Patient Out-of-Network Expenses: A Comparison of PPOs

FINDING: Patients with Delta Dental of Washington PPO coverage pay the highest out-of-pocket expenses for care delivered at out-of-network dental practices.

The following Explanation of Benefit (EOB) forms reflect real patient experiences with 10 different dental PPO carriers for a typical preventive care visit (exam, cleaning and radiographs) at out-of-network dental offices in Washington state.

WSDA staff obtained these statements with the help of out-of-network dental practices. All HIPPA-protected or unique identification information has been redacted to maintain patient privacy.

The dental offices on these EOB forms all charged fees in the 85th to 90th percentile UCR.

Patient Out-of-Pocket	$0	$0	$0	$0	$0	$0	$0	$2	$6	$204
Carrier	#1	#2	#3	#4	#5	#6	#7	#8	#9	DDWA

CONCLUSION

Delta Dental of Washington is an outlier whose policies punish patients that choose a dentist outside of the company's network. Other PPO carriers in Washington state do not employ this discriminatory pricing model, nor do other Delta Dental carriers in other states.

Anthem Blue Cross and Blue Shield
P.O. Box 188
Minneapolis, MN 55440-0188

Washington patient with Anthem reiceved care from a non-contracted dentist that billed at a rate around 85th to 90th percentile UCR.

EXPLANATION OF BENEFITS

1-855-648-1412
www.anthem.com

Issue Date: [redacted]/2023

EXPLANATION OF BENEFITS
THIS IS NOT A BILL

Provider ID: [redacted]
Subscriber ID [redacted]
Claim: [redacted]

Provider: [redacted]
Subscr [redacted]
Patient [redacted]

Treating Addr [redacted]
Group-Subgr [redacted]
Patient DOB: [redacted]

OUT OF NETWORK

Tooth # - Surface	Service Date	Proc Code	Procedure Description	Submitted Amount	Approved Amount	Allowed Amount	Network Savings	Deductible Amount	Cov %	Patient Owes	Plan Payment	*See Notes
	[redacted]2023	D0120	Periodic oral exam	90.00	90.00	90.00	0.00	0.00	100	0.00	90.00	
	[redacted]023	D1110	Prophylaxis - adult	156.00	156.00	156.00	0.00	0.00	100	0.00	156.00	
	[redacted]2023	D1206	Fluoride varnish	65.00	65.00	65.00	0.00	0.00	100	0.00	65.00	
Totals				311.00	311.00	311.00	0.00	0.00		0.00	311.00	

Appeal Comments

Anthem paid 100% of billed amount ($311) for an exam and preventive care. Patient paid $0 out-of-pocket.

Current Plan Payment:	$311.00

[redacted]

[redacted]

Washington patient with BlueCross BlueShield of Texas received care from a non-contracted dentist that billed at a rate around 85th to 90th percentile UCR.

[redacted]

[redacted]

BlueCross BlueShield of Texas
P.O Box 660247
Dallas TX 75266-0247

Forwarding Service Requested

[redacted]

Summary of All Claims Processed

Amount Billed	$311.00
Discounts and Reductions	$0.00
Dental Plan Responsibility	$246 00
Patient May Owe	$65.00

have selected Zelis™ Payments as our ePayment vendor to assist us in expediting payment and remittance transactions In we
nplying with PPACA Section 1104 To sign up for ePayments using ACH or Virtual Payment Cards, as well as electronic remittanc
F ntact Zelis Pr vi er Enrollment Advisor today at 1-855-496-1571 or visit https Aww zelis om/provider-solutions pr v d
nfo cr

Amount Billed	$311.00
Discounts and Reductions	$0.00
Dental Plan Responsibility	$246.00
Patient May Owe	$65.00

Subscriber Name: [redacted]
Subscriber #:
Patient:
Patient Account #:

Group Name: [redacted]
Group #:
Processed Date: 24
Claim #:

Service Information — Patient May Owe

Service Description	Service Dates	Amount Billed	Discounts and Reductions	Allowed Amount	Dental Plan Responsibility	Deductible Amount	Copay Amount	Coinsurance	Amount Not Covered	Patient Costs
D0120 Periodic Oral Evaluation - Established P	[redacted]24	90.00	0.00	90.00	90.00	0.00	0.00	0.00	0 00	0 00
D1110 Prophylaxis - Adult	[redacted]24	156.00	0.00	156.00	156.00	0.00	0.00	0.00	0.00	0 00

BlueCross BlueShield of Texas paid 100% of billed amount for exam and cleaning. Patient paid $0 out-of-pocket.

