

PLAN **C** PRIME

SUMMARY OF COVERAGE

Deductible

per person per calendar year

Annual Benefit Maximum with To GoSM**

per person per calendar year

Delta Dental PPO SM Dentist	Delta Dental Premier [®] Dentist	Out-of-Network Dentist
\$50*	\$75	\$75
\$1,000		

BENEFIT CATEGORIES

Diagnostic & Preventive Services

(check-ups, teeth cleaning, x-rays, maintenance therapy)

Routine & Restorative Services

(cavity repair, tooth extractions, general anesthesia/sedation, restoration of decayed or fractured teeth, routine oral surgery)

Posterior Composites

(tooth-colored filling on back teeth)

Endodontic Services

(root canals and therapy, apicoectomy, direct pulp cap, retrograde fillings)

Periodontal Services

(gum and bone diseases, complex procedures)

High Cost Restorations

(cast restorations – crowns, inlays, onlays, posts, cores)

Prosthetics

(bridges, dentures)

Implants

Enhanced Benefits Program

(extra dental benefits based on medical conditions)

Coinsurance paid by member

0%	10%	30%
0%	10%	30%
20%	30%	50%
50%	60%	70%
50%	50%	60%
50%	50%	60%
50%	50%	60%
50%	50%	60%
60%	60%	70%
Pregnancy, high-risk cardiac conditions, suppressed immune systems, diabetes, periodontal disease, cancer, chemotherapy, radiation, and kidney failure or dialysis		

* Deductible is waived for all diagnostic and preventive care.

** To GoSM annual maximum carryover – see Benefits Certificate for details.

The information on this page summarizes your benefits and payment obligations. This is a general description of your benefits. Please see your benefits document for a full description of coverage.

