

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 at <https://www.deltadentalwa.com/our-plans/wahbe> or by calling 1-888-899-3734.

Important Questions	Answers	Why this Matters
Is there a waiting period before I can use my benefits?	No	Covered services are not subject to waiting periods and are included as soon as your dental coverage starts.
What is the premium amount?	Adult: \$43.17 Child \$60.92	The premium amount is a monthly fee you must pay to your insurance company to receive dental insurance.
What is the overall deductible?	Adult: \$50 Child: \$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.
Is there an overall out-of-pocket limit on my share of dental costs?	Adult: No Child: Yes \$450 for 1 child \$900 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. Only fees paid to a Delta Dental PPO plus Premier Dentists accrue to the annual Out-Of-Pocket Maximum.
Is there an overall annual limit on what the plan pays?	Adult: Yes, \$1000 Child: 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 <i>specific</i> 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.

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Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed starting on page 3. 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. Some services in this plan are not covered for adults. The plan does not cover the service if adult copayment and coinsurance costs are not shown.

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	Adult: 0%	0%	Covered twice per benefit period
		Child: 0%	0%	Covered twice per benefit period
	Teeth Cleanings	Adult: 0%	0%	Covered twice in a Benefit Period for any combination of prophylaxis or periodontal maintenance. Covered for additional prophylaxis or periodontal maintenance (up to four total treatments combined) if your gums have Pocket Depth readings of 5mm or greater.

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		Child: 0%	0%	Prophylaxis cleanings are covered two times per benefit period. Periodontal (gum) Maintenance is covered once per Quadrant every 12-months.
	Fluoride	Adult: 0%	0%	Covered twice in a benefit period.
		Child: 0%	0%	Fluoride treatments are covered when dentally appropriate.
	Sealants	Adult: 0%	0%	Covered once per tooth every two years for posterior teeth that have no restorations on the biting surface.
		Child: 0%	0%	
	Full Mouth X-rays	Adult: 0%	0%	Covered once every five years
		Child: 0%	0%	
	Bitewing X-rays	Adult: 0%	0%	Covered once per benefit period. NOTE: When multiple x-rays are taken on the same day, with the exception of a panoramic x-ray, and the combined fees are more than a comprehensive series of x-rays, then all the x-rays taken on the same day will be considered a comprehensive series of x-rays for the purpose of payment and benefit Limitations.
		Child: 0%	0%	NOTE: When multiple x-rays are taken on the same day, with the exception of a panoramic x-ray, and the combined fees are more than a comprehensive series of x-rays, then all the x-rays taken on the same day will be considered a comprehensive series of x-rays for the purpose of payment and benefit Limitations.
	Single Tooth X-rays	Adult: 0%	0%	NOTE: When multiple x-rays are taken on the same day, with the exception of a panoramic x-ray, and the combined fees are more than a comprehensive series of x-rays, then all the x-rays taken on the same day will be considered a comprehensive series of x-rays for the purpose of payment and benefit Limitations.
		Child: 0%	0%	
	Space Maintainers	Adult: Not Covered	Not Covered	

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		Child: 0%	0%	Replacement of space maintainers are covered when dentally necessary.
	Nitrous oxide	Adult: Not Covered	Not Covered	
		Child: 30%	30%	Covered once per day. Plan deductible applies.
Filling a Cavity	Amalgam (Silver Fillings) Front Tooth	Adult: 50%	50%	Covered once every two years on the same surface(s) of the tooth. Plan deductible applies.
		Child: 30%	30%	The same surface on the same tooth covered once every two years from treatment date. Plan deductible applies.
	Amalgam (Silver Fillings) Back Tooth	Adult: 50%	50%	Covered once every two years on the same surface(s) of the tooth. Plan deductible applies.
		Child: 30%	30%	The same surface on the same tooth covered once every two years from treatment date. Plan deductible applies.
	Composite Front Tooth	Adult: 50%	50%	Covered once every two years on the same surface(s) of the tooth. Plan deductible applies.
		Child: 30%	30%	The same surface on the same tooth covered once every two years from treatment date. Plan deductible applies.
	Composite Back Tooth	Adult: 50%	50%	Covered once every two years on the same surface(s) of the tooth. Plan deductible applies.
		Child: 30%	30%	The same surface on the same tooth covered once every two years from treatment date. Plan deductible applies.
	Nitrous oxide	Adult: Not Covered	Not Covered	
		Child: 30%	30%	Covered once per day. Plan deductible applies.
	Temporary Fillings	Adult: Not Covered	Not Covered	
		Child: Not Covered	Not Covered	
Restorative Care	Periodontal Maintenance/ Cleaning (Treatment of gums)	Adult: 50%	50%	Covered twice in a Benefit Period for any combination of prophylaxis or periodontal maintenance.

