

## PLAN B PRIME - C (with orthodontia)

### SUMMARY OF COVERAGE

**Deductible**

per person per calendar year

**Annual Benefit Maximum with To Go<sup>SM</sup>\*\***

per person per calendar year

Delta Dental Premier® Dentist	Out-of-Network Dentist
\$25*	\$50
\$2,000	

### BENEFIT CATEGORIES

Coinsurance paid by member

**Diagnostic & Preventive Services**

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

0%

20%

**Routine & Restorative Services**

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

20%

40%

**Posterior Composites**

(tooth-colored filling on back teeth)

50%

60%

**Endodontic Services**

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

50%

60%

**Periodontal Services**

(gum and bone diseases, complex procedures)

50%

60%

**High Cost Restorations**

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

50%

60%

**Prosthetics**

(bridges, dentures)

50%

60%

**Implants**

60%

70%

**Corrective Orthodontia Benefit & Lifetime Maximum**

up to age 19

50% coinsurance and \$2,500 lifetime maximum

**Enhanced Benefits Program**

(extra dental benefits based on medical conditions)

Pregnancy, high-risk cardiac conditions, suppressed immune systems, diabetes, periodontal disease, cancer, chemotherapy, radiation, and kidney failure or dialysis

C = Corrective Orthodontia

\* Deductible is waived for all diagnostic and preventive care.

\*\* To Go<sup>SM</sup> 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.

