Sonja T.
Caregiver, Renton

2026-2027

Healthcare Coverage Guide

Explore your options and next steps.

Call 1-877-606-6705 if you have questions 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。

ទទួលបានព័ត៌មានអំពីការធានារ៉ាប់រងសុខភាពជាភាសារបស់អ្នក។

한국어로 된 의료 보험 정보를 확인하십시오.

ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਹੈਲਥਕੇਅਰ ਕਵਰੇਜ ਬਾਰੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰੋ।

Получите информацию о медицинском страховом покрытии на вашем языке.

Ku hel macluumaadka 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.

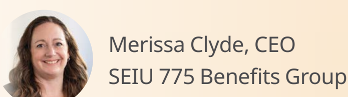
myseiu.be/hc

Caregivers show up every day to care for others, and you deserve care and support too.

Our goal is to make it easier for you to access high-quality, affordable healthcare so you can focus on your health, your family and the important work you do.

This guide will walk you through your coverage options and the steps to apply. We're proud to support you and the essential care you provide.

After reviewing your healthcare coverage, take time to explore your other caregiver benefits. From training opportunities and retirement benefits to free slip-resistant shoes and job-matching through Carina, these benefits are designed to support you. Visit myseiu.be/bg to learn more.



Merissa Clyde, CEO
SEIU 775 Benefits Group

A Step-by-Step Guide to Applying for Coverage

1) Learn about your coverage

- ◯ **Explore your coverage options and review your Plan Details** to understand the out-of-pocket costs for prescriptions, treatments and common services.
- ◯ **Review your eligibility** details on page 5 to see if you qualify.
- ◯ **Select a coverage option and dental plan.**

2) Prepare to apply

- ◯ **Gather your information.** You'll need your Social Security number and employer name to apply.
- ◯ **Coverage for Kids: Gather your Dependent Verification documents.** Learn more and find instructions at **myseiu.be/cfk**.

3) Create a health benefits account

- ◯ **Learn how to create an account at myseiu.be/hba.** Your account is managed by MagnaCare, your health benefits administrator. Accounts are currently available in English. If you need help or language support call 1-877-606-6705.

4) Submit your application

- ◯ **Complete an application before the deadline** at **myseiu.be/magnacare** or by mail. Learn more on page 5.
- ◯ **Coverage for Kids: Submit Dependent Verification document**s when you apply. Learn how to submit your documents at **myseiu.be/cfk**.

You'll receive an application receipt by email within 1 day and a coverage decision email within 30 days. If not, call 1-877-606-6705.

Healthcare Coverage 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.

Option 1

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 6 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.

Eligibility

Work 120 hours or more a month.

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, acupuncture, and virtual wellness programs.

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 and your children 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

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	**$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 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**

Healthcare Coverage FAQ

How do I qualify 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 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 on the application. U.S. postage is required.

You'll receive an application receipt by email 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**.

How do I qualify 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.

They're enrolled in the same plan as you and can only be enrolled under 1 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 online or printed 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 more details:

- How to apply for Coverage for Kids.
- Who you can add to coverage.
- Submitting verification documents.

Not Eligible Yet? You can still apply during Open Enrollment.

Submit an application* to start individual coverage when you work 80+ hours a month. Coverage for Kids begins when you work 120+ hours a month.

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

Sandra C.
Caregiver, Kennewick

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. If received by the 15th, coverage ends the 1st of the next month. If received after the 15th, coverage ends the 1st of the following month.

Important: You can only re-enroll during Open Enrollment or after a Qualifying Life Event. Waivers recieved before July 1 reset during Open Enrollment. You must submit a new Waive Coverage form to keep your waiver. If you had coverage in the past 12 months, you'll be automatically re-enrolled unless you submit a new waiver.

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'll receive a self-pay letter and email directing you to pay your co-premium. You can pay by check, or using your online health benefits account.

CDWA caregivers: your first payment will be a self-pay.

What if I don't work enough hours?

Grace Months provide up to 2 one-month extensions of healthcare coverage each year, helping you and your dependents stay covered if you don't meet the required work hours. Learn more at myseiu.be/gm.

If you lose coverage, COBRA information will be provided if you want to continue coverage for a monthly payment. If you stop caregiving, check eligibility for Washington Apple Health or visit wahealthplanfinder.org.

How do work hours 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.