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				Covered for additional prophylaxis or periodontal maintenance (up to four total treatments combined) if your gums have Pocket Depth readings of 5mm or greater.
		Child: 0%	0%	Covered once per quadrant every 12 months.
	Periodontal Scaling and Root Planing	Adult: 50%	50%	Covered once per quadrant every three years. Plan deductible applies.
		Child: 30%	30%	Covered once per quadrant every two years. Plan deductible applies.
	Crowns	Adult: Not Covered	Not Covered	
		Child: 50%	50%	Permanent crowns are covered once per tooth every five years from the seat date. Plan deductible applies.
	Replacement of a Crown	Adult: Not Covered	Not Covered	
		Child: 50%	50%	Permanent crowns are covered once per tooth every five years from the seat date. Plan deductible applies.
	Onlays	Adult: Not Covered	Not Covered	
		Child: 50%	50%	Covered once per tooth every five years from the seat date. Plan deductible applies.
	Root canal (per tooth)	Adult: Not Covered	Not Covered	
		Child: 30%	30%	Covered for anterior, bicuspid, and molar teeth. Plan deductible applies.
	Pulpotomy	Adult: Not Covered	Not Covered	
		Child: 30%	30%	Covered for Primary and Permanent teeth. Plan deductible applies.
Tooth Extraction	Extraction (per tooth)	Adult: Not Covered	Not Covered	
		Child: 30%	30%	Plan deductible applies.
	Surgical Extraction (per tooth)	Adult: Not Covered	Not Covered	
		Child: 30%	30%	Plan deductible applies.
Advanced Oral Surgery	Oral surgery	Adult: Not Covered	Not Covered	
		Child: 30%	30%	Not Covered:

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				Bone replacement/grafting; tooth transplant, generative osseous filling. Plan deductible applies.
	Periodontal Surgery	Adult: Not Covered	Not Covered	
		Child: 30%	30%	Covered once per quadrant every three years. Plan deductible applies.
	General Anesthesia	Adult: Not Covered	Not Covered	
		Child: 30%	30%	Covered when your child is having endodontic, periodontic, or oral surgery services that are covered by this plan, covered for children through age 8. Plan deductible applies.
Orthodontia	Braces	Adult: Not Covered	Not Covered	
		Child: 50%	50%	Medically necessary Orthodontic services must be preauthorized before treatment begins. Cosmetic Orthodontic services are not covered.
	Removable appliances	Adult: Not Covered	Not Covered	
		Child: 50%	50%	Replacement or repair of removable orthodontic retainers, or orthodontic appliances are not covered.
Prosthetics	Implants	Adult: Not Covered	Not Covered	
		Child: Not Covered	Not Covered	
	Partial Dentures	Adult: Not Covered	Not Covered	
		Child: 50%	50%	Covered once every seven years. Plan deductible applies.
	Complete Dentures	Adult: Not Covered	Not Covered	
		Child: 50%	50%	Covered for one complete upper and lower denture during the time your child is enrolled on this plan. Plan deductible applies.
	Bridge or Denture Repair	Adult: Not Covered	Not Covered	
		Child: 50%	50%	Covered after one year from the original Seate Date. Plan deductible applies.
	Rebase or Reline of Dentures	Adult: Not Covered	Not Covered	
		Child: 50%	50%	Covered once per arch every three years after the initial six-months from the Seat Date. Plan deductible applies.

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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.)

Braces for children that do not meet the medically necessary requirements; Implant; Cosmetic services or supplies, Adult Crowns, Adult Root Canals, Adult Oral Surgery, Adult Dentures (Replacement of teeth).

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, or 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.

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