

CATEGORY	DELTA DENTAL OF WA-NETWORK DENTAL PLAN – PPO		
	NETWORK	NONNETWORK	LIMITATIONS AND EXCEPTIONS
PROVIDER CHOICE	Use any network dentist to receive highest payment levels, your cost for orthodontia care will be lower at a network provider	Use any nonnetwork dentist and receive lower payment levels, your cost for orthodontia care will be higher at a nonnetwork provider	
PLAN YEAR DEDUCTIBLES	\$50 per individual, \$150 per family	\$75 per individual, \$225 per family	Doesn't apply to orthodontia or network preventive care and diagnostics, network-nonnetwork combined
DEDUCTIBLE WAIVED FOR PREVENTIVE/DIAGNOSTIC CARE	Yes		
ANNUAL MAXIMUM COVERAGE PER PERSON	\$3,000 per individual	\$3,000 per individual	For all covered services except orthodontia, network-nonnetwork combined
PREVENTIVE CARE	No charge, deductible does not apply	20% after deductible	2 exams and 2 cleanings every year, plus 2 additional cleanings if periodontal disease is present, refer to plan provisions for details
BASIC SERVICES	20% after deductible	50% after deductible	
MAJOR SERVICES	40% after deductible	50% after deductible	
ORTHODONTIA SERVICES	50%, deductible does not apply	50%, deductible does not apply	\$4,000 limit per individual per lifetime, network-nonnetwork combined
IMPLANTS	40% after deductible	50% after deductible	
NIGHT GUARDS	40% after deductible	50% after deductible	
ACCIDENT	No charge, deductible does not apply	No charge, deductible does not apply	

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DAVIS VISION PLAN

ROUTINE VISION EXAMS	In-Network	\$20 copayment per visit
	Out-of-Network	Up to \$50 allowance
FRAMES	In-Network	\$0 copayment up to \$150 allowance for frames, 20% off remaining balance
	Out-of-Network	Up to \$90 allowance for frames
CONTACT LENSES (MEDICALLY NECESSARY)	In-Network	\$0 copayment up to \$225 allowance
	Out-of-Network	Up to \$120 allowance
CONTACT LENSES (CONVENTIONAL OR ELECTIVE, IN LIEU OF FRAMES/LENSES)	In-Network	\$0 copayment up to \$150 allowance
	Out-of-Network	Up to \$120 allowance
SINGLE LENSES	In-Network	\$20 copayment for 2 lenses
	Out-of-Network	Up to \$50 allowance for 2 lenses
BIFOCAL LENSES	In-Network	\$20 copayment for 2 lenses
	Out-of-Network	Up to \$80 allowance for 2 lenses
TRIFOCAL LENSES	In-Network	\$20 copayment for 2 lenses
	Out-of-Network	Up to \$95 allowance for 2 lenses
LENTICULAR LENSES	In-Network	\$20 copayment for 2 lenses
	Out-of-Network	Up to \$155 allowance for 2 lenses
PROGRESSIVE LENSES	In-Network	Member cost: \$50 Standard, \$90 Premium, \$140 Ultra, \$175 Ultimate
	Out-of-Network	Not covered
OPTIONAL FRAMES, LENS TYPES AND COATINGS	In-Network	Member cost varies
	Out-of-Network	Member cost varies

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