RETIREE DENTAL and VISION PLANS

DELTA DENTAL Delta Dental of Washington	DELTA DENTAL	
Deductible (Waived on Class I)	$50 per person $150 per family	
Annual Maximum	$2,000	
Class I Diagnostic & Preventive (Sealants covered to age 15)	80% PPO dentists 80% Premier dentists 80% Nonparticipating	
Class II - Restorative Restorations, Endodontics, Periodontics, Oral Surgery	80% PPO dentists 80% Premier dentists 80% Nonparticipating	
Class III - Major Crowns, Dentures, Partials, Bridges, and Implants	50% PPO dentists 50% Premier dentists 50% Nonparticipating	
Orthodontia	Not covered	
Rates	Retiree	$62.05
	Retiree/Spouse*	$124.03
	Retiree/Child(ren)	$123.18
	Retiree/Spouse* /Child(ren)	$185.15

Willamette Dental Group	WILLAMETTE DENTAL	
Deductible	No Deductible	
Annual Maximum	No Annual Maximum	
General Office Visit	$15 copay per visit	
Diagnostic and Preventive Services	Covered at 100%	
Restorative Dentistry, Endodontics, Periodontics, Oral Surgery	Copays vary based on type of service. Examples include: Fillings (Amalgam) Covered at 100% Root Canal Therapy - Molar $200 copay Root Planing (per Quadrant) $75 copay Porcelain-Metal Crown $275 copay Complete Upper or Lower Denture $450 copay	
Specialty Office Visit	$30 copay per visit	
Orthodontia	$2,800 Copay $150 copay for Pre-Orthodontic Service; fee is credited towards orthodontic copay if patient accepts treatment plan.	
Rates	Retiree	$57.63
	Retiree/Spouse*	$115.15
	Retiree/Child(ren)	$114.43
	Retiree/Spouse* /Child(ren)	$171.96

vsp	VISION SERVICE PLAN (VSP)	
Eye Examination	Once every 12 months 100% after $10 copay	
Diabetic Eyecare Exam	100% after $20 copay	
Frames and Lenses	Lenses: once every 12 months Frames: once every 24 months 100%* after $25 copay **frame of your choice covered up to $150.00*	
Contact Lenses	Once every 12 months Up to $120 allowance for contacts (copay does not apply) and contact lens exam up to $60 copay (fitting and evaluation)	
Benefit Limitations	Members may choose between the benefit of glasses or contacts, but not both, during any benefit plan period.	
Rates	Retiree	$6.31
	Retiree & dependent(s)	$21.58

NOTE: Extra discounts, value-added benefits, and savings apply when using a VSP provider. Please refer to the plan summary for more information. If you decide to use an Out-of-Network provider, you are required to pay the provider in full at the time of your appointment and submit a claim to VSP for partial reimbursement. Benefit frequency limits apply for both VSP and Out-of-Network coverage.

This benefit comparison is intended to provide a brief description of 2019 coverage and is not a complete explanation of covered services, exclusions, limitations reductions, or the terms under which a program may remain in force. This summary is not a contract. For full coverage provisions, including a description of waiting periods, limitations, and exclusions please refer to the appropriate summary plan documents posted to www.wcif.net. 2019 documents will be posted as they are approved.