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 **DeltaDentalWA.com** or by calling **1-800-526-8323**.

Important Questions	Answers	Why this Matters
What is the premium amount?	$ 43.80 - 1 child $ 87.60 - 2 children $ 131.40 - 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 deductible?	$ 85	You must pay all the costs related to services up to the deductible amount before this plan begins to pay for covered services you use. 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, x-rays 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 annual limit on what the plan pays?	No	There is no overall annual limit on what the plan will pay. The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services for children. This plan does not cover benefits for adults.
Who is included in this plan's network of providers?	See **www.DeltaDentalWA.com** or call **1-800-526-8323** 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, or anesthesiologist) 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.
Does my child need a referral to see a specialist?	No	You can see the specialist you choose **without** permission from this plan.
Does my child need preauthorization before receiving certain dental services?	Yes	You **do** need to call the plan at **1-800-526-8323** 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 3. 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	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%	Topical fluoride treatment is covered up to 3 times per benefit period.
	Sealants	0%	0%	1 time every 2 years.
	X-rays	0%	0%	Bitewings 1 time per benefit period.
	Nitrous oxide	30%	30%	Can be used for sedation once per day.
Filling a Cavity	Amalgam	30%	30%	
	Composite	30%	30%	
	Nitrous oxide	30%	30%	Can be used for sedation once per day.
Restorative Care	Treatment of gums	30%	30%	
	Crowns	50%	50%	Permanent crowns are allowed for ages 12-18.
	Root canals	30%	30%	
	Dentures	50%	50%	1 time every 5 years.

Dental Treatment	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
Tooth Extraction	Extraction	30%	30%	
Advanced Oral Surgery	Oral surgery	30%	30%	
Medically Necessary Orthodontia	Braces	50%	50%	You must receive a preauthorization before service is provided.
	Removable appliances	50%	50%	

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 is covered at 100%, meaning no cost to you.

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: **Member Appeals, Delta Dental of Washington, P.O. Box 75983, Seattle, WA 98175-0983. Fax: 800-239-9241.**

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.