[redacted]

BlueCross BlueShield of Texas paid 0% of billed amount for flouride varnish because "patient does meet the age restriction specific to this procedure."

Service Information					Patient May Owe					
Service Description	Service Dates	Amount Billed	Discounts and Reductions	Allowed Amount	Dental Plan Responsibility	Deductible Amount	Copay Amount	Coinsurance	Amount Not Covered	Patient Costs
D1206 Topical Application Of Fluoride Varnish	[redacted]v24	65.00	0.00	65.00	0.00	0.00	0.00	0 00	65.00 (AR)	65 00
CLAIM TOTALS		$311.00	$0.00	$311.00	$246.00	$0.00	$0.00	$0.00	$65.00	$65.00

Total covered benefits approved for this claim: $246.0[redacted]24

BENEFIT YEAR MAX REMAINING: $1,754.00

ORTHODONTIA MAX REMAINING: $1,500.00

Notes about amounts under [redacted] and

(AR) AR - THIS PROCEDURE HAS BEEN DENIED. THE PATIENT DOES NOT MEET THE AGE RESTRICTION SPECIFIC TO THIS PROCEDURE.

If you are covered by more than one health plan, you should file all your claims with each plan. To protect the confidentiality of the member's Social Security Number and avoid processing delays, the Unique Identification Number on the member's ID card must be used when submitting claims. Providers, Customers, and Individuals Cooperate with us to stop fraud. If you ever have any questions, call our fraud hotline at 800-411-2463.

Effective May 23, 2008 all electronically submitted claims must have a national provider identified (NPI). If your NPI is not on the file the claim will be rejected. A NPI number can be obtained by visiting www.nppes.cms.hhs.gov. If you have a NPI, please forward it to us by mailing it to Provider Administration, 701 East 22nd Street, Suite 300, Lombard, IL 60148, or you can fax it to 630-495-0575

Cigna.

Cigna Dental
Cigna Health and Life Insurance Company
As administrator for

Explanation of dental payment

THIS IS NOT A BILL

Your payment summary

Enclosed is a payment to:
Amount: $519.00
Payment date: 2024
Payment number:

Washington patient with Cigna Dental received care from a non-contracted provider dentist that billed at a rate of around 85th to 90th percentile UCR.

Claim details

RECEIVED DATE: 2024 PROCESSED DATE: , 2024 Administrative Services Only - ERISA

AMOUNT YOU CHARGED ($)	YOUR CONTRACTED AMOUNT ($)	AMOUNT ELIGIBLE FOR COVERAGE BY THE PLAN ($)	PATIENT COPAY/ DEDUCTIBLE ($)	REMAINING BALANCE ($)	PATIENT COINSURANCE ($)	THE PLAN COVERED (%)	THE PLAN COVERED ($)
For service on 2024: D0120*							
96.00	0.00	96.00	0.00	96.00	0.00	100%	96.00
For service on 2024: D0220*							
53.00	0.00	53.00	0.00	53.00	0.00	100%	53.00
For service on 2024: D0230*							
47.00	0.00	47.00	0.00	47.00	0.00	100%	47.00
For service on 2024: D0230*							
47.00	0.00	47.00	0.00	47.00	0.00	100%	47.00
For service on 2024: D0274*							
112.00	0.00	112.00	0.00	112.00	0.00	100%	112.00
For service on 8, 2024: D1110*							
164.00	0.00	164.00	0.00	164.00	0.00	100%	164.00
For service on 2024: D1206* *(see note OA)*							
70.00	0.00	0.00	0.00	0.00	0.00	0%	0.00
$589.00	**$0.00**	**$519.00**	**$0.00**	**$519.00**	**$0.00**		**$519.00**

Amount paid by the plan $519.00
Customer's responsibility $70.00

Notes

OA - Benefits for fluoride treatments are not provided for this individual due to age limitation.

Cigna Dental paid 100% of billed amount except fluoride varnish. Cigna paid 0% for fluoride varnish.

[redacted]

METLIFE
GROUP DENTAL CLAIMS
PO BOX 981282
EL PASO TX 79998

Forwarding Service Requested

[redacted]

[redacted]

MetLife

Metropolitan Life Insurance Company

We're here to help. Please visit us at metdental.com to find available dental benefits, claim details, to submit claims, and more or call 877-638-3379, Monday - Friday, 8am-11pm ET.

