care	\$25 co-pay, deductible waived.	\$25 co-pay, deductible and co-insurance applies.
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/Preferred Generic (Tier 1)/Preferred Brand (Tier 2)/Non-preferred (Tier 3) \$4/\$8/\$25/\$50 Insulin: Preferred generic (Tier 1)/preferred brand (Tier 2)/non-preferred (Tier 3) \$0/\$0/\$25 co-pay Inhalers & EPI Pens: Preferred Generic (Tier 1)/Preferred Brand (Tier 2)/Non-preferred (Tier 3) \$8/\$25/\$35	Preferred generic (Tier 1)/preferred brand (Tier 2)/non-preferred (Tier 3) \$13/\$30/\$55 co-pay Insulin: Preferred generic (Tier 1)/preferred brand (Tier 2)/non-preferred (Tier 3) \$13/\$30/\$35 co-pay Inhalers & EPI Pens: 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 \$25 co-pay, deductible and coinsurance apply
Ambulance services	\$200 co-pay, deductible applies	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. Outpatient: \$25 co-pay, deductible and coinsurance apply

Benefits	In-Network	Out-of-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	Covered at 100%, 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, no limit per ear every 3 years toward the cost of a hearing aid. Learn more at myseiu.be/epic .	
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.
Hospice services	Fully covered, deductible waived	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 \$25 co-pay, deductible and coinsurance apply
Massage services	\$25 co-pay (20 visits per calendar year)	Shared with preferred provider visit limit \$25 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.	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. 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
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

Benefits	In-Network	Out-of-Network
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.
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 Tubal 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 & optical hardware	Covered through a separate benefit: VSP Vision Care. Learn more at myseiu.be/vspvision	



Melissa E.
Caregiver, Seattle

Dental Plan Options

Dental is included in your healthcare coverage. Use the chart to compare plans and select the plan that's right for you.

	 DELTA DENTAL®	 Willamette Dental
Annual Maximum Benefit	\$1,000	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 locations in western Washington, making it easy to find a Willamette dentist along the I-5 corridor.
Find a Dentist Near You	deltadentalwa.com/fad/search Select 'Delta Dental PPO' to filter your search results.	locations.willamettedental.com Enter your ZIP code into the search.
More Information	1-800-554-1907 DeltaDentalWA.com	1-855-433-6825 myseiu.be/willamette

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:
1/1/2027-12/31/2027

Benefit Period Maximum*
(per person; does not apply to
Class I): \$1,000

*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 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	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	\$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	
Fillings (Amalgam)	You pay a \$35 Copay
Porcelain-Metal Crown	You pay a \$350 Copay**
Prosthodontics	
Complete Upper or Lower Denture	You pay a \$500 Co-pay
Bridge (per Tooth)	You pay a \$350 Co-pay
Endodontics & Periodontics	
Root Canal Therapy – Anterior	You pay a \$150 Co-pay
Root Canal Therapy – Bicuspid	You pay a \$250 Co-pay
Root Canal Therapy – Molar	You pay a \$275 Co-pay
Osseous Surgery (per Quadrant)	You pay a \$250 Co-pay
Root Planning (per Quadrant)	You pay a \$115 Co-pay
Oral Surgery	
Routine Extraction (Single Tooth)	You pay a \$40 Co-pay
Surgical Extraction	You pay a \$175 Co-pay
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 Co-pay 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.

This is only a summary. For more information about your new vision coverage, please contact VSP Vision at 800-785-0699.

VSP Essential Plan Full Service	
Copays (Exams / Glasses)	\$0 / \$10
Frequencies	
Examination	Every 12 Months
Lenses	Every 12 Months
Frame	Every 12 Months
Benefits with a VSP Network Provider	
Comprehensive Eye Examination	\$0 Copay
Contact Lens Examination	\$0
Retinal Screening	\$0
Essential Medical Eye Care	Covered Under Medical Plan Subject to Applicable Office Visits Cost Share
Lenses	
Single Vision	Covered
Lined Bifocal	Covered
Lined Trifocal	Covered
Allowances*	
Retail Frame Allowance	\$150
Featured Frame Brand Allowance	\$170
Costco Equivalent Frame	\$150
Elective Contact Lenses In lieu of lenses or frames	\$300
Lens Enhancement Out-of-pocket Cost	
Polycarbonate	\$35 Fully covered for Children under 19
Anti-Reflective Coating	\$41 - \$85
Scratch and UV Coating	Covered
High Index	\$56 - \$60
Photochromic	\$75
Standard Progressives	Covered
Custom/Premium Progressives	\$95 - \$175
All Other Discounted Lens Enhancements	30%

Non-VSP Provider Allowances	
Examination	\$45
Single Vision	\$30
Bifocal	\$50
Trifocal	\$65
Lenticular	\$100
Progressive Lenses	\$50
Frame	\$70
Elective Contact Lenses In lieu of lenses or frames	\$105

Resources

If you have questions about coverage,
contact Human Resources.

Kaiser Permanente of Washington		 KAISER PERMANENTE®
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

Aetna		aetna®
Member Services	1-855-736-9469	aetna.com
Mental Health Services	1-800-424-4047	aetna.com
24 Hour Nurse Line	1-800-556-1555	aetna.com
Find the Right PCP	1-888-982-3862	aetna.com
Member Language Assistance	1-855-736-9469	myseiu.be/aetna-language
Sav-Rx	1-800-228-3108	savrx.com

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	1-833-233-0517	myseiu.be/progyny
VSP Vision Care	1-800-785-0699	myseiu.be/vspvision