

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

	New 2019 Plan	Current 2018 Plan	
	PPO plus Premier Plan C Prime	PPO plus Premier Plan C Plus - H	
SUMMARY OF COVERAGE			
	Adult/Child	Adult	Child
<b>Deductible</b> per person per calendar year	\$50*-\$75	\$50*-75	\$25*
<b>Annual Benefit Maximum with To Go<sup>SM</sup>**</b>	\$1,000	\$1,000	
<b>Diagnostic &amp; Preventive Services</b> (check-ups, teeth cleaning, x-rays, maintenance therapy)	0-10%	0-10%	0%
<b>Basic Services</b> (cavity repair, tooth extractions, general anesthesia/sedation, restoration of decayed or fractured teeth, routine oral surgery)	20-30%	20-30%	20-50%
<b>Major Services</b> (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%
<b>Medically Necessary Orthodontia</b> (only applies to in-network)	Not covered	Not covered	50% for child only
<b>Child Annual Out-of-Pocket Limit</b> (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 (except for adults when seeing a Premier network dentist).

\*\* 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.