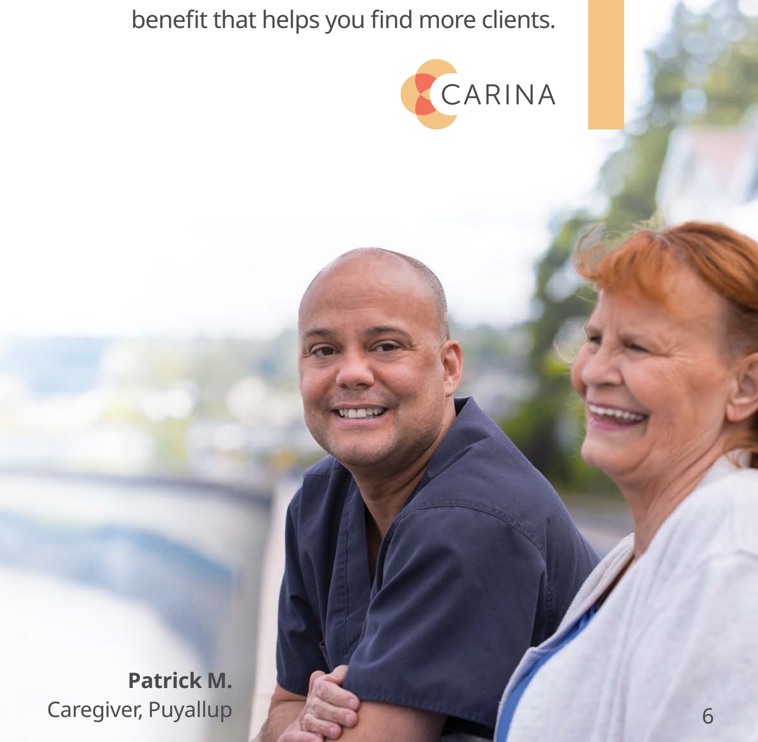
The paid hours you work this month: → Determine coverage this month:

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

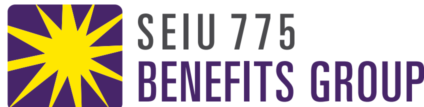
Get more hours to maintain your coverage.

If you need more hours to get or keep coverage, try Carina.org, a free job-matching benefit that helps you find more clients.

CARINA



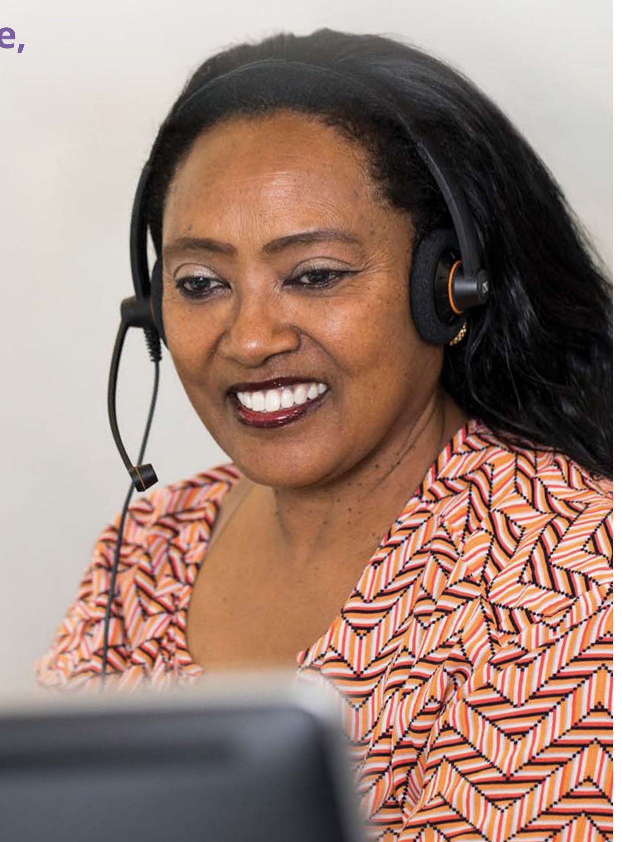
Patrick M.
Caregiver, Puyallup



Get Support

with questions about healthcare 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.

Understand Common Insurance Terms

See definitions of common terms to better understand your coverage.

myseiu.be/hc-terms

Learn More About Coverage for Kids

Learn how to apply and complete your application.

myseiu.be/cfk

Access Your Health Benefits Account

Learn how to create an account and apply for coverage online.

myseiu.be/hba

Caregiver Kicks: Free Shoes for Caregivers

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. Eligible caregivers can get a free pair every year!

myseiu.be/kicks

2026-2027
HEALTHCARE COVERAGE

Plan Details

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, 2026.

