2019 Plan Comparison | PPO plus Premier – Plan A Prime

DELTA DENTAL

For 2019, the plan you are currently enrolled in will no longer be offered. Your group will be automatically enrolled in the **Delta Dental PPO plus Premier – Plan A Prime**. Below is a comparison of your new plan and your 2018 plan.

If you would like to look at other plan options, contact your broker, or view the 2019 Small Group Product Guide.

	New 2019 Plan	Current 2018 Plan	
SUMMARY OF COVERAGE	**PPO plus Premier Plan A Prime**	**PPO plus Premier Plan A Plus - L**	
	Adult/Child	Adult	Child
Deductible per person per calendar year	$25*-50	$25*-50	$75*
Annual Benefit Maximum with To GoSM**	$1,500	$1,500	
Diagnostic & Preventive Services (check-ups, teeth cleaning, x-rays, maintenance therapy)	20-30%	20-30%	0-50%
Basic Services (cavity repair, tooth extractions, general anesthesia/sedation, restoration of decayed or fractured teeth, routine oral surgery)	50%	50%	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

L = Low Child Plan
Percentages shown are what the patient pays when seeing an in-network dentist.
* Deductible is waived for all diagnostic and preventive care (expect for adults when seeing a Premier network dentist).
** 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.

DELTA DENTAL

For 2019, the plan you are currently enrolled in will no longer be offered. Your group will be automatically enrolled in the **Delta Dental PPO plus Premier - Plan A Prime – C** (with orthodontia). Below is a comparison of your new plan and your 2018 plan.

If you would like to look at other plan options, contact your broker, or view the 2019 Small Group Product Guide.

	New 2019 Plan	Current 2018 Plan	
SUMMARY OF COVERAGE	**PPO plus Premier Plan A Prime – C** (with orthodontia)	**PPO plus Premier Plan A Plus – LC** (with orthodontia)	
	Adult/Child	Adult	Child
Deductible per person per calendar year	$25*-50	$25*-50	$75*
Annual Benefit Maximum with To Go℠**	$1,500	$1,500	
Diagnostic & Preventive Services (check-ups, teeth cleaning, x-rays, maintenance therapy)	20-30%	20-30%	0-50%
Basic Services (cavity repair, tooth extractions, general anesthesia/sedation, restoration of decayed or fractured teeth, routine oral surgery)	50%	50%	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
Corrective Orthodontia Benefit & Lifetime Maximum (up to age 19)	50% copay and $1,500 lifetime maximum	50% copay and $1,500 lifetime maximum	

L = Low Child Plan C = Corrective Orthodontia
Percentages shown are what the patient pays when seeing an in-network dentist.
* Deductible is waived for all diagnostic and preventive care (expect for adults when seeing a Premier network dentist).
** 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.

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DELTA DENTAL

For 2019, the plan you are currently enrolled in will no longer be offered. Your group 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.

If you would like to look at other plan options, contact your broker, or view the 2019 Small Group Product Guide.

	New 2019 Plan	Current 2018 Plan	
SUMMARY OF COVERAGE	**PPO plus Premier Plan C Prime**	**PPO plus Premier Plan C Plus – H**	
	Adult/Child	Adult	Child
Deductible per person per calendar year	$50*-$75	$50*-75	$25*
Annual Benefit Maximum with To Go^{SM}**	$1,000	$1,000	
Diagnostic & Preventive Services (check-ups, teeth cleaning, x-rays, maintenance therapy)	0-10%	0-10%	0%
Basic Services (cavity repair, tooth extractions, general anesthesia/sedation, restoration of decayed or fractured teeth, routine oral surgery)	20-30%	20-30%	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 (expect for adults when seeing a Premier network dentist).
** To Go^{SM} 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.

2019 Plan Comparison | PPO plus Premier – Plan C Prime - C

For 2019, the plan you are currently enrolled in will no longer be offered. Your group will be automatically enrolled in the **Delta Dental PPO plus Premier - Plan C Prime – C** (with orthodontia). Below is a comparison of your new plan and your 2018 plan.

If you would like to look at other plan options, contact your broker, or view the 2019 Small Group Product Guide.

