



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, go to <https://regence.com> or call 1 (888) 370-6156. 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 [healthcare.gov/sbc-glossary](https://www.healthcare.gov/sbc-glossary) or call 1 (888) 370-6156 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	\$3,500 individual (single coverage) / \$7,000 family*. *An individual on family coverage will not have their <u>deductible</u> exceed \$5,000.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
Are there services covered before you meet your <u>deductible</u>?	Yes. Certain <u>preventive care</u> and those services listed below as " <u>deductible</u> does not apply."	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	\$5,000 individual (single coverage) / \$10,000 family* per calendar year. *An individual on family coverage will not have their <u>out-of-pocket limit</u> exceed \$5,000.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u>?	<u>Premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u>?	Yes. See https://regence.com/go/WW/Preferred or call 1 (888) 370-6156 for a list of <u>network providers</u> .	You pay the least if you use a <u>provider</u> in the preferred <u>network</u> . You pay more if you use a <u>provider</u> in the participating <u>network</u> . You will pay the most if you use a <u>non-participating provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use a <u>non-participating provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u>?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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
		Preferred Provider (You pay the least)	Participating Provider (You pay more)	Non-participating Provider (You pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% <u>coinsurance</u>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Specialist</u> visit	20% <u>coinsurance</u>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	
	<u>Preventive care/screening/immunization</u>	No charge, <u>deductible</u> does not apply	No charge, <u>deductible</u> does not apply	40% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://regence.com/go/2024/WW/3tier	Tier 1 (Typically, generic drugs with highest overall value)	Not applicable, refer to <u>participating provider</u> and <u>non-participating provider</u> columns.	20% <u>coinsurance</u> / retail prescription; 20% <u>coinsurance</u> / home delivery prescription	20% <u>coinsurance</u> / retail prescription; 20% <u>coinsurance</u> / home delivery prescription	<u>Prescription drugs</u> not on the Drug List are not covered, unless an exception is approved. <u>Deductible</u> does not apply for insulin and drugs specifically designated as preventive for treatment of certain chronic diseases that are on the Optimum Value Medication List. 90-day supply / retail prescription (your <u>cost share</u> is per 30-day supply) 90-day supply / home delivery prescription 30-day supply / <u>specialty drug</u> prescription <u>Specialty drugs</u> are not available through home delivery. Coverage includes compound medications at 50% <u>coinsurance</u> . <u>Cost shares</u> for insulin will not exceed \$35 / 30-day supply retail prescription or \$105 / 90-day supply home delivery prescription. No charge, <u>deductible</u> does not apply for certain preventive drugs, contraceptives and immunizations at a participating pharmacy.
	Tier 2 (Typically, brand drugs with moderate overall value)	Not applicable, refer to <u>participating provider</u> and <u>non-participating provider</u> columns.	20% <u>coinsurance</u> / retail prescription; 20% <u>coinsurance</u> / home delivery prescription	20% <u>coinsurance</u> / retail prescription; 20% <u>coinsurance</u> / home delivery prescription	
	Tier 3 (Typically, brand drugs with lower overall value)	Not applicable, refer to <u>participating provider</u> and <u>non-participating provider</u> columns.	20% <u>coinsurance</u> / retail prescription; 20% <u>coinsurance</u> / home delivery prescription	20% <u>coinsurance</u> / retail prescription; 20% <u>coinsurance</u> / home delivery prescription	
	<u>Specialty drugs</u>	Not applicable, refer to <u>participating</u>	Refer to tier 1, 2 and 3 drugs above.	Refer to tier 1, 2 and 3 drugs above.	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Provider (You pay the least)	Participating Provider (You pay more)	Non-participating Provider (You pay the most)	
		<u>provider</u> and <u>non-participating provider</u> columns.			The first fill of <u>specialty drugs</u> may be provided by a retail pharmacy; additional refills must be provided by a specialty pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u> for ambulatory surgery centers; 20% <u>coinsurance</u> for all other facilities	40% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Physician/surgeon fees	10% <u>coinsurance</u> for ambulatory surgery center physicians; 20% <u>coinsurance</u> for all other physicians	40% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	
	<u>Urgent care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you are pregnant	Office visits	20% <u>coinsurance</u>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive</u>

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Provider (You pay the least)	Participating Provider (You pay more)	Non-participating Provider (You pay the most)	
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>services</u> . Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	130 visits / year
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	30 inpatient days / year 25 outpatient visits / year Includes physical therapy, occupational therapy and speech therapy.
	<u>Habilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	25 professional neurodevelopmental visits / year Includes physical therapy, occupational therapy and speech therapy.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	90 inpatient days / year
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Hospice services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	14 respite inpatient or outpatient days / lifetime
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	Not covered	

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.)

