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Dental Plan Options - Plan Year 2021

	ManhattanLife Since 1850		moda HEALTH			PacificSource HEALTH PLANS			PROVIDENCE Health Plan	Spirit DENTAL & VISION				Willamette Dental Group
Plan Name	Dental, Vision, Hearing		PPO	Exclusive PPO	PPO Bright Smiles	Dental Advantage		Kids Dental Advantage	Progressive Dental	3500	1200/2500/5000	1200	750/1000/1250	TrueCare
Network (click to search)	See Any Dentist		Delta Dental PPO			Advantage			Progressive	Ameritas				Willamette Dental
Plan Brochure (click to view)	Brochure		Brochure			Brochure			Brochure	Brochure				Brochure
Annual Benefit Maximum (age 19+)	$1,000	$1,500	$1,000	$1,500	None	$1,000	$1,500	None	$1,000	$3,500	1200/2500/5000	$1,200	750/1000/1250	None
Deductible	$100/person		$0			$0			$25/person, $75/family	$100/person - Lifetime				None
Preventive (In-Network)	Year 1: 60% Year 2: 70% Year 3+: 80%		Under 19: 100% Adults: 75%	100%	100%	100%			100% Deductible does not apply	100%				$0 - $35
Basic (In-Network)	Year 1: 60% Year 2: 70% Year 3+: 80%		Under 19: 75% Adults: 60%	70%	25%	80%			Year 1: 50% Year 2: 60% Year 3 and after: 80%	Year 1: 65% Year 2: 80% Year 3+: 90%	Year 1: 50% Year 2: 60% Year 3+: 80%	Year 1: 50% Year 2: 65% Year 3+: 80%	Year 1: 50% Year 2: 60% Year 3+: 80%	$45 - $80
Major (In-Network)	Year 1: 0% Year 2: 70% Year 3+: 80%		Under 19: 75% Adults: 50%	50%	25%	50%			Year 1: 25% Year 2: 35% Year 3 and after: 50%	Year 1: 10% Year 2: 50% Year 3+: 65%	Year 1: 20% Year 2: 30% Year 3+: 50%	Year 1: 25% Year 2: 50% Year 3+: 50%	Year 1: 25% Year 2: 30% Year 3+: 50%	Under 19: $100 - $350 Adults: $100 - $600
Orthodontia	Not Covered		Under 19: 25% Adults: Not covered	Under 19: 50% Adults: Not covered	25%	Not Covered			Not Covered	Year 1: 10%, Year 2: 25%, Year 3: 50%, $1,200 Max			Not Covered	$2,800 copay
Out of Pocket Pediatric Maximum (ages 0-18)	N/A		$350/child, $700/family (In-network only)			$350/child, $700/family (In-network only)			None	N/A				None
Deductible (Out of Network)	Same as in-network Plan payments based on Usual, Customary and Reasonable charges		$0	Not Covered		$50/person, $150/family			Not Covered	Network Plan pays based on contracted fees (Maximum Allowable Charges) Choice Plan pays based on 90th percentile of Usual, Customary, and Reasonable charges.				Not Covered Out of area emergency treatment is reimbursed up to $100 minus applicable copayments.
Preventive (Out of Network)			50% No balance billing for Delta Dental Premier only			80%								
Basic (Out of Network)						80% after deductible								
Major (Out of Network)						50% after deductible								
Waiting Period (ages 19+) Preventive Services	None		None			None			None	None				None
Waiting Period: (ages 19+) Basic Services	None		6 months		None	6 months*		None						None
Waiting Period: (ages 19+) Major Services	12 months		12 months		None	12 months*		None						12 months
Important Notes, **PLEASE READ**	This is a reimbursement policy. Also covers vision and hearing. Children can only enroll as dependents, not individually. See brochure for family rates.		**You can only enroll during open enrollment or if you have a qualifying event.** Waiting periods may be waived with proof of prior dental coverage. See brochure for full details.			*Waiting periods may be waived with proof of prior dental coverage.			**You must be enrolled with Providence Health Plan to get this dental plan.** See brochure for coverage limitations.					See brochure for fee schedule
Age	**Manhattan Life**		**Moda**	**Moda**	**Moda (Kids)**	**PacificSource**		**PacificSource (Kids)**	**Providence**	**Spirit**				**Willamette**
0 - 17	N/A	N/A	$36	$40	$36	$42	$42	$41	$32	N/A				$46.77
18	$30.25	$40								Network Plan Indiv $56.18 Family $188.68 Choice Plan Indiv $89.87 Family $296.51	Network Plan Indiv $48.80 Family $165.07 Choice Plan Indiv $78.19 Family $259.13	Network Plan Indiv $39.42 Family $135.08 Choice Plan Indiv $65.69 Family $220.03	Network Plan Indiv $36.58 Family $117.04 Choice Plan Indiv $61.14 Family $195.66	
19 - 24			$27	$29	N/A		$48	N/A						$50.96
25 - 29						$45	$50							
30 - 34			$39	$31		$48	$54							$56.49
35 - 39			$32	$35		$52	$59							
40 - 44	$32.75	$42.33	$33	$36		$58	$65							$66.18
45 - 49			$34	$37		$62	$70							
50 - 54			$37	$40		$64	$71							
55 - 59	$35.08	$46.00	$42	$44		$67	$75							$78.11
60 - 64			$45	$48		$70	$79							
65 - 74	$37.58	$49.67	$47	$50										
75 - 85	$43.17	$57.08								Waive the $25 application fee with code SMILE20				
	Enroll Direct	Enroll Direct	Enroll Direct	Enroll Direct	Enroll Direct	Enroll Direct	Enroll Direct	Enroll Direct	Ask Us	Enroll Direct				Enroll Direct

This sheet is a simplified plan comparison. Refer to plan summaries for complete plan benefits.