DELTA DENTAL®

Delta Dental of Washington

2025 Delta Dental Individual & Family™ Plans****

Coverage you can count on.

Dental care is an important factor in your overall health. And our Individual and Family™ plans are a great way to protect yours and your family's oral health for years to come. With a wide range of coverage options – each with unique features designed to fit your lifestyle – there's something for every smile and every budget.

Plus, we've teamed up with VSP® Vision Care – one of the nation's most trusted vision plan providers – to bring you two great vision coverage options.

DeltaVision® - Essential 150**	DeltaVision® - Brilliance 200**
Affordable coverage with low copays on wellness visits, exams, and prescriptions. Cost-sharing for glasses and contacts.	100% coverage for wellness visits, exams, and prescriptions. Glasses and contacts are covered in full* when seeing a VSP Network Doctor.
Cost per month: **Individual Only - $12.50** **Individual + Spouse - $26.25** **Individual + Child(ren) - $27.50** **Individual + Spouse + Child(ren) - $41.25**	**Cost per month:** **Individual Only - $15.55** **Individual + Spouse - $32.65** **Individual + Child(ren) - $34.20** **Individual + Spouse + Child(ren) - $51.30**

*Up to the plans benefit allowance.

**For a breakdown of detailed vision plan information, see page 2.

****Revised May 2025.

VSP is a registered trademark of Vision Service Plan.

Our dental plans at-a-glance***:

Plan	Top Features
Premium	**High maximum, three periodontal maintenance cleanings**, and **policy lifetime deductible**.
Plus Ortho	This plan is for everybody. Mouthguard coverage for young athletes ages 6-18, teeth grinders and treating periodontal disease. Major and restorative procedures and **50% coverage on orthodontics, up to $1,500**.
Ascent	**No waiting period and 100% coverage for preventive care services** like cleanings and exams. Your loyalty is rewarded with a **per person maximum that increases** over the first two years that you renew.
Enhanced	**100% coverage for cleanings, exams, x-rays, and fluoride**. And most major procedures are covered at 50%.
Basic	**Most affordable plan** that covers preventive care, fillings, and non-surgical extractions.

***For a breakdown of monthly costs and detailed plan information, see pages 3 & 4.

DeltaVision®
In Partnership with VSP®

DeltaVision Plan comparison for Individual & Families

	DeltaVision® - Essential 150	DeltaVision® - Brilliance 200
Benefit frequency		
Exams & lenses	Every 12 months	
Frames		
Contacts (instead of glasses)		
Copays		
WellVision Exam®	$10	$0
Prescription glasses	$10	$0
Contact lens exam (fitting and evaluation)	Up to $40	$0
In-network allowances		
Retail frame value (Included in prescription glasses copay)	$150	$200
	$80 Costco & Walmart Frame allowance	$110 Costco & Walmart Frame allowance
Lenses (Included in prescription glasses copay)	Single vision, lined bifocal and lined trifocal lenses and lenticular	
Covered lens enhancements	Impact-resistant lens enhancements for children: $0; Standard progressives: $55	Impact-resistant lens enhancements for children: $0; Standard progressives, UV protection, scratch resistant coating, gradient tints: $0
Contact lenses (instead of glasses)	$150	$200
Extra discounts and savings		
Additional glasses and sunglasses	20% savings on additional glasses and non-prescription sunglasses, including lens enhancements, from any VSP provider within 12 months of last WellVision Exam®	
Routine retinal screening	Max $39 copay on routine retinal screening as an enhancement to a WellVision Exam®	
Coverage with out-of-network providers		
Not covered		
DeltaVision eligibility		
Vision benefits are only offered in conjunction with a Delta Dental of Washington - Delta Dental Covers Me Individual Dental Plan. All other eligibility requirements are shared with the dental plan. Add a DeltaVision® plan to your new dental plan at checkout or existing dental plan at any time.		

Please note: This is only a partial summary of benefits for these vision plans. Please refer to the plan policy for full details of benefits, exclusions and limitations. Plan designs and rates are subject to change.

2025 Delta Dental Individual & Family™ Plans

	Premium	Plus Ortho	Ascent	Enhanced	Basic
Per Person Maximum Benefit (per policy year)	**$2,000**	**$1,500** (plus shared household maximum)	**$1,000/$1,250/$1,500** Yr1, Yr2, Yr3	**$1,000**	$1,000
Deductible (per person covered on the plan)	**$100** (one-time)	**$50**	**$50**	**$50**	**$0**
Preventive Care (exams, cleanings, bitewing x-rays)	**100%** (inc. 3 exams and cleanings per year)	**100%**	**100%**	**100%**	**100%**
Office Copay	**$0**	**$0**	**$0**	**$0**	**$15** per office visit
Repairing Teeth (crowns)	**50%**	**50%**	**50%**	**50%**	Not Covered
Replacing Teeth (implants, bridges, dentures)	**50%**	**50%**	**50%**	**50%**	Not Covered
Fillings (remove and repair tooth decay)	**80%**	**50%**	**50%/60%/70%** Yr1, Yr2, Yr3	**50%**	**50%**
Root Canals (save a damaged natural tooth)	**50%**	**50%**	**50%**	**50%**	Not Covered
Periodontal Maintenance (for gum disease)	**50%** no wait period (three per benefit year)	**50%** (one every six months)	**50%/60%/70%** Yr1, Yr2, Yr3	**50%**	Not Covered
Nightguards	Not Covered	**50%**	Not Covered	Not Covered	Not Covered
Orthodontics (straightening your smile)	Not Covered	**50%** ($1,500 lifetime maximum w/ 12-month waiting period)	Not Covered	Not Covered	Not Covered
Waiting Period – applies to some plans without prior qualifying dental coverage	Yes	Yes	**No**	Yes	Yes

On Premium, Plus Ortho, Enhanced, and Basic plans, waiting periods may be waived when transferring over from another qualifying dental plan.
Waiting periods do not apply to Ascent.

This is only a partial summary of benefits for these dental plans. Please refer to the plan policy for full details of benefits, exclusions and limitations. Plan designs and rates are subject to change. There may be limits on how many times you can use certain services in a year. Monthly premiums may be different based on plan effective date, plan choice, your age, your location, number of people insured, their age, and relationship to you.

2025 Delta Dental Individual & Family™ Plans Rates

Eastern WA ZIP code range: 98801 - 99403 | Western WA ZIP code range: 98002 - 98687

2025	Premium		Plus Ortho		Ascent	
	West WA	East WA	West WA	East WA	West WA	East WA
Coverage Tier	Monthly Rate	Monthly Rate	Monthly Rate	Monthly Rate	Monthly Rate	Monthly Rate
Single	$74.25	$64.65	$67.55	$58.80	$64.50	$56.10
Single + Spouse	$148.50	$129.25	$135.10	$117.60	$128.85	$112.15
Single + Child(ren)	$166.70	$145.05	$151.65	$132.05	$144.65	$125.90
Single + Spouse + Child(ren)	$241.05	$209.75	$219.35	$190.85	$209.25	$182.05

2025	Enhanced		Basic	
	West WA	East WA	West WA	East WA
Coverage Tier	Monthly Rate	Monthly Rate	Monthly Rate	Monthly Rate
Single	$60.25	$52.35	$36.25	$31.45
Single + Spouse	$120.45	$104.70	$72.45	$62.90
Single + Child(ren)	$135.20	$117.60	$81.30	$70.35
Single + Spouse + Child(ren)	$195.40	$170.00	$117.30	$102.75

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DDCM I&F / MAY 2025

To apply by phone: 877.943.8335.
Be sure to provide the name of your broker.

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