- Bariatric surgery
- Cosmetic surgery, except congenital anomalies
- Dental care
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care
- Routine foot care, except for diabetic patients
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Abortion
- Acupuncture, 12 visits / year
- Chiropractic care, 10 spinal manipulations / year
- Hearing aids, \$3,000 per ear / 36 months
- Non-emergency care when traveling outside the U.S.

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: the U.S. Department of Labor, Employee Benefits Security Administration at 1 (866) 444-3272 or dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1 (877) 267-2323 ext. 61565 or ccio.cms.gov or your state insurance department. You may also contact the plan at 1 (888) 370-6156. 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 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 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 plan at 1 (888) 370-6156 or visit regence.com or the U.S. Department of Labor, Employee Benefits Security Administration at 1 (866) 444-3272 or dol.gov/ebsa/healthreform. You may also contact the Office of the Insurance Commissioner of Washington State by calling 1 (800) 562-6900, or through the Internet at: 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

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) 370-6156.

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** **\$3,500**
- **Specialist coinsurance** **20%**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

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
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In this example, Peg would pay:

Cost Sharing

<u>Deductibles</u>	\$3,500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,500

What isn't covered

Limits or exclusions	\$60
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The total Peg would pay is	\$5,060
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Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **\$3,500**
- **Specialist coinsurance** **20%**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

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
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In this example, Joe would pay:

Cost Sharing

<u>Deductibles</u>	\$2,000
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$900

What isn't covered

Limits or exclusions	\$200
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The total Joe would pay is	\$3,100
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Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **\$3,500**
- **Specialist coinsurance** **20%**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

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
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In this example, Mia would pay:

Cost Sharing

<u>Deductibles</u>	\$2,800
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0

What isn't covered

Limits or exclusions	\$0
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The total Mia would pay is	\$2,800
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The plan would be responsible for the other costs of these EXAMPLE covered services.

NONDISCRIMINATION NOTICE

Regence complies with applicable Federal and Washington state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity or sexual identity. Regence does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity or sexual orientation.

Regence:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, and accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services listed above, please contact:

Medicare Customer Service

1-800-541-8981 (TTY: 711)

Customer Service for all other plans

1-888-344-6347 (TTY: 711)

If you believe that Regence has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity or sexual orientation, you can file a grievance with our civil rights coordinator below:

Medicare Customer Service

Civil Rights Coordinator
MS: B32AG, PO Box 1827
Medford, OR 97501
1-866-749-0355, (TTY: 711)
Fax: 1-888-309-8784
medicareappeals@regence.com

Customer Service for all other plans

Civil Rights Coordinator
MS CS B32B, P.O. Box 1271
Portland, OR 97207-1271
1-888-344-6347, (TTY: 711)
CS@regence.com

You can also file a civil rights complaint with:

- The U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW,
Room 509F HHH Building
Washington, DC 20201

1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

- The Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint portal available at <https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status>, or by phone at 800-562-6900, 360-586-0241 (TDD).

Complaint forms are available at <https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx>

Language assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-344-6347 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-344-6347 (TTY: 711)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-344-6347 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-344-6347 (TTY: 711) 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-344-6347 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-344-6347 (телетайп: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-344-6347 (ATS : 711)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-344-6347 (TTY:711) まで、お電話にてご連絡ください。

Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'déé', t'áá jiik'eh, éí ná hóló, kojí' hódíílnih 1-888-344-6347 (TTY: 711.)