[redacted]

Patient Benefits Statement with payment

Statement date: [redacted] 2024

This is an explanation of how we determined benefits for your patients. It should not be distributed to patients or other insurance carriers. Please save it for your records.

Claim summary

You submitted	$516.00
MetLife paid you	$451.00

If you need to return a payment for a specific patient's claim, please send a separate check for the returned amount with a copy of this statement indicating which patient the check is for. Please don't return the attached check, as it includes payment for all patients included in this statement.

Date of service	Name	You submitted	MetLife paid	Patient owes
[redacted]/24	[redacted]	$219.00	$219.00	$0.00
[redacted]9/24		$297.00	$232.00	$65.00
Totals		**$516.00**	**$451.00**	**$65.00**

Additional claim detail on following page(s)

Washington patient with MetLife received care from a non-contracted provider dentist that billed at around a 85th to 90th percentile UCR. MetLife paid 100% of the patient evaluation, radiographs, and periodontal maintenance. Metlife paid $0 for fluoride varnish.

MetLife continued.

Claim detail

[redacted]

Name/Relationship: [redacted]
Claim:
ID:

Dentist:
Name:
Employer:
Group:

Date of service	Service code, units, description	You submitted	Allowed amount		MetLife Paid	Patient Owes
[redacted]/24	D0140, LIMITED ORAL EVALUATION	$127.00	$127.00	100%	$127.00	$0.00
/24	D0220, PERIAPICAL RADIOGRAPHIC IMAGE	$50.00	$50.00	100%	$50.00	$0.00
/24	D0230, 01, ADD'L PERIAPICAL IMAGES	$42.00	$42.00	100%	$42.00	$0.00
Totals		$219.00	$219.00		$219.00	$0.00

Claim detail

[redacted]

Name/Relationship: [redacted]
Claim:
ID:

Dentist:
Name:
Employer:
Group:

Date of service	Service code, description	You submitted	Allowed amount	MetLife Paid	Patient Owes
[redacted]/24	D1206, TOPICAL FLUORIDE-VARNISH	$65.00		Fluorides not covered on ee/spouse.	$65.00

Continued on next page

MetLife Continued.

[redacted]

[redacted]

[redacted]

[-cc]

Claim detail

Name/Rela[redacted]
Claim:
ID:

Dentist:
Name:
Employer:
Group:

Date of service	Service code, description	You submitted	Allowed amount		MetLife Paid	Patient Owes
[redacted]/24	D4910, PERIODONTAL MAINTENANCE	$232.00	$232.00	100%	$232.00	$0.00
Totals		$297.00	$232.00		$232.00	$65.00

[redacted]

Washington patients with Premera reiceved care from a non-contracted dentist that billed at a rate around 85th to 90th percentile UCR.

[redacted]

PREMERA | BLUE CROSS

P.O. Box 91059
Seattle, WA 9911 -9159

[redacted]

Premera Blue Cross provides administrative and/or network access services only. The Employer/Sponsor, and not Premera Blue Cross assumes any/all financial risk or obligation with respect to claims.

[redacted] 2024

DETAILED EXPLANATION OF PAYMENT

[redacted]

SERVICE DATES	CODE/ MODIFIER	UNITS BILLED/ ALLOWED	APC / APG / DRG / ROOM TYPE	BILLED CHARGES	ALLOWED AMOUNT	PROVIDER ADJUSTMENT (A) DISALLOWED (D)	OTHER INSURANCE ADJUSTMENT	PATIENT LIABILITY FEE ADJUST (A) COB SAV APP (B) COINSURANCE (C) DEDUCTIBLE (D) FUNDING ACCT (F) INELIGIBLE (I) COPAY (P)	PAYABLE AMOUNT	REASON REMARKS
[redacted] /24	D0120 D0120 D1110 D1206	1/1		$96	$96.00	$96		$0.00	$96.00	221
/24	D1110	1/1		$164	$164.00	$164		$0.00	$164.00	689
/24	D1206	1/3		$70	$0.00	$0		$70.00	$0.00	378
		Paid to C		$330	$260.00	$260	$0.00	$0.00	$260.00	
				$330	$260			$70		
Voucher Total				$330.00	$260.00	$0.00	$0.00	$70.00	$260.00	
								Less Paid to Codes Listed as "S" or "C"	$260.00	
								Total Payable Amount	$260.00	

Our records indicate your current TAX ID as being 91-1452450

Paid To Code: P = Provider/Facility Group [redacted] = IPA or Rollup of Group S = Subscriber C = Copayee Check I = Blank, no payment was made

Reason Remarks Explanation
221 Your plan limits benefits for exam nations office calls and consultations as described in the member benefit booklet
378 Member/Provider: This members plan doesn't cover this service
689 Your plan limits prophylaxis

relevant text reads: This members plan doesn't cover this service for D1206 Fluoride Varnish

[redacted]

[redacted]

Premera paid 100% of billed amount ($260) for an exam and preventive care and 0% of billed amount for fluoride varnish.

