SEBB Plan Summary for San Juan Island School District #149

Annual costs (what you pay)	Medical deductible (applies to medical out-of-pocket limit)	Medical out-of-pocket limit (see separate prescription drug out-of-pocket limit for some plans)	Prescription drug deductible	Prescription drug out-of-pocket limit
Uniform Medical Plan				
UMP Achieve 1	$750/person $2,250/family	$3,500/person $7,000/family	Tier 2 and specialty; $250/person $750/family (applies to prescription out-of-pocket limit)	$2,000/person $4,000/family
UMP Achieve 2	$250/person $750/family	$2,000/person $4,000/family	Tier 2 and specialty; $100/person $300/family (applies to prescription out-of-pocket limit)	$2,000/person $4,000/family
UMP High Deductible	$1,400/person $2,800/family[2]	$4,200/person $8,400/family[3]	Combined (medical and prescription) deductible	Combined (medical and prescription) out-of-pocket limit

Benefits (what you pay)	Ambulance (air or ground) per trip	Diagnostic tests, laboratory, and x-rays	Durable medical equipment, supplies, and prosthetics	Emergency room (copay waived if admitted)	Routine annual hearing exam	Hearing hardware	Home health	Therapy: Physical, occupational, speech, and neurodevelopmental (per-office visit cost)
Uniform Medical Plan								
UMP Achieve 1	20%	20%	20%	$75+20%	$0	$800 max benefit every 3 years	20%	20% (80 combined/year)
UMP Achieve 2	20%	15%	15%	$75+15%	$0	$800 max benefit every 3 years	15%	15% (80 combined/year)
UMP High Deductible	20%	15%	15%	15%	15%	$800 max benefit every 3 years	15%	15% (80 combined/year)

Benefits (what you pay)	Hospital services: Inpatient	Hospital services: Outpatient	Office visit: Primary care	Office visit: Urgent care	Office visit: Specialist	Office visit: Mental health	Number of visits covered per year:		
Uniform Medical Plan									
UMP Achieve 1	$200/day up to $600 for facility+20% for professional services	20%	20%	20%	20%	20%	16	16	16
UMP Achieve 2	$200/day up to $600 for facility+15% for professional services	15%	15%	15%	15%	15%	16	16	16
UMP High Deductible	15%	15%	15%	15%	15%	15%	16	16	16

Benefits (what you pay) Prescription drugs: Retail pharmacy (up to a 30-day supply)	Value Tier (specific high-value prescrip-tion drugs used to treat certain chronic conditions)	Tier 1 (primarily low-cost generic drugs)	Tier 2 (preferred brand-name drugs, high-cost generic drugs, and specialty drugs for UMP)	Tier 3 (nonpreferred brand-name drugs and nonpreferred generic drugs[4])	Tier 4 (specialty and certain high cost generic drugs)
Uniform Medical Plan					
UMP Achieve 1	5% up to $10	10% up to $25	30% up to $75 after deductible	N/A	N/A
UMP Achieve 2	5% up to $10	10% up to $25	30% up to $75 after deductible	N/A	N/A
UMP High Deductible	15% after combined (medical and prescription) deductible	15% after combined (medical and prescription) deductible	15% after combined (medical and prescription) deductible	N/A	N/A

Benefits (what you pay) Prescription drugs: Mail order (up to a 90-day supply)	Value Tier (specific high-value prescription drugs used to treat certain chronic conditions)	Tier 1 (primarily low-cost generic drugs)	Tier 2 (preferred brand-name drugs)	Tier 3 (nonpreferred brand-name drugs and nonpreferred generic drugs[4])
Uniform Medical Plan				
UMP Achieve 1	5% up to $30	10% up to $75	30% up to $225	N/A
UMP Achieve 2	5% up to $30	10% up to $75	30% up to $225	N/A
UMP High Deductible	15% after combined (medical and prescription) deductible	15% after combined (medical and prescription) deductible	15% after combined (medical and prescription) deductible	N/A

	Employee monthly premium				Annual medical deductible
Plan	Subscriber (employee only)	Subscriber & spouse[1]	Subscriber & children[2]	Subscriber, spouse[1] & children[2]	Employee/ family
UMP Achieve 1[3]	$33	$66	$58	$99	$750/$2,250
UMP Achieve 2[3]	$98	$196	$172	$294	$250/$750
UMP High Deductible[3]	$25	$50	$44	$75	$1,400/$2,800

Note: We recommend calling your provider directly to confirm what plans they accept before making your selection.

