

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 Premier® Dentist	Out-of-Network Dentist
\$50*	\$75
\$1,000	

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%

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

* 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.