Washington patient with Sun Life reiceved care from a non-contracted dentist that billed at a rate around 85th to 90th percentile UCR.

Sun Life

Sun Life
PO Box 2940
Clinton IA 52733-2940

Forwarding Service Requested

[redacted]

Explanation of Benefits

THIS IS NOT A BILL

Customer Service Information

Please direct correspondence to:
Sun Life
PO Box 2940
Clinton, IA 52733
T 800-442-7742 [redacted]

Claim #: [redacted]
Client/Group No.: [redacted]
Network:

Pati [redacted]
Provid
Insured:

Date: [redacted]/2024
Relationship: Member

Service Date	Submitted Service Description	Tth No.	Submitted Services	Submitted Charges	Allowed Service	Allowed Amount	Co-Pay %	Deductible	Patient Resp	Remark Code(s)	Plan Payment
[redacted]/24	Periodic oral examination	01	D0120	$96.00	D0120	$96.00	100	$0.00	$0.00		$96.00
[redacted]/24	Prophylaxis--adult	01	D1110	$164.00	D1110	$164.00	100	$0.00	$0.00		$164.00
[redacted]/24	Top fluoride: tx app mod+h risk	01	D1206	$70.00	D1206	$70.00	100	$0.00	$0.00		$70.00
	TOTALS			$330.00		$330.00		$0.00	$0.00		$330.00

Draft/Check	Benefit	COB Amount	Adjustment	Payment	Payee
[redacted]	$330.00	$0.00	$0.00	$330.00	[redacted]

Amount applied to patient's deductible for this accumulator period $0.00
Amount of patients deductible to be met for this accumulator period $25.00
Amount applied to $2,000.00 policy maximum for this accumulator period $0.00
Amount left on $2,000.00 policy maximum for this accumulator period $2,000.00

[redacted]

Sun Life paid 100% of billed amount ($330) for an exam, preventive care, and fluoride varnish. Patient paid $0 out-of-pocket.

Washington patient with WPAS reiceved care from a non-contracted dentist that billed at a rate around 85th to 90th percentile UCR.

[redacted]
P.O. Box 34203
Seattle, WA 98124

Address Service Requested

[redacted] SINGLE PIECE

[redacted]

234

[redacted]

Attention Doctors, Hospitals and other health providers, use phone (800) 735-7053 for benefit inquiry

Member [redacted]
Group
WPAS ID
Patient
Type
Claim No
Check No

[redacted]

1 OF [redacted]

[redacted]

Explanation of Benefits
Please Retain for Your Records

Service Dates		Description	Charges Submitted	Not Covered	Reason Code	Discount Amount	Allowed Amount	Deductible Applied	Co-Pay Applied	Paid At %	Total
[redacted]2023	120		90.00	0.00	ID	0.00	90.00	0.00	0.00	100	90.00
[redacted]/2023	1110		156.00	0.00	ID	0.00	156.00	0.00	0.00	100	156.00
		Totals:	246.00	0.00		0.00	246.00	0.00	0.00		246.00

Benefit Adjustment (A)	0.00
COB Allow (B)	0.00
COB Payment (C)	0.00
Other Adjustments (D)	0.00
Payment Amount	246.00
Patient Responsibility	0.00

Messages / Reason Code Description

ID REASONABLE AND CUSTOMARY CHARGE HAS BEEN ALLOWED.
DENTISTS - For FASTER reimbursement submit charges electronically through payer ID [redacted]

WPAS paid 100% of billed amount ($246) for an exam and preventive care.

[redacted]

[redacted]

Guardian PO BOX 981572
EL PASO, TX 79998-1572

Washington patient with Guardian received care from a non-contracted provider dentist that billed at a rate of around 85th to 90th percentile UCR.

