DELTA DENTAL
Delta Dental of Washington

2027 Delta Dental Individual & Family™ Plans

DeltaDentalWA.com
To apply by phone: 1.888.899.3736

DENTAL PLANS

	Optimum		Premium		Plus Ortho		Ascent	
	NEW for 2027 **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		**NEW for 2027** **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 (amount you pay)	Basic
Monthly Premium Western Washington	**$111.70**	**$85.50**	**$84.55**	**$73.15**	**$63.75**	**$43.00** ages 0-25 **$50.90** ages 26-50 **$55.40** ages 51+	**$39.00**
Monthly Premium Eastern Washington	**$97.30**	**$74.40**	**$73.60**	**$63.60**	**$55.40**	**$30.50** ages 0-25 **$38.50** ages 26-50 **$44.05** ages 51+	**$33.85**
Plan Year Maximum	**$2,000** Yr1 **$3,000** Yr2 **$5,000** Yr3	**$2,000**	**$1,500** (plus shared household maximum of $250 per person up to $1,250)	**$1,000** Yr1 **$1,250** Yr2 **$1,500** Yr3	**$1,000**	N/A	**$1,000**
Deductible (per person)	**$100**	**$100**	**$50**	**$50**	**$50**	**$0**	**$0**
Preventive Care (exams, cleanings, bitewing x-rays)	**100%**	**100%**	**100%**	**100%**	**100%**	**$85** Copay	**100%** cleanings and exams **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 **$2,400** Copay per 3-unit bridge **$800** Copay per denture	Not Covered
Fillings	**80%**	**80%**	**50%**	**50%** Yr1 **60%** Yr2 **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 (for gum disease)	**60%** (three per benefit year)	**50%** (three per benefit year)	**50%**	**50%** Yr1 **60%** Yr2 **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 whithening or bleaching **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®
In Partnership with VSP®

DeltaVision Plan comparison for Individual & Families

	DeltaVision® - Essential 150	DeltaVision® - Brilliance 200
Monthly Premium		
Individual Only	$12.50	$15.55
Individual + Spouse	$26.25	$32.65
Individual + Child(ren)	$27.50	$34.20
Individual + Spouse + Child(ren)	$41.25	$51.30
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.

I&F 2027 BROKER BROCHURE/SEPTEMBER 2026

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Be sure to provide the name of your broker.

DeltaDentalWA.com

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