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, 2026, to July 31, 2027.

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

1-877-606-6705
Monday-Friday, 8 a.m. to 6 p.m.

SEIU775BG-caregiver@magnacare.com

Maila C.
Caregiver, Seattle

Summary of Material Modifications and Reductions

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, 2026.

Effective August 1, 2026, plan benefits and the eligibility rules for healthcare coverage will change. APs and IPs should be aware of the following benefit enhancements:

- VSP Vision Care will be your new routine vision provider for routine eye exams, hardware and contact lenses.
- The dollar limit on EPIC hearing aid coverage has been removed.
- You will be able to receive up to a 12-month supply of hormone therapy or contraceptive medications in a single fill.

This Summary of Material Reductions (“SMR”) 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, 2026.

Effective August 1, 2026, plan benefits and the eligibility rules for healthcare coverage will change. APs and IPs should be aware of the following:

- SEIU Healthcare NW Health Benefits Trust will no longer offer services through Headspace.

For further information regarding these changes, please contact Customer Service at 1-877-606-6705 (Monday-Friday, 8 a.m. to 6 p.m.) or email SEIU775BG-caregiver@magnacare.com.

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 • 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 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.	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 Deductible and coinsurance apply **Outpatient:** $15 co-pay, deductible and coinsurance apply. Routine care not subject to outpatient services co-pay.
Mental Health	**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

Benefits	Inside Network	Outside Network
Naturopathy	$0 co-pay. Unlimited visits per calendar year without preauthorization. Covered in full.	$15 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 Services	Covered at cost shares when medical criteria is met	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 **Outpatient:** $0 co-pay	Shared with in-network **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
Preventive care **Well-care physicals, immunizations, pap smear exams, mammograms**	Covered in full Women's preventive care services (including contraceptive drugs and devices and sterilization) are covered in full.	Deductible and coinsurance apply Women's preventive care services (including contraceptive drugs and devices and sterilization) are subject to thenapplicable Preventive Care cost share and benefit maximums. Routine mammograms: Deductible and coinsurance apply
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 **Outpatient:** 60 visits per calendar year. Services with mental health diagnoses are covered with no limit. No co-pay primary/$15 co--pay specialty	**Inpatient:** Day limits shared with in-network $100 co-pay, per day for up to 5 days per admit Deductible and coinsurance apply **Outpatient:** Visit limits shared with in-network $15 co-pay, deductible and coinsurance apply
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.	**Inpatient:** $100 co-pay, per day for up to 5 days per admit, deductible and coinsurance apply Deductible and coinsurance apply **Outpatient:** $15 co-pay, deductible and coinsurance apply Women's sterilization procedures are covered subject to the applicable Preventive Care cost share and benefit maximums.
Temporomandibular Joint (TMJ) services	**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 Deductible and coinsurance apply **Outpatient:** $15 co-pay, deductible and coinsurance apply
Tobacco cessation counseling	Quit for Life Program - covered in full	Applicable cost shares apply
Routine vision care and optical hardware	Covered through a separate benefit: VSP Vision Care. Learn more at myseiu.be/vsp	

PPO Dental Plan Snapshot

Effective Date 8/1/2026

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:
January 1 - December 31

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 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	o		
Files claims forms for you	o	o	
Quality management and cost protection	o	o	

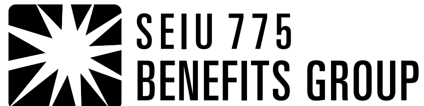
Dental Emergency: Participating Providers will provide treatment for Dental Emergencies during office hours. The Company will provide benefits for Covered Services provided by Participating Providers for treatment of a Dental Emergency. The Enrollee may see treatment for a Dental Emergency from a Non-Participating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

Dental Plan Snapshot
Effective Date 8/1/2026

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
Prosthondotics	
Complete Upper or Lower Denture	You pay a $400 Co-pay
Bridge (per Tooth)	You pay a $250 Co-pay
Endotontics & 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.



vsp vision

VSP Advantage Plan Snapshot

Effective Date 8/1/2026

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

VSP Advantage Plan Full Service	
Copays (Exams / Glasses)	$0 / $0
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	$250
Featured Frame Brand Allowance	$270
Costco Equivalent Frame	$250
Elective Contact Lenses In lieu of lenses or frames	$600
Lens Enhancement Out-of-pocket Cost	
Polycarbonate	Covered
Anti-Reflective Coating	$40 Copay
Scratch and UV Coating	Covered
High Index	Covered
Photochromic	Covered
Standard Progressives	Covered
Custom/Premium Progressives	$55 Copay
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

