



Delta Dental of Washington

DeltaDentalWA.com

To apply by phone: 1.888.899.3736

## 2027 Delta Dental Individual &amp; Family™ Plans

| DENTAL PLANS                 | Optimum                                                                                              |              | Premium                                                                   |              | Plus Ortho                                                               |              | Ascent                                                                           |              |
|------------------------------|------------------------------------------------------------------------------------------------------|--------------|---------------------------------------------------------------------------|--------------|--------------------------------------------------------------------------|--------------|----------------------------------------------------------------------------------|--------------|
|                              | <b>NEW for 2027</b><br>Cosmetic benefits and highest cost-sharing for restorative and major services |              | High maximum and three periodontal maintenance cleanings per benefit year |              | Orthodontic benefits such as braces and aligners installed by DMD or DDS |              | No waiting period and coverage that increases over the first two years you renew |              |
|                              | Western WA                                                                                           | Eastern WA   | Western WA                                                                | Eastern WA   | Western WA                                                               | Eastern WA   | Western WA                                                                       | Eastern WA   |
| Coverage Tier                | Monthly Rate                                                                                         | Monthly Rate | Monthly Rate                                                              | Monthly Rate | Monthly Rate                                                             | Monthly Rate | Monthly Rate                                                                     | Monthly Rate |
| Single                       | \$111.70                                                                                             | \$97.30      | \$85.50                                                                   | \$74.40      | \$84.55                                                                  | \$73.60      | \$73.15                                                                          | \$63.60      |
| Single + Spouse              | \$223.40                                                                                             | \$194.55     | \$171.00                                                                  | \$148.80     | \$169.10                                                                 | \$147.20     | \$146.10                                                                         | \$127.15     |
| Single + Child(ren)          | \$250.80                                                                                             | \$218.30     | \$191.90                                                                  | \$167.00     | \$189.85                                                                 | \$165.30     | \$164.00                                                                         | \$142.75     |
| Single + Spouse + Child(ren) | \$362.70                                                                                             | \$315.65     | \$277.55                                                                  | \$241.50     | \$274.60                                                                 | \$238.95     | \$237.25                                                                         | \$206.40     |

| DENTAL PLANS                 | Enhanced                                                                         |              | Basic                                                                                    |              | SimpleChoice                                                                                         |              |              |
|------------------------------|----------------------------------------------------------------------------------|--------------|------------------------------------------------------------------------------------------|--------------|------------------------------------------------------------------------------------------------------|--------------|--------------|
|                              | 100% coverage on most preventive care services and 50% on most dental procedures |              | Most affordable plan that covers preventive care, fillings, and non-surgical extractions |              | <b>NEW for 2027</b><br>Fixed out-of-pocket costs, no deductible, no copays, and no plan year maximum |              |              |
|                              | Western WA                                                                       | Eastern WA   | Western WA                                                                               | Eastern WA   |                                                                                                      | Western WA   | Eastern WA   |
| Coverage Tier                | Monthly Rate                                                                     | Monthly Rate | Monthly Rate                                                                             | Monthly Rate | Member Age Tier                                                                                      | Monthly Rate | Monthly Rate |
| Single                       | \$63.75                                                                          | \$55.40      | \$39.00                                                                                  | \$33.85      | Age 0-25                                                                                             | \$43.00      | \$30.50      |
| Single + Spouse              | \$127.40                                                                         | \$110.75     | \$77.95                                                                                  | \$67.65      | Age 26-50                                                                                            | \$50.90      | \$38.50      |
| Single + Child(ren)          | \$143.05                                                                         | \$124.40     | \$87.45                                                                                  | \$75.70      | Age 51+                                                                                              | \$55.40      | \$44.05      |
| Single + Spouse + Child(ren) | \$206.75                                                                         | \$179.85     | \$126.20                                                                                 | \$110.55     | Price per member                                                                                     |              |              |

| VISION PLANS | DeltaVision® - Essential 150                                                   | DeltaVision® - Brilliance 200                                                               |
|--------------|--------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|
|              | Our standard plan with \$150 retail frame (or elective contact lens) allowance | Our premium plan with \$200 retail frame (or elective contact lens) allowance and no copays |

See vision rates  
and details on page 3

Broker Name:

Email:

Phone:

Apply Online:

## 2027 Delta Dental Individual & Family™ Plans

|                                                        | Optimum                                         | Premium                         | Plus Ortho                                                                | Ascent                                    | Enhanced    | SimpleChoice<br>(amount you pay)                                                        | Basic                                                                        |
|--------------------------------------------------------|-------------------------------------------------|---------------------------------|---------------------------------------------------------------------------|-------------------------------------------|-------------|-----------------------------------------------------------------------------------------|------------------------------------------------------------------------------|
| Monthly Premium<br>Western Washington                  | \$111.70                                        | \$85.50                         | \$84.55                                                                   | \$73.15                                   | \$63.75     | \$43.00 ages 0-25<br>\$50.90 ages 26-50<br>\$55.40 ages 51+                             | \$39.00                                                                      |
| Monthly Premium<br>Eastern Washington                  | \$97.30                                         | \$74.40                         | \$73.60                                                                   | \$63.60                                   | \$55.40     | \$30.50 ages 0-25<br>\$38.50 ages 26-50<br>\$44.05 ages 51+                             | \$33.85                                                                      |
| Plan Year Maximum                                      | \$2,000 Yr1<br>\$3,000 Yr2<br>\$5,000 Yr3       | \$2,000                         | \$1,500 (plus shared household maximum of \$250 per person up to \$1,250) | \$1,000 Yr1<br>\$1,250 Yr2<br>\$1,500 Yr3 | \$1,000     | N/A                                                                                     | \$1,000                                                                      |
| Deductible (per person)                                | \$100                                           | \$100                           | \$50                                                                      | \$50                                      | \$50        | \$0                                                                                     | \$0                                                                          |
| Preventive Care<br>(exams, cleanings, bitewing x-rays) | 100%                                            | 100%                            | 100%                                                                      | 100%                                      | 100%        | \$85 Copay                                                                              | 100% cleanings and exams<br>50% full mouth and panoramic x-rays and fluoride |
| Office Copay                                           | \$0                                             | \$0                             | \$0                                                                       | \$0                                       | \$0         | None                                                                                    | \$15 per office visit                                                        |
| Crowns                                                 | 60%                                             | 50%                             | 50%                                                                       | 50%                                       | 50%         | \$800 Copay                                                                             | Not Covered                                                                  |
| Implants, Bridges, Dentures                            | 60%                                             | 50%                             | 50%                                                                       | 50%                                       | 50%         | \$2,750 Copay per implant<br>\$2,400 Copay per 3-unit bridge<br>\$800 Copay per denture | Not Covered                                                                  |
| Fillings                                               | 80%                                             | 80%                             | 50%                                                                       | 50% Yr1<br>60% Yr2<br>70% Yr3             | 50%         | \$125 Copay                                                                             | 50% excludes back teeth tooth-colored fillings                               |
| Root Canals                                            | 60%                                             | 50%                             | 50%                                                                       | 50%                                       | 50%         | \$600 Copay                                                                             | Not Covered                                                                  |
| Periodontal Maintenance<br>(for gum disease)           | 60%<br>(three per benefit year)                 | 50%<br>(three per benefit year) | 50%                                                                       | 50% Yr1<br>60% Yr2<br>70% Yr3             | 50%         | Included in Preventive Care Visit                                                       | Not Covered                                                                  |
| Nightguards                                            | Not Covered                                     | Not Covered                     | 50%                                                                       | Not Covered                               | Not Covered | Not Covered                                                                             | Not Covered                                                                  |
| Cosmetic                                               | 50% teeth whitening or bleaching<br>60% veneers | Not Covered                     | Not Covered                                                               | Not Covered                               | Not Covered | Not Covered                                                                             | Not Covered                                                                  |
| Orthodontics                                           | Not Covered                                     | Not Covered                     | 50% (\$1,500 lifetime maximum w/ 12-month waiting period)                 | Not Covered                               | Not Covered | Not Covered                                                                             | Not Covered                                                                  |
| Waiting Period                                         | Yes                                             | Yes                             | Yes                                                                       | No                                        | Yes         | Yes                                                                                     | Yes                                                                          |

Coverage percentages displayed in the table above represent the percentage of the allowed amount that is covered by Delta Dental of Washington.

On Optimum, Premium, Plus Ortho, Enhanced, SimpleChoice, and Basic plans, waiting periods may be waived when transferring 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 choice, age, location, number of people insured, their age and relationship to you.*

## 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. VSP is a registered trademark of Vision Service Plan.*