

For 2019, the plan you were enrolled in will no longer be offered. You will be automatically enrolled in the **Delta Dental Premier - Plan C Prime**. Below is a comparison of your new plan and your 2018 plan.

	New 2019 Plan	Current 2018 Plan	
	Premier Plan C Prime	Premier Plan C Plus – H	
SUMMARY OF COVERAGE			
	Adult/Child	Adult	Child
Deductible per person per calendar year	\$50*	\$50*	\$25*
Annual Benefit Maximum with To GoSM**	\$1,000	\$1,000	
Diagnostic & Preventive Services (check-ups, teeth cleaning, x-rays, maintenance therapy)	0%	0%	0%
Basic Services (cavity repair, tooth extractions, general anesthesia/sedation, restoration of decayed or fractured teeth, routine oral surgery)	20%	20%	50%
Major Services (root canals and therapy, apicoectomy, direct pulp cap, retrograde fillings, gum and bone diseases, complex procedures, cast restorations – crowns, inlays, onlays, posts, cores, bridges and dentures)	50%	50%	50%
Medically Necessary Orthodontia (only applies to in-network)	Not covered	Not Covered	50% for child only
Child Annual Out-of-Pocket Limit (only applies to in-network)	Does not apply	Does not apply	\$350 per child or \$700 for all children under 21

H = High Child Plan

Percentages shown are what the patient pays when seeing an in-network dentist.

* 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.