Delta Dental of Washington: Washington Kids **Plan Type: PPO Plus Premier** **Coverage Period: 1/1/2025 – 12/31/2025**
Summary of Benefits for Dental Coverage: What the Plan Covers & What it Costs **Coverage for:** Children age 0-18

This is only a summary. If you want more detail about dental coverage and costs under this plan, you can get the complete terms in the policy or plan document at **Delta Dental of Washington Exchange Plans** or by calling **1-888-899-3734**.

Important Questions	Answers	Why this Matters
What is the premium amount?	$50.93 1 child; $101.86 2 children; $152.79 3 children	The premium amount is a monthly fee you must pay to your insurance company to receive dental insurance.
What is the overall deductible?	**$85**	You must pay all the costs related to covered services up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible period starts (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Does the deductible apply to preventive services?	No	The deductible **does not** apply to preventive exams, cleanings, or other preventive services. See the chart starting on page 2 for how much you pay for covered preventive services.
What is the out–of–pocket limit on my expenses?	$350 for 1 child $700 for 2+ children	The out-of-pocket limit is the most you could pay during the coverage year for your share of the cost of covered services. This limit helps you plan for dental care expenses.
What is not included in the out-of-pocket limit?	Premiums, non-covered services and out of network services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	No	There is no overall annual limit on what the plan will pay for children. The chart starting on page 2 describes any limits on what the plan will pay for adult coverage and other *specific* covered services for children.
Who is included in this plan's network of providers?	See Dentist Search or call 1-888-899-3734 for a list of participating providers.	If you use an in-network provider, this plan will pay some or all of the cost of the covered services. Be aware, your in-network dentist may use an out-of-pocket provider (e.g., a hospital) for some services. Plans use the term in-network, preferred, or participating for providers in their networks. See chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a specialist?	No	You can see the specialist you choose **without** permission from this plan.
Do I need preauthorization before receiving certain dental services?	Yes	You **do** need to call the plan at **1-888-899-3734** before receiving certain dental services. See your policy or plan document for additional information.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services.

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- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered dental care, usually at the time of the service.
- **Coinsurance**, which is different from copayments, is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for a restorative procedure (e.g., a crown) is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network dentist charges $1,500 for a crown and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

⚠ All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Dental Treatment	Services You May Need	What you will pay if you use:		Limitations, Exceptions & Other Important Information
		In-Network Provider	[1]Out-of-Network Provider	
Routine Check-up	Oral Exams	0%	0%	2 times per benefit period
	Teeth Cleanings	0%	0%	Prophylaxis cleanings are covered 2 times per benefit period. Periodontal (gum) maintenance is covered once per quadrant every 12 months.
	Fluoride	0%	0 %	2 times per benefit period for age seven and older. 3 times through age six.
	Sealants	0%	0%	Covered once per tooth every two years for posterior teeth that have no restorations (includes preventive resin restorations) on the biting surface.
	Full Mouth X-rays	0%	0%	Complete series or panoramic x-ray are covered once every three years.
	Bitewing X-rays	0%	0%	One bitewing x-ray for each quadrant every 12 months.

	Single Tooth X-rays	0%	0%	Periapical x-rays show the entire tooth, from the chewing surface to below the gums to the tip of the root. These are covered when dentally appropriate.
	Space Maintainers	0%	0%	Covered one time for each of the four sections (Quadrants).
	Nitrous oxide	30%	30%	Can be used for sedation once per day. Plan deductible applies.
Filling a Cavity	Amalgam (Silver Filings) Front Tooth	30%	30%	The same surface on the same tooth covered once every two years from treatment date.
	Amalgam (Silver Filings) Back Tooth	30%	30%	The same surface on the same tooth covered once every two years from treatment date.
	Composite Front Tooth	30%	30%	The same surface on the same tooth covered once every two years from treatment date.
	Composite Back Tooth	30%	30%	The same surface on the same tooth covered once every two years from treatment date.
	Nitrous oxide	30%	30%	Can be used for sedation once per day
	Temporary Filings	Not Covered	Not Covered	
Restorative Care	Periodontal Maintenance. Cleanings (Treatment of gums)	0%	0%	Covered once per quadrant every 12 months.
	Periodontal Scaling and Root Planing	30%	30%	Periodontal Scaling and root planing is covered for children 13 years and older, once per quadrant every two years.
	Crowns	50%	50%	Permanent crowns are covered for children ages 12-18, and only once per tooth every five years from the seat date.
	Replacement of a Crown	50%	50%	Permanent crowns are covered for children ages 12-18, and only once per tooth every five years from the seat date.
	Onlays	50%	50%	Covered one time per 5 years for children ages 12-18.

	Root canal (per tooth)	30%	30%	Covered for anterior, bicuspid and molar teeth.
	Pulpotomy	30%	30%	
Tooth Extraction	Extraction (per tooth)	30%	30%	
	Surgical Extraction (per tooth)	30%	30%	
Advanced Oral Surgery	Oral surgery	30%	30%	Not covered: bone replacement/grafting; tooth transplant; generative osseous filling.
	Periodontal Surgery	30%	30%	Covered once per quadrant every three years.
	General Anesthesia	30%	30%	Covered case-by-case basis when your child is having endodontic, periodontic, or oral surgery services that are covered by this plan, ages 9-18.
Orthodontia	Braces	50%	50%	Cosmetic orthodontic services are not covered. Medically necessary orthodontic services must be preauthorized before treatment is performed.
	Removable appliances	50%	50%	Replacing or repair of removable orthodontic retainers, or orthodontic appliances are not covered.
Prosthetics	Implants	Not Covered	Not Covered	
	Partial Dentures	50%	50%	Covered once every seven years.
	Complete Dentures	50%	50%	Covered for one complete upper and lower during the time your child is enrolled on this plan.
	Bridge or Denture Repair	50%	50%	Covered once per arch every three years after the initial six-months from the Seat Date.
	Rebase or Reline of Dentures	50%	50%	Covered once per arch every three years after the initial six-months from the Seat Date.

[1]Delta Dental has no control over the charges or billing practices of dentists who do not contract with us. Our payments for services performed by theses dentists with be based on actual charges or Delta Dental of Washington's maximum allowable fees for non-participating dentists.

Excluded Services & Other Covered Services

Services This Plan Does NOT Cover (This isn't a complete list. Check the policy or plan document for other excluded services.)

Adult dental care; Traditional Braces; Implant; Cosmetic services or supplies

Other Covered Services (This isn't a complete list. Check the policy or plan document for other covered services.)

Accidental injury

Grievance and Appeals Rights

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: Delta Dental of Washington P.O. Box 75983 Seattle, WA 98175-0983, Email memberappeals@deltadentalwa.com. Or, call us at 888-899-3734.

Does this Coverage Provide Minimum Essential Coverage?

This plan or policy meets the Affordable Care Act's minimum value and benefits requirements for the pediatric dental essential health benefit.