	New 2019 Plan	Current 2018 Plan	
SUMMARY OF COVERAGE	**PPO plus Premier Plan C Prime – C** (with orthodontia)	**PPO plus Premier Plan C Plus – HC** (with orthodontia)	
	Adult/Child	Adult	Child
Deductible per person per calendar year	$50*-75	$50*-75	$25*
Annual Benefit Maximum with To Go^{SM}**	$1,000	$1,000	
Diagnostic & Preventive Services (check-ups, teeth cleaning, x-rays, maintenance therapy)	0-10%	0-10%	0%
Basic Services (cavity repair, tooth extractions, general anesthesia/sedation, restoration of decayed or fractured teeth, routine oral surgery)	20-30%	20-30%	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
Corrective Orthodontia Benefit & Lifetime Maximum (up to age 19)	50% copay and $1,500 lifetime maximum	50% copay and $1,500 lifetime maximum	

H = High Child Plan C = Corrective Orthodontia
Percentages shown are what the patient pays when seeing an in-network dentist.
* Deductible is waived for all diagnostic and preventive care (expect for adults when seeing a Premier network dentist).
** To Go^{SM} 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.

2019 Plan Comparison | Premier – Plan A Prime

DELTA DENTAL

For 2019, the plan you are currently enrolled in will no longer be offered. Your group will be automatically enrolled in the **Delta Dental Premier - Plan A Prime**. Below is a comparison of your new plan and your 2018 plan.

If you would like to look at other plan options, contact your broker, or view the 2019 Small Group Product Guide.

	New 2019 Plan	Current 2018 Plan	
SUMMARY OF COVERAGE	**Premier Plan A Prime**	**Premier Plan A Plus – L**	
	Adult/Child	Adult	Child
Deductible per person per calendar year	$25*	$25*	$75*
Annual Benefit Maximum with To Go℠**	$1,500	$1,500	
Diagnostic & Preventive Services (check-ups, teeth cleaning, x-rays, maintenance therapy)	20%	20%	25%
Basic Services (cavity repair, tooth extractions, general anesthesia/sedation, restoration of decayed or fractured teeth, routine oral surgery)	50%	50%	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

L = Low 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 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.

2019 Plan Comparison | Premier – Plan A Prime - C

DELTA DENTAL

For 2019, the plan you are currently enrolled in will no longer be offered. Your group will be automatically enrolled in the **Delta Dental Premier - Plan A Prime – C** (with orthodontia). Below is a comparison of your new plan and your 2018 plan.

If you would like to look at other plan options, contact your broker, or view the 2019 Small Group Product Guide.

	New 2019 Plan	Current 2018 Plan	
SUMMARY OF COVERAGE	**Premier Plan A Prime – C** (with orthodontia)	**Premier Plan A Plus – LC** (with orthodontia)	
	Adult/Child	Adult	Child
Deductible per person per calendar year	$25*	$25*	$75*
Annual Benefit Maximum with To GoSM**	$1,500	$1,500	
Diagnostic & Preventive Services (check-ups, teeth cleaning, x-rays, maintenance therapy)	20%	20%	25%
Basic Services (cavity repair, tooth extractions, general anesthesia/sedation, restoration of decayed or fractured teeth, routine oral surgery)	50%	50%	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
Corrective Orthodontia Benefit & Lifetime Maximum (up to age 19)	50% copay and $1,500 lifetime maximum	50% copay and $1,500 lifetime maximum	

L = Low Child Plan C = Corrective Orthodontia
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.

2019 Plan Comparison | Premier – Plan C Prime

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

If you would like to look at other plan options, contact your broker, or view the 2019 Small Group Product Guide.

	New 2019 Plan	Current 2018 Plan	
SUMMARY OF COVERAGE	**Premier Plan C Prime**	**Premier Plan C Plus – H**	
	Adult/Child	Adult	Child
Deductible per person per calendar year	$50*	$50*	$25*
Annual Benefit Maximum with To Go^{SM}**	$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 Go^{SM} 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.

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2019 Plan Comparison | Premier – Plan C Prime - C

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

If you would like to look at other plan options, contact your broker, or view the 2019 Small Group Product Guide.

	New 2019 Plan	Current 2018 Plan	
SUMMARY OF COVERAGE	**Premier Plan C Prime – C** (with orthodontia)	**Premier Plan C Plus – HC** (with orthodontia)	
	Adult/Child	Adult	Child
Deductible per person per calendar year	$50*	$50*	$25*
Annual Benefit Maximum with To Go℠**	$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
Corrective Orthodontia Benefit & Lifetime Maximum (up to age 19)	50% copay and $1,500 lifetime maximum	50% copay and $1,500 lifetime maximum	

H = High Child Plan C = Corrective Orthodontia
Percentages shown are what the patient pays when seeing an in-network dentist.
*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.

