

## PLAN C PRIME

### SUMMARY OF COVERAGE

	Delta Dental PPO™ Dentist	Delta Dental Premier® Dentist	Out-of-Network Dentist
<b>Deductible</b> per person per calendar year	\$50*	\$75	\$75
<b>Annual Benefit Maximum with To Go<sup>SM</sup>**</b> per person per calendar year	\$1,000		

### BENEFIT CATEGORIES

	Coinsurance paid by member		
	Delta Dental PPO™ Dentist	Delta Dental Premier® Dentist	Out-of-Network Dentist
<b>Diagnostic &amp; Preventive Services</b> (check-ups, teeth cleaning, x-rays, maintenance therapy)	0%	10%	30%
<b>Routine &amp; Restorative Services</b> (cavity repair, tooth extractions, general anesthesia/sedation, restoration of decayed or fractured teeth, routine oral surgery)	20%	30%	50%
<b>Posterior Composites</b> (tooth-colored filling on back teeth)	50%	60%	70%
<b>Endodontic Services</b> (root canals and therapy, apicoectomy, direct pulp cap, retrograde fillings)	50%	50%	60%
<b>Periodontal Services</b> (gum and bone diseases, complex procedures)	50%	50%	60%
<b>High Cost Restorations</b> (cast restorations – crowns, inlays, onlays, posts, cores)	50%	50%	60%
<b>Prosthetics</b> (bridges, dentures)	50%	50%	60%
<b>Implants</b>	60%	60%	70%
<b>Enhanced Benefits Program</b> (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		

\* 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.

