

Selecting a dental plan

If you are eligible for SEBB Program benefits, dental 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 dental plan.

There are three SEBB Program dental plans to choose from—two managed care plans and one preferred-provider plan. Make sure you check with the plan to see if the dentist you want is in the plan’s network. The dental benefit comparison chart is available on page 51.

Things to keep in mind before you select a dental plan or provider

DeltaCare and Willamette Dental Group are managed-care plans. You must choose a primary dental provider within their networks. If you do not choose a primary dental provider, one will be chosen for you. These plans will not pay claims if you see a provider outside of their network.

Uniform Dental Plan (UDP) is a preferred provider organization (PPO) plan. You may choose any dental provider, but will generally have lower out-of-pocket costs if you see network providers.

Check with the plan to see if your dentist is in the plan’s network. Make sure you correctly identify your dental plan’s network and group number (see table below). This is especially important because DeltaCare and UDP are both administered by Delta Dental of Washington. You can call the dental plan’s customer service (listed in the beginning of this guide), or use the dental plan network’s online

directory. Carefully review your selection before enrolling in SEBB My Account or submitting your paper enrollment form.

How do the DeltaCare and Willamette Dental Group plans work?

DeltaCare and Willamette Dental Group are managed-care plans. You must select and receive care from a primary care dental provider in that plan’s network. If you choose one of these plans and seek services from a dentist not in the plan’s network, the plan will not pay your dental claims. Before enrolling, call the plan to make sure your dentist is in the plan’s network. Do not rely solely on information from your dentist’s office.

Neither plan has an annual deductible. You don’t need to track how much you have paid out of pocket before the plan begins covering benefits. You pay a set amount (copay) when you receive dental services. Neither plan has an annual maximum that they pay for covered benefits (some specific exceptions apply). Referrals are required from your primary care dental provider to see a specialist. You may change providers in your plan’s network at any time.

DeltaCare is administered by Delta Dental of Washington. Its network is DeltaCare SEBB (Group 09601).

Willamette Dental Group is underwritten by Willamette Dental of Washington, Inc. Its network is Willamette Dental Group, P.C., with dental offices in Washington, Oregon, and Idaho. Willamette Dental Group administers its own dental network (WA 733).

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

How does the Uniform Dental Plan (UDP) work?

UDP is a preferred-provider organization (PPO) plan. You can choose any dental provider and change providers at any time. More than three out of four dentists in Washington State participate with this PPO.

When you see a network provider, your out-of-pocket expenses are generally lower than if you chose a provider who is not part of this network. Under UDP, you pay a percentage of the plan's allowed amount (coinsurance) for dental services after you have met the annual deductible. UDP pays up to an annual maximum of \$1,750 for covered benefits for each enrolled dependent, including preventive visits.

UDP is administered by Delta Dental of Washington. Its network is 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)	Williamette 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

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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

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, frames are covered up to \$150 every 24 months, and then 80 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	\$45-\$85 (\$5)	\$41-\$85 ¹
Scratch-resistant	\$0	\$0 (\$5)	\$17-\$33 ¹
Polycarbonate	\$30	\$40 ²	\$31-\$35 ¹
Photochromic/transitions	\$65	\$75 ²	\$47-\$82 ¹
Polarized	\$75	80% of retail price ²	80% of retail price ¹
Tinting	\$0	\$15 ²	\$17-\$44 ¹
UV treatment	\$12	\$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.

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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 your pay for in-network services

Vision care service (once per calendar year)	Davis Vision	EyeMed	MetLife
Routine eye exam	\$0	\$0	\$0
Frames	\$150 allowance; 80% off balance above \$150	\$150 allowance; 80% off balance above \$150	\$150 allowance; 80% off balance above \$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