



# Delta Dental Premier<sup>®</sup> Plan B Prime

Small Group Employer Choice

	Delta Dental Premier <sup>®</sup> Dentist	Out-of-Network Dentist
<b>Deductible</b> (per person per calendar year)	\$25*	\$50
<b>Annual Benefit Maximum with To Go<sup>SM**</sup></b>	\$2,000	
<b>Benefit Categories</b>	Coinsurance paid by member	
<b>Diagnostic &amp; Preventive Services</b> check-ups, teeth cleaning, x-rays, maintenance therapy	0%	20%
<b>Routine &amp; Restorative Services</b> cavity repair, tooth extractions, general anesthesia/sedation, restoration of decayed or fractured teeth, routine oral surgery	20%	40%
<b>Posterior Composites</b> tooth-colored filling on back teeth	50%	60%
<b>Endodontic Services</b> root canals and therapy, apicoectomy, direct pulp cap, retrograde fillings	50%	60%
<b>Periodontal Services</b> gum and bone diseases, complex procedures	50%	60%
<b>High Cost Restorations</b> cast restorations - crowns, inlays, onlays, posts, cores	50%	60%
<b>Prosthetics</b> bridges, dentures	50%	60%
<b>Implants</b>	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.