

PLAN **A** PRIME - C (with orthodontia)

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
\$25*	\$50	\$50
\$1,500		

BENEFIT CATEGORIES

Coinsurance paid by member

Diagnostic & Preventive Services
(check-ups, teeth cleaning, x-rays, maintenance therapy)

20%

30%

50%

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

50%

50%

60%

Posterior Composites
(tooth-colored filling on back teeth)

60%

70%

80%

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

50%

50%

60%

Periodontal Services
(gum and bone diseases, complex procedures)

50%

50%

60%

High Cost Restorations
(cast restorations - crowns, inlays, onlays, posts, cores)

50%

50%

60%

Prosthetics
(bridges, dentures)

50%

50%

60%

Implants

60%

60%

70%

Corrective Orthodontia Benefit & Lifetime Maximum
up to age 19

50% coinsurance and \$1,500 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 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.