FAKATOKANGA'I: Kapau 'oku ke Lea-Fakatonga, ko e kau tokoni fakatonu lea 'oku nau fai atu ha tokoni ta'etotongi, pea te ke lava 'o ma'u ia. ha'o telefonimai mai ki he fika 1-888-344-6347 (TTY: 711)

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-344-6347 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711)

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតល្អល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-888-344-6347 (TTY: 711)។

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-888-344-6347 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachdienstleistungen zur Verfügung. Rufnummer: 1-888-344-6347 (TTY: 711)

ማስታወሻ:- የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጅተዋል፤ በሚከተለው ቁጥር ይደውሉ 1-888-344-6347 (መስማት ለተሳናቸው:- 711)::

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-888-344-6347 (телетайп: 711)

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-888-344-6347 (टिक्टाइप: 711)

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-888-344-6347 (TTY: 711)

MAANDO: To a waawi [Adamawa], e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-888-344-6347 (TTY: 711)

โปรดทราบ: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-888-344-6347 (TTY: 711)

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ຄວນມີຜ້ອມໃຫ້ທ່ານ. ໂທ 1-888-344-6347 (TTY: 711)

Afaan dubbattan Oroomiffaa tiif, tajaajjila gargaarsa afaanii tola ni jira. 1-888-344-6347 (TTY: 711) tiin bilbilaa.

توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-888-344-6347 (TTY: 711) تماس بگیرید.

ملحوظة: إذا كنت تتحدث فاذاكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-344-6347 (رقم هاتف الصم والبكم 711 TTY)

Building Industry Association of WA
Group # 01093

Delta Dental PPO Plus Premier™ Plan - Benefit Summary

Effective Date	May 1, 2024
Benefit Period	January – December
Benefit Period Maximum (Per Person)	\$1,500

	Dental Network		
	Delta Dental PPO SM Dentist	Delta Dental Premier [®] Dentist	Non-Participating Dentist
Benefit Period Deductible			
Does Not Apply to Class I (Per Person/Per Family)	\$50/\$150	\$50/\$150	\$50/\$150
Class I – Diagnostic & Preventive			
Exams	100%	100%	100%
Cleaning			
Fluoride			
X-Rays			
Sealants			
Class II – Restorative			
Fillings	80%	80%	80%
Endodontics (Root Canal)			
Periodontics			
Oral Surgery			
Class III – Major *			
Dentures	50%	50%	50%
Partial Dentures			
Implants			
Bridges			
Crowns			
Onlays			



***Important Note:** There is a six-month waiting period on Class III services. Participants must be enrolled in the plan for six months before coverage is provided for Class III services.

This is a summary of benefits for comparison and isn't a contract. Once you're enrolled, you can get a benefits booklet that will provide all the details of your dental plan. Please feel free to call our customer service department or visit our website at DeltaDentalWA.com if you have any questions.

Keep in mind, you will likely experience the greatest savings when you see a Delta Dental PPO dentist.

Get the most from your benefits!



Create a MySmile® account

It gives you secure, 24/7 access to your ID card, benefits information, out-of-pocket cost estimates, and more! Our “Find your member ID” tool makes registration easy. Visit DeltaDentalWA.com to create your account.

Choose an in-network dentist

Seeing a non-participating dentist means greater out-of-pocket costs! Your plan gives you access to the Delta Dental PPOSM and Delta Dental Premier[®] networks.

	Delta Dental PPO	Delta Dental Premier	Non-Delta Dental
Your plan’s network	✓	✓	
Least out-of-pocket costs	✓		
Files claims forms for you	✓	✓	
Comes with our quality management and cost protection	✓	✓	
No cost protection which means greatest out-of-pocket costs			✓

Find an in-network dentist near you:

1. Visit DeltaDentalWA.com
2. Click on ‘Online Tools’ and use our ‘Find a Dentist’ tool
3. Select ‘Delta Dental PPO’ or ‘Delta Dental Premier’ to filter your search results



Visit your dentist regularly

Your plan covers preventive care visits each year. Regular cleanings and check-ups are essential to keeping your smile healthy and preventing painful, expensive problems down the road.

Get out-of-pocket cost estimates

Knowing your cost upfront helps you and your dentist plan treatments to maximize your benefits.