The Guardian Life Insurance Company of America

If you have any questions contact: 800-541-7846 WWW.GUARDIANANYTIME.COM

Provider: [redacted]
Date: [redacted]/2023
Payee: [redacted]
Check No.:
Payment Amount: $244.00

[redacted]

Your name [redacted] Tax ID have been verified by

Expedite cash flow with e-payments. Sign up today!
Guardian has contracted with Change Healthcare, a leading provider of revenue and payment cycle solutions, to deliver Electronic Funds Transfer (EFT) services! Sign-up today by going to www.changehealthcare.com/support/customer-resources/enrollment-services for more information. Enrollment for this service is offered to you at no additional cost and is available online or by calling 1.866.777.0713 and selecting Option 1.

PROVIDER EXPLANATION OF BENEFITS - THIS IS NOT A BILL

Important! Please examine this statement for accuracy. Save this statement for tax purposes.

[redacted]

Payment Week: *8* ***Payment Date:*** *02/21/2023* Page 1 of 2

Claim Number: [redacted]
Patient Name: [redacted]
Planholder:
Patient Account #: [redacted]
Employee Name:
Plan Number: [redacted]
Relationship:

Line No.	Submitted ADA Codes/Descriptions	Alt Code	Tooth No.	Date of Service	Submitted Charge	Considered Charge	Covered Charge	Deductible Amount	Coverage Percent	Benefit Amount
1	D0120/Periodic Eval		FM	[redacted]/23	90.00	90.00	* 88.00	0.00	100%	88.00
2	D1110/Adult Cleaning		FM	[redacted]23	156.00	156.00	156.00	0.00	100%	156.00
3	D1206/Fluoride Varn		FM	[redacted]/23	65.00	65.00	0.00	0.00	100%	0.00
	TOTALS				311.00	311.00	244.00	0.00		244.00

[redacted]

BENEFIT SUMMARY

TOTAL BENEFIT PAYABLE.....	$244.00
HIGHER ALLOWABLE.....	$244.00
PAID BY OTHER INSURANCE.....	$0.00
ADJUSTMENTS.....	$0.00
TOTAL BENEFIT PAID.....	$244.00
PATIENT'S RESPONSIBILITY.....	$67.00

Remarks for claim [redacted]
Benefits are based on the use of a Non-Contracted Dentist
3.The dental plan covers fluoride treatment only for covered patients under the age of 19.
* Charges greater than amount allowed for this procedure.

Comments

Log on to www.GuardianAnytime.com for instant access to benefits information for Guardian members. Verify eligibility, view benefits, check claim status and more!

Guardian paid $244 of $246 for cleaning and patient evaluation and $0 for fluoride varnish.

[redacted]

Explanation Of Benefits

Please Retain for Future Reference

aetna

P.O. BOX 14079
LEXINGTON KY 40512-4079
USA

Payment Address: [redacted]

Provider Address: [redacted]

Printed: [redacted]2024
Page: 2 of 4

PIN:
TIN:
Check Number:
Check Amount: [redacted]

Washington patients with Aetna reiceved care from a non-contracted dentist that billed at a rate around 85th to 90th percentile UCR.

Patient Name: [redacted]

Claim ID: [redacted] Rec[redacted]24 Member ID [redacted] Patient Account: [redacted]
Member: [redacted]
Group Name: [redacted] Group Number: [redacted]
Product: Aetna Dental® PPO
Contract State: FL
Aetna Life Insurance Company

Aetna paid $168 out of $177 billed for these limited exam and x-ray codes. Patient paid $9.

Network ID: [redacted]
Funding: Insured
Network Status: Out-of-Network

SERVICE DATES	SERVICE CODE	ALTERNATE BENEFIT CODE	TOOTH NUM.	SURFACE	NUM. SVCS	SUBMITTED CHARGES	ALLOWABLE AMOUNT/COPA	COPAY AMOUNT	NOT PAYABLE	SEE REMARKS	DEDUCTIBLE	CO INSURANCE	PATIENT RESP	PAYABLE AMOUNT
[redacted]/24	D0220		01		1.0	50.00	42.00		8.00	1			8.00	42.00
[redacted]/24	D0140		01		1.0	127.00	126.00		1.00	1			1.00	126.00
TOTALS						177.00	168.00		9.00				9.00	168.00

ISSUED AMT: $168.00

[redacted]

Remarks:
1 - *This amount is over the recognized charge for this service. We determine the recognized charge based on the geographic area, the member's plan and we calculate it based on either:*
- The FAIR Health percentile
- The plan's nonparticipating fee schedule
We believe our payment to you was fair. If you have more information or questions, let us know. Use the number on this statement. [551]

[redacted]

For questions regarding this claim or if you wish a review of this decision:
P.O. BOX 14094 LEXINGTON, KY 40512-4094
CALL (800) 451-7715 FOR ASSISTANCE
Note: All inquiries should reference the ID number above for prompt response.