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 Preferred generic drugs	$4 (retail) $8 (retail); $3 (mail order) / prescription	$13 (retail) / prescription, deductible does not apply.	Up to a 30-day supply (retail); up to a 90-day supply (mail order). No charge for contraceptives. Subject to formulary guidelines.
	Preferred brand drugs	$25 (retail); $20 (mail order) / prescription	$30 (retail) / prescription, deductible does not apply.	Up to a 30-day supply (retail); up to a 90-day supply (mail order). Subject to formulary guidelines.
	Non-preferred drugs	$50 (retail); $45 (mail order) / prescription	$55 (retail) / prescription, deductible does not apply.	Up to a 30-day supply (retail); up to a 90-day supply (mail order). Subject to formulary guidelines .
	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
	Physician/surgeon fees	No charge	20% coinsurance	None
If you need immediate medical	Emergency room care	$200 / visit	$200 / visit, 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.

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)	
attention				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 needs	Home health care	No charge	20% coinsurance	Preauthorization required
	Rehabilitation 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 Habilitation services: Outpatient: 60 visit limit / year. Inpatient: 60-day limit / year, preauthorization required or will not be covered. Limits are combined with in and out-of-network provider networks.
	Habilitation services	Outpatient: No charge	Outpatient: $15 / visit, then	Combined with Rehabilitation services:

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)	
		Inpatient: $100 / day up to $500 / admission	20% coinsurance Inpatient: $100 / day up to $500 / admission, then 20% coinsurance	Outpatient: 60 visit limit / year. Inpatient: 60-day limit / year, preauthorization required or will not be covered. 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	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	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.)

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

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 No

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 at'ohwol ninisingo, kwiijigo 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 (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi 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.

Make Eye Health a Priority with VSP!

Your health comes first with VSP and SEIU HBT ADVANTAGE PLAN. Take a look at your VSP vision care coverage.

VSP members save an annual average of

$489*

More Ways to Save

Extra $20 to spend on Featured Frame Brands†

bebe | Calvin Klein | COLE HAAN | DRAGON | FLEXON | LONGCHAMP PARIS | Nike and more

Up to 40% Savings on lens enhancements‡

See all brands and offers at **vsp.com/offers**.

Create an account today.
Questions?
vsp.com
800.877.7195 (TTY: 711)

Scan QR code or visit **vsp.com** to learn more.

Routine eye exams have saved lives.

Did you know an eye exam is the only non-invasive way to view blood vessels in your body? Your VSP® network doctor can detect signs of more than 270 health conditions during your annual eye exam—including diabetes and high blood pressure, as well as eye conditions such as glaucoma and diabetic eye disease.**

Savings you'll love.

See and look your best without breaking the bank. VSP members get exclusive savings on popular frame brands and contact lenses, and they get additional discounts on things like LASIK, and more.

The choice is yours!

With private practice doctors, Visionworks®, and Eyemart Express retail locations to choose from nationwide, getting the most out of your benefits is easy at a VSP Premier Edge™ location.

Get more at preferred in-network doctor locations

private practice doctors | Visionworks | EYEMART EXPRESS FAMILY OF STORES

Using your benefit is easy!

Create an account on **vsp.com** to view your in-network coverage, find the VSP network doctor who's right for you, and discover savings with exclusive member extras. At your appointment, just tell them you have VSP.

†Frame brands and promotion subject to change. Only available to VSP members with applicable plan benefits. Only available at in-network locations. Members who participate in a Medicaid/state-funded plan are not eligible.
‡Savings based on doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. Ask your VSP network doctor for more details.
*Based on state and national averages for eye exams and most commonly purchased brands. This represents the average savings for a VSP member with a full-service plan at an in-network provider. Your actual savings will depend on the eyewear you choose, the plan available to you, the eye doctor you visit, your copays, your premium, and whether it is deducted from your paycheck pre-tax. Source: VSP book-of-business paid claims data for Aug-Jan of each prior year. **Full Picture of Eye Health, American Optometric Association, 2020. +Coverage with a retail chain may be different or not apply.

VSP guarantees member satisfaction from VSP providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business. TruHearing is not available directly from VSP in the states of California and Washington. VSP Premier Edge™ is not available in all states.