MySmile Cost GenieSM gives you instant, cost estimates. It’s great for basic treatments like fillings. Simply sign into MySmile account to get your personalized estimate.

When you need extensive treatment, like a crown, ask your dentist for a “Predetermination.” You’ll get a **Confirmation of Treatment and Cost** from us. It details your dentist’s treatment plan, what your benefits cover, and how much you may owe your dentist for the treatment.



Still have questions? Contact us, we’re happy to help.

Call 800.554.1907, Monday – Friday from 7am to 5pm, Pacific Time
 Text 833.604.1246, Monday – Friday from 7am to 5pm, Pacific Time
 Visit DeltaDentalWA.com

DeltaVision - BV 20 benefit highlights

Now you can enjoy the benefits of comprehensive vision care. DeltaVision®, delivered in partnership with VSP® Vision Care, offers the quality coverage, exceptional service, and unparalleled networks you've come to enjoy with Delta Dental.

WellVision Exam®		\$20 Copay
Exams Once every Calendar Year	Annual eye exam to ensure overall visual wellness.	
Essential Medical Eye Care		\$20 Copay
Retinal imaging for members with diabetes covered-in-full. 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. Available as needed.		
Prescription glasses		\$0 Copay
Frames Once every Calendar Year	<ul style="list-style-type: none"> \$150 allowance for wide selection of frames - 20% savings on amount over allowance \$150 Walmart/Sam's Club frame allowance \$80 Costco frame allowance 	Included in prescription glasses copay
Lenses Once every Calendar Year	<ul style="list-style-type: none"> Single vision, lined bifocal, lined trifocal and lenticular lenses 	Included in prescription glasses copay
Covered lens enhancements	<ul style="list-style-type: none"> Impact-resistant lenses for children Standard Progressive lenses Average savings of 30% on other lens enhancements 	\$0
Elective contact lenses - instead of glasses		
Contacts Once every Calendar Year	<ul style="list-style-type: none"> \$150 allowance for contacts 	\$0 Copay
	<ul style="list-style-type: none"> Contact lens exam (fitting and evaluation) 	\$50 or the VSP Doctor's fee, whichever is less

Continued on back page ►

Extra savings

Featured frames	Additional \$20 allowance on Featured Frame Brands. Check vsp.com for current offers.
Glasses and sunglasses	20% savings on additional prescription and non-prescription glasses/sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam®
Retinal Screening	Member cost of \$39 or less on routine retinal screening as an enhancement to a WellVision Exam®
Laser Vision Correction	Average 15%-20% discount off retail price or 5% off the promotional price from a contracted facility. Visit vsp.com/offers for details.

Coverage with out-of-network providers (copays apply)

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	Elective Contact Lenses - up to \$105
Single Vision Lenses - up to \$30	Lenticular Lenses - up to \$100	Necessary Contact Lenses - up to \$210

Please Note: This is a summary of your benefits for comparison only and isn't a contract. Once you're enrolled, you will have access to your benefits booklet that provides more details of your vision plan. Policies are underwritten by Delta Dental of Washington, VSP is the vision plan administrator. Delta Dental and Delta Vision are registered trademarks of the Delta Dental Plans Association. VSP and WellVision Exam are registered trademarks.

Disclaimer: Coverage with any retail chain may differ or may not apply.
 Lens enhancements are not covered through an out-of-network provider.



Personalized Care

DeltaVision members receive quality care that focuses on their eyes and overall wellness. Our eye care provider will look for vision problems and signs of other health conditions.



Eyewear

Choose eyewear that's right for you and your budget. From classic styles to the latest designer fashions, there are hundreds of options for DeltaVision members.



Value and Savings

DeltaVision members receive great benefits on exams and eyewear at an affordable price.



Online

Visit vsp.com to find a provider near you, learn more about your vision benefits, and access claims.



Mobile App

Download the mobile app for Apple or Android. To download, visit the App Store (Apple) or Google Play (Android) and search for VSP.



Customer Service

Call VSP customer service representatives at 800.877.7195 and ask if your provider is participating in the VSP Doctor Network.