PLAN B PRIME

SUMMARY OF COVERAGE	Delta Dental Premier® Dentist	Out-of-Network Dentist
Deductible per person per calendar year	$25*	$50
Annual Benefit Maximum with To Go℠** per person per calendar year	$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%
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 Go℠ 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.

DELTA DENTAL®