



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

	New 2019 Plan	Current 2018 Plan
SUMMARY OF COVERAGE	Premier Plan B Prime	Premier Plan B (Plan 207)
Deductible per person per calendar year	\$25*	Individual - \$25** Family - \$75**
Annual Benefit Maximum with To GoSM***	\$2,000	\$2,000
Diagnostic & Preventive Services (check-ups, teeth cleaning, x-rays, maintenance therapy)	0%	0%
Basic Services (cavity repair, tooth extractions, general anesthesia/sedation, restoration of decayed or fractured teeth, routine oral surgery)	20%	20%
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%
Implants	60%	50% Implants limited to the amount paid for a bridge

Percentages shown are what the patient pays when seeing an in-network dentist.
 * Deductible is waived for all diagnostic and preventive care.
 ** Deductible is waived for check-ups and teeth cleanings only.
 *** 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.