This is only a summary. If you want more detail about dental coverage and costs under this plan, you can contact us at customersupport@deltadentalcoversme.com or by calling 1-888-899-3734.

Important Questions	Answers	Why this Matters
What is the premium amount?	$ 47.48 – 1 child $ 94.96 – 2 children $ 142.44 – 3 or more 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 **www.DeltaDentalCoversMe.com** 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-network 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.

- **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.

Dental Treatment	Services You May Need	Your Cost If You Use an In-Network Provider	[1]Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
Routine Check-up	Exams	0%	0%	2 times per benefit period
	Cleanings	0%	0%	2 times per benefit period
	Fluoride	0%	0%	2 times per benefit period
	Sealants	0%	0%	Covered on molars and bicuspids that have no fillings on the biting surface, once per tooth every two years from the treatment date.
	X-rays	0%	0%	• One bitewing x-ray for each quadrant per benefit period. • Complete series or panoramic x-ray are covered once every three years. • 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.

	Nitrous oxide	30%	30%	Can be used for sedation once per day.
Filling a Cavity	Amalgam	30%	30%	The same surface on the same tooth covered once every two years from treatment date.
	Composite	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.
Restorative Care	Treatment of gums	30%	30%	• Periodontal (gum) maintenance is covered only if you have completed active periodontal treatment. • Any combination of prophylaxis or periodontal maintenance is covered twice in a benefit period. • Additional prophylaxis or periodontal maintenance is covered (up to four treatments combined) if your gums have pocket depth readings of 5mm or greater.
	Crowns	50%	50%	• Implant crowns and bridges are covered once per tooth every seven years from the seat date. • Permanent crowns are covered for children ages 12-18, and only once per tooth every five years from the seat date. • Crowns used to keep removable partial dentures in place are not

				covered unless the tooth qualifies for a crown on its own
	Root canals	30%	30%	Covered for anterior, bicuspid and molar teeth (except wisdom teeth).
	Replacement of teeth	50%	50%	These prosthodontic services are not covered: • Crowns in conjunction with overdentures. • Surgical placement or removal of implants. • Attachments to implants.
Tooth Extraction	Extraction	30%	30%	
Advanced Oral Surgery	Oral surgery	30%	30%	These oral surgery services are not covered: • Filling in a hole in the jawbone after a tooth or implant is removed - called bone replacement grafting - for ridge preservation. • Bone grafts of any kind to the upper or lower jaws unless they are needed to treat periodontal (gum) disease. • Tooth transplants - re-implanting or relocating a tooth in the jaw. • Generate osseous filling - placing materials in a hole in the jawbone to regrow bone after a tooth or implant is removed.
Medically Necessary Orthodontia	Braces	50%	50%	Cosmetic orthodontic services, like teeth straightening for a

				more attractive smile, are not covered.
	Removable appliances	50%	50%	Replacing or repair of removable orthodontic retainers, or orthodontic appliances are not covered.

1. If you prefer a Dentist that does not participate in the Delta Dental Networks, we will pay our coinsurance % for covered services up to the Maximum Allowable Fee for Non-Participating Dentists, or the actual charge, whichever is less. As a result, your out-of-pocket costs may be substantially higher if you use a Non-Participating Dentist than with a Delta Dental PPO plus Premier Dentist. You will be responsible for payment of any balance remaining after the DDWA benefit is paid

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
- Cosmetic services or supplies
- Implants

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: **888-899-3734 or email CustomerService@DeltaDentalCoversMe.com or fax 800-807-1970**

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.