

**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 [www.\[insert\].com](http://www.[insert].com) or by calling 1-800-[insert]

Important Questions	Answers	Why this Matters
What is the premium amount?	\$	The premium amount is a monthly fee you must pay to your insurance company to receive dental insurance.
What is the overall deductible?	\$	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?		The deductible [ <b>does/ does not</b> ] 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?	\$___ for 1 child \$___ 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?		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 <i>specific</i> covered services for children.
Who is included in this plan's network of providers?	See <a href="http://www.[insert].com">www.[insert].com</a> or call 1-800-[insert] 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?		You can see the specialist you choose <b>without</b> permission from this plan.
Do I need preauthorization before receiving certain dental services?		You <b>do</b> need to call the plan at 1-800-[insert] before receiving certain dental services. See your policy or plan document for additional information.
Are there services this plan doesn't cover?		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.



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	Out-of-Network Provider	
Routine Check-up	Oral Exams			
	Teeth Cleanings			
	Fluoride			
	Sealants			
	Full Mouth X-rays			
	Bitewing X-rays			

Insurance Company 1: Plan Option 1

Plan Type: [ PPO/HMO/EPO]

Coverage Period: 1/1/2026 – 12/31/2026

Summary of Benefits for Dental Coverage: What the Plan Covers & What it Costs

Coverage for: Children age 0-18

	Single Tooth X-rays			
	Space Maintainers			
	Nitrous oxide			
<b>Filling a Cavity</b>	Amalgam (Silver Fillings) Front Tooth			
	Amalgam (Silver Fillings) Back Tooth			
	Composite Front Tooth			
	Composite Back Tooth			
	Nitrous oxide			
	Temporary Fillings			
<b>Restorative Care</b>	Periodontal Maintenance. Cleanings (Treatment of gums)			
	Periodontal Scaling and Root Planing			
	Crowns			
	Replacement of a Crown			
	Onlays			

Questions: Call 1-800-[insert] or visit us at www.[insert].com.

Insurance Company 1: Plan Option 1

Plan Type: [ PPO/HMO/EPO]

Coverage Period: 1/1/2026 – 12/31/2026

Summary of Benefits for Dental Coverage: What the Plan Covers & What it Costs

Coverage for: Children age 0-18

	Root canal (per tooth)			
	Pulpotomy			
<b>Tooth Extraction</b>	Extraction (per tooth)			
	Surgical Extraction (per tooth)			
<b>Advanced Oral Surgery</b>	Oral surgery			
	Periodontal Surgery			
	General Anesthesia			
<b>Orthodontia</b>	Braces			
	Removable appliances			
<b>Prosthetics</b>	Implants			
	Partial Dentures			
	Complete Dentures			
	Bridge or Denture Repair			
	Rebase or Reline of Dentures			

Questions: Call 1-800-[insert] or visit us at www.[insert].com.

Insurance Company 1: Plan Option 1

Plan Type: [ PPO/HMO/EPO]

Coverage Period: 1/1/2026 – 12/31/2026

Summary of Benefits for Dental Coverage: What the Plan Covers & What it Costs

Coverage for: Children age 0-18

## 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](#)

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

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## 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: **[insert applicable contact information]**.

## 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.

Questions: Call 1-800-[insert] or visit us at www.[insert].com.