Total Patient Responsibility: $9.00
Claim Payment: $168.00

[redacted]

Patient Name: [redacted]

Claim ID: [redacted] Rec[redacted]24 Member [redacted] Patient Account [redacted]
Member: [redacted]
Group Name: [redacted] Group Number: [redacted]
Product: Aetna Dental® PPO
Contract State: FL
Aetna Life Insurance Company

Aetna paid $305 out of $311 billed for these exam, cleaning, and fluoride varnish codes. Patient paid $6.

Network ID: [redacted]
Funding: Insured
Network Status: Out-of-Network

SERVICE DATES	SERVICE CODE	ALTERNATE BENEFIT CODE	TOOTH NUM.	SURFACE	NUM. SVCS	SUBMITTED CHARGES	ALLOWABLE AMOUNT/COPA	COPAY AMOUNT	NOT PAYABLE	SEE REMARKS	DEDUCTIBLE	CO INSURANCE	PATIENT RESP	PAYABLE AMOUNT
[redacted]/24	D1206		01		1.0	65.00	65.00							65.00
[redacted]/24	D1110		01		1.0	156.00	154.00		2.00	1			2.00	154.00
[redacted]/24	D0120		01		1.0	90.00	85.00		4.00	1			4.00	86.00
TOTALS						311.00	305.00		6.00				6.00	305.00

ISSUED AMT: $305.00

[redacted]

Remarks:
1 - *This amount is over the recognized charge for this service. We determine the recognized charge based on the geographic area, the member's plan and we calculate it based on either:*

Continued on Next Page

DELTA DENTAL | Washington State Health Care Authority

PO Box 75983 | Seattle, WA 98175-0983

[redacted]

Delta Dental of Washington Explanation of Benefits UNIFORM DENTAL PLAN

Forwarding Service Requested

[redacted]

THIS IS NOT A BI[redacted]

Patient Name [redacted]
Member ID
Group ID

Washington patient with Delta Dental of Washington reiceved care from a non-contracted dentist that billed at a rate around 85th to 90th percentile UCR.

For the Period: [redacted]/2024 through [redacted]/2024

The claim information listed here reflects dental claims for this date range.

Dear [redacted]

This Explanation of Benefits is a summary of recent dental office visits and treatments. It shows how much of the plan benefits were applied, how much is left to use, and if there are any expected out-of-pocket charges from the dentist.

Save a tree, save yourself the wait. Activate your MySmile® account to choose "paperless communications". Reduce your carbon footprint AND get your EOBs faster. Visit: DeltaDentalWA.com/mysmile

Total Billed	Other Insurance	Your Share	Network Savings
$304.00	$0.00	$204.00	$0.00

Claim # [redacted] **Service Provided By** [redacted] **Claim Paid Date** [redacted]24

Claim Notes	Service	Service Date	Amount Billed	Network Discount	Deductible Applied	Paid By Your Dental Plan	Your Share
	Perdc Oral Eval	[redacted]24	$88.00	$0.00	$0.00	$23.20	$64.80
	Prophy - Adult	[redacted]/24	$149.00	$0.00	$0.00	$51.20	$97.80
	Fluoride Vrnsh	[redacted]4	$67.00	$0.00	$0.00	$25.60	$41.40
TOTAL			$304.00	$0.00	$0.00	$100.00	$204.00

Have a Question? Contact Customer Service via:

Text: 833-604-1246

Call: 1-800-554-1907

If you have questions or concerns about the actions of your insurance company or agent, or would like information on your rights to file an appeal, contact the Washington state Office of the Insurance Commissioner's consumer protection hotline at 1-800-562-6900 or visit www.insurance.wa.gov. The insurance commissioner protects and educates insurance consumers, advances the public interest, and provides fair and efficient regulation of the insurance industry.

YOUR BENEFITS SUMMARY | Benefit Period: 01/01/2024 - 12/31/2024

	paid-to date	annual
Deductible	$0.00	$50.00
Family Deductible	[redacted]	$150.00
Maximum		$1,750.00
	paid-to date	lifetime
Orthodontia Maximum	$0.00	$1,750.00
Orthognathic Maximum	$0.00	$5,000.00

Delta Dental of WA paid $100 out of $304 billed for these exam, cleaning, and fluoride varnish codes. Patient paid $204.