Dental plan options

Plan name	Plan type	Plan administrator	Plan network	Plan group number
DeltaCare	Managed-care plan	Delta Dental of Washington	DeltaCare SEBB	Group 09601
Willamette Dental Group Plan	Managed-care plan	Willamette Dental of Washington, Inc.	Willamette Dental Group, P.C.	WA 733
Uniform Dental Plan (UDP)	Preferred-provider plan	Delta Dental of Washington	Delta Dental PPO	Group 09600

Dental Benefits Comparison

For information on specific benefits and exclusions, refer to the dental plan's certificate of coverage or contact the plan directly. A PPO refers to a preferred-provider organization (network). If anything in these charts conflicts with the plan's Certificate of Coverage (COC), the COC takes precedence and prevails.

Annual costs	PPO	Managed-care plans	
	Uniform Dental Plan (Group 09600)	DeltaCare (Group 09601)	Willamette Dental Group (Group WA 733)
Deductible	$50 individual/ up to $150 family	None	None
Plan maximum (see specific benefit maximums below)	$1,750	No general plan maximum	No general plan maximum

Benefits	PPO	Managed-care plans	
	Uniform Dental Plan (Group 09600)	DeltaCare (Group 09601)	Willamette Dental (Group WA 733)
	You pay after deductible:	You pay:	
Dentures	50% PPO and out of state; 60% non-PPO	$140 for complete upper or lower	$140 for complete upper or lower
Root canals (endodontics)	20% PPO and out of state; 30% non-PPO	$100 to $150	$100 to $150
Nonsurgical TMJ	30% of costs until plan has paid $500 for PPO, out of state, or non-PPO; then any amount over $500 in member's lifetime	30% of costs, then any amount after plan has paid $1,000 per year, then any amount over $5,000 in member's lifetime	Any amount over $1,000 per year and $5,000 in member's lifetime
Oral surgery	20% PPO and out of state; 30% non-PPO	$10 to $50 to extract erupted teeth	$10 to $50 to extract erupted teeth

Benefits	PPO	Managed-care plans	
	Uniform Dental Plan (Group 09600 PPO)	DeltaCare (Group 09601)	Williamette Dental (Group WA733)
	You pay after deductible:	You pay:	
Orthodontia	50% of costs until the plan has paid a maximum of $1,750 for member's lifetime (separate from the annual maximum of $1,750)	Up to $1,500 copay per case	Up to $1,500 copay per case
Orthognathic surgery	30% of costs until plan has paid $5,000 for PPO, out of state, or non-PPO; then any amount over $5,000 in member's lifetime	30% of the lesser of the maximum allowable or the fees actually charged; then any amount over $5,000 in member's lifetime	30%, then any amount over $5,000 in member's lifetime
Periodontic services (treatment of gum disease)	20% PPO and out of state; 30% non-PPO	$15 to $100	$15 to $100
Preventive/ diagnostic (deductible doesn't apply)	$0 PPO; 10% out of state; 20% non-PPO	$0	$0
Restorative fillings	20% PPO and out of state; 30% non-PPO	$10 to $50	$10 to $50
Restorative crowns	50% PPO and out of state; 60% non-PPO	$100 to $175	$100 to $175

Note: We recommend calling your provider directly to confirm what plans they accept before making your selection.

Selecting a vision plan

If you are eligible for SEBB Program benefits, vision coverage is included for you and your eligible dependents; your employer pays the premium. You and any enrolled dependents must enroll in the same SEBB vision plan. The vision benefit comparison chart is available on page 53.

Vision plan options

There are three SEBB Program vision plans to choose from.

- Davis Vision
- EyeMed Vision Care
- MetLife Vision

Routine eye exams are covered at 100 percent under any of the three plans. In general, the plan covers frames up to $150 every 24 months, and then pays 20 percent of the balance over $150.

Before you select a vision plan, check with the plan to see if your vision provider is in the plan's network. You can call the vision plan's customer service (listed in the beginning of this guide), or use the vision plan network's online directory. Some vision plans have their own clinics, where you get the plan's best price for services and hardware.

Vision Benefits Comparison

For information on specific benefits and exclusions, refer to the vision plan's certificate of coverage or contact the plan directly. The figures listed below show what you pay for in-network coverage, with the amount up to which you would be reimbursed for out-of-network services in parentheses. If anything in these charts conflicts with the plan's Certificate of Coverage (COC), the COC takes precedence and prevails.