To learn about your privacy rights and how your protected health information may be used, see the VSP Notice of Privacy Practices on **vsp.com**. Visionworks, Eyeconic, and Eyemart Express family of stores are VSP-affiliated companies.

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Classification: Restricted

Your VSP Vision Benefits Summary

Prioritize your health and your budget with a VSP plan through SEIU 775 BENEFITS GROUP - ADVANTAGE PLAN.

Provider Network:
VSP Choice
Effective Date:
08/01/2026

BENEFIT	DESCRIPTION	COPAY	FREQUENCY
YOUR COVERAGE WITH A VSP DOCTOR			
WELLVISION EXAM	• Focuses on your eyes and overall wellness	$0	Every 12 months
ESSENTIAL MEDICAL EYE CARE	• Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more. • Coordination with your medical coverage may apply. Ask your VSP network doctor for details.	$20 per exam	Available as needed
PRESCRIPTION GLASSES			
FRAME[+]	• $270 Featured Frame Brands allowance • $250 frame allowance • 20% savings on the amount over your allowance	$0	Every 12 months
LENSES	• Single vision, lined bifocal, and lined trifocal lenses	$0	Every 12 months
LENS ENHANCEMENTS	• Standard progressive lenses • Premium and Custom progressive lenses • High Index • Anti-glare coating • Impact-resistant lenses • Scratch-resistant coating • UV protection • Light-reactive lenses • Average savings of 30% on other lens enhancements	$0 $55 $0 $40 $0 $0 $0 $0	Every 12 months
CONTACTS (INSTEAD OF GLASSES)	• $600 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)	$0	Every 12 months
RETINAL SCREENING	• Takes a picture of the back of your eyes and helps your VSP doctor find possible signs of eye disease.	$0	Every 12 months
ADDITIONAL SAVINGS	**Glasses and Sunglasses** • Discover all current eyewear offers and savings at **vsp.com/offers**. • 20% savings on unlimited additional pairs of prescription or non-prescription glasses/sunglasses, including lens enhancements, from a VSP provider within 12 months of your last WellVision Exam. **Laser Vision Correction** • Average of 15% off the regular price; discounts available at contracted facilities. **Exclusive Member Extras for VSP Members** • Contact lens rebates, lens satisfaction guarantees, and more offers at **vsp.com/offers**. • Save up to 60% on digital hearing aids with TruHearing®. Visit **vsp.com/offers/special-offers/hearing-aids** for details. • Enjoy everyday savings on health, wellness, and more with VSP Simple Values.		

COVERAGE WITH AN OUT-OF-NETWORK DOCTOR

With so many in-network choices, VSP makes it easy to maximize your benefits. Choose from our large doctor network including private practice and retail locations. Plus, you can shop eyewear online at Eyeconic®. Log in to **vsp.com** to find an in-network doctor. Your plan provides the following out-of-network reimbursements:

Exam .... up to $45	Lined Bifocal Lenses .... up to $50	Progressive Lenses .... up to $50
Frame .... up to $70	Lined Trifocal Lenses .... up to $65	Contacts .... up to $105
Single Vision Lenses .... up to $30		

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services
Coverage Period: **08/01/2026 – 07/31/2027**
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.

HIPAA NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

If you or your dependents become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, or if you or your dependents lose Medicaid or children's health insurance program coverage because you are no longer eligible, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or obtain more information, please contact the Trust Administrator:

MagnaCare
P.O. Box 24811
Seattle, WA 98124
Phone: (877) 606-6705
Fax: (516) 723-7395

<u>Important Note Regarding Retroactivity</u>

Please note that if you may elect COBRA continuation coverage back to your COBRA qualifying event or special enrollment for a new dependent based on birth or adoption back to the date of birth or adoption, you must pay any required premiums for all months before retroactive coverage will be provided. Retroactive coverage must be continuous from the time of first retroactive eligibility. You may submit claims for services during the suspended period, but they will be pended until you make the necessary premium payments.

If you have any questions about how this information applies to you, please contact SEIU 775 Customer Service at (877) 606-6705.

Premium Assistance Under Medicaid and theChildren's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2026. Contact your State for more information on eligibility –

MONTANA – Medicaid	OREGON – Medicaid and CHIP
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
WASHINGTON – Medicaid	
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	

To see if any other states have added a premium assistance program since January 31, 2026, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 3/31/2026)

Plan Resources

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

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

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/vsp

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.