Adults (19 and older)

Vision care service	Davis Vision	EyeMed	MetLife
Routine eye exam (once per calendar year, starting January 1)	$0 ($40)	$0 ($84)	$0 ($45)
Frames (once every 24 months starting January 1 in even years)	$0 up to $150, then 80% of balance over $150; or, $0 at Visionworks; or, $0 for any of the Exclusive Frame Collection ($50)	$0 up to $150, then 80% of balance over $150 ($75)	$0 up to $150, then 80% of balance over $150 ($70)
Lenses (once every 24 months starting January 1 in even years)	$0 (Single, $40; bifocal, $60; trifocal, $80; lenticular, $100)	$0 (Single, $25; bifocal, $40; trifocal, $55; lenticular, $55)	$0 (Single, $30; bifocal, $50; trifocal, $65; lenticular, $100)
Progressive lenses (once every 24 months starting January 1 in even years)	$50-$140 ($60)	$55-$175 ($55)	$0-$175 ($50)

Lens enhancements	Davis Vision	EyeMed	MetLife
Anti-reflective coating	$35–$60[2]	$45–$85 ($5)	$41–$85[1]
Scratch-resistant	$0[2]	$0 ($5)	$17–$33[1]
Polycarbonate	$30[2]	$40[2]	$31–$35[1]
Photochromic/transitions	$65[2]	$75[2]	$47-$82[1]
Polarized	$75[2]	80% of retail price[2]	80% of retail price[1]
Tinting	$0[2]	$15[2]	$17–$44[1]
UV treatment	$12[2]	$15[2]	$0[1]

[1] Reimbursement for out-of-network lens enhancements is applied to the out-of-network reimbursement amount for each lens (single, $30; bifocal, $50; trifocal, $65; lenticular, $100; progressive, $50).
[2] No out-of-network lens enhancement reimbursement is available.

Contact lenses (in lieu of glasses)	Davis Vision	EyeMed	MetLife
Conventional*	$0 up to $150, then 85% of balance over $150; or, four boxes from Collection lenses ($105)	$0 up to $150, then 85% of balance over $150 ($150)	$0 up to $150, then 100% of balance over $150 ($105)
Disposable*	$0 up to $150, then 85% of balance over $150; or eight boxes from Collection lenses ($105)	$0 up to $150, then 100% of balance over $150 ($150)	$0 up to $150, then 100% of balance over $150 ($105)
Medically necessary	$0 ($225)	$0 ($300)	$0 ($210)

* Conventional lenses, with proper care and cleaning, can be used for longer periods of time, from one month to up to one year. Disposable contact lenses are single-use lenses and are removed and discarded after a determined period of time, typically at the end of each day or week.

(continued)

Benefits listed in red updated as of 9/13/19

Additional member savings	Davis Vision	EyeMed	MetLife
Additional glasses	30% off	Up to 40% off	20% off
LASIK surgery	40-50% off national average	15% off retail price; or, 5% off a promotional offer	15% off retail price; or, 5% off a promotional offer

Children (under age 19) – what you pay for in-network services

Vision care service (once per calendar year)	Davis Vision	EyeMed	MetLife
Routine eye exam	$0	$0	$0
Frames	$0 up to $150, then 80% of balance over $150	$0 up to $150, then 80% of balance over $150	$0 up to $150, then 80% of balance over $150
Lenses	$0	$0	$0
Progressive lenses	$50-$140	$0-$175	$0-$175

Lens enhancements	Davis Vision	EyeMed	MetLife
Anti-reflective coating	$35-$60	$45-$85	$41–$85
Scratch-resistant	$0	$0	$0
Polycarbonate	$0	$0	$0
Photochromic/transitions	$65	$75	$47–$82
High Index	$0	$0	$0
Tinting	$0	$15	$17–$44
UV treatment	$0	$15	$0

Contact lenses (in lieu of glasses)	Davis Vision	EyeMed	MetLife
Conventional*	$0 up to 4 boxes annually	Any amount over $300	Any amount over $300
Disposable*	$0 up to 8 boxes annually	Any amount over $300	Any amount over $300
Medically necessary	$0	Any amount over $300	$0

* Conventional lenses, with proper care and cleaning, can be used for longer periods of time, from one month to up to one year. Disposable contact lenses are single-use lenses and are removed and discarded after a determined period of time, typically at the end of each day or week.

Additional member savings	Davis Vision	EyeMed	MetLife
Additional glasses	50% off at Visionworks; 30% off at other providers	40% off	20% off
LASIK surgery	40%-50%	15% off retail price, or 5% off promotional price	15% off retail price, or 5% off promotional price

Benefits listed in red updated as of 9/13/19