2019 Plan Comparison | PPO plus Premier – Plan A Prime

For 2019, the plan you are currently enrolled in will no longer be offered. Your group will be automatically enrolled in the **Delta Dental PPO plus Premier – Plan A Prime**. Below is a comparison of your new plan and your 2018 plan.

If you would like to look at other plan options, contact your broker, or view the 2019 Small Group Product Guide.

	New 2019 Plan	Current 2018 Plan
SUMMARY OF COVERAGE	**PPO plus Premier Plan A Prime**	**PPO plus Premier Plan A** (Plan 405)
Deductible per person per calendar year	$25*-50	Individual – $25**-50 Family – $75**-150
Annual Benefit Maximum with To Go℠**	$1,500	$1,500
Diagnostic & Preventive Services (check-ups, teeth cleaning, x-rays, maintenance therapy)	20-30%	20-30%
Basic Services (cavity repair, tooth extractions, general anesthesia/sedation, restoration of decayed or fractured teeth, routine oral surgery)	50%	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%
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 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.

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2019 Plan Comparison | PPO plus Premier – Plan A Prime - C

DELTA DENTAL

For 2019, the plan you are currently enrolled in will no longer be offered. Your group will be automatically enrolled in the **Delta Dental PPO Plus Premier - Plan A Prime – C** (with orthodontia). Below is a comparison of your new plan and your 2018 plan.

If you would like to look at other plan options, contact your broker, or view the 2019 Small Group Product Guide.

	New 2019 Plan	Current 2018 Plan
SUMMARY OF COVERAGE	**PPO Plus Premier Plan A Prime – C** (with orthodontia)	**PPO Plus Premier Plan A** (Plan 404 with orthodontia)
Deductible per person per calendar year	$25*-50	Individual – $25** Family – $75**
Annual Benefit Maximum with To GoSM***	$1,500	$1,500
Diagnostic & Preventive Services (check-ups, teeth cleaning, x-rays, maintenance therapy)	20-30%	20-30%
Basic Services (cavity repair, tooth extractions, general anesthesia/sedation, restoration of decayed or fractured teeth, routine oral surgery)	50%	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%
Implants	60%	50% Implants limited to the amount paid for a bridge
Corrective Orthodontia Benefit & Lifetime Maximum (up to age 19)	50% copay and $1,500 lifetime maximum	50% copay and $1,500 lifetime maximum

C = Corrective Orthodontia
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.

2019 Plan Comparison | PPO plus Premier – Plan B Prime

For 2019, the plan you are currently enrolled in will no longer be offered. Your group will be automatically enrolled in the **Delta Dental PPO Plus Premier – Plan B Prime**. Below is a comparison of your new plan and your 2018 plan.

If you would like to look at other plan options, contact your broker, or view the 2019 Small Group Product Guide.

	New 2019 Plan	Current 2018 Plan
SUMMARY OF COVERAGE	**PPO Plus Premier Plan B Prime**	**PPO Plus Premier Plan B** (Plan 407)
Deductible per person per calendar year	$25*-50	Individual – $25**-50 Family – $75**-150
Annual Benefit Maximum with To GoSM***	$2,000	$2,000
Diagnostic & Preventive Services (check-ups, teeth cleaning, x-rays, maintenance therapy)	0-10%	0-10%
Basic Services (cavity repair, tooth extractions, general anesthesia/sedation, restoration of decayed or fractured teeth, routine oral surgery)	20-30%	20-30%
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.

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2019 Plan Comparison | PPO plus Premier – Plan B Prime - C

For 2019, the plan you are currently enrolled in will no longer be offered. Your group will be automatically enrolled in the **Delta Dental PPO plus Premier - Plan B Prime – C** (with orthodontia). Below is a comparison of your new plan and your 2018 plan.

If you would like to look at other plan options, contact your broker, or view the 2019 Small Group Product Guide.

	New 2019 Plan	Current 2018 Plan
SUMMARY OF COVERAGE	**PPO plus Premier Plan B Prime – C** (with orthodontia)	**PPO plus Premier Plan B** (Plan 406 with orthodontia)
Deductible per person per calendar year	$25*-50	Individual – $25**-50 Family – $75**-150
Annual Benefit Maximum with To GoSM***	$2,000	$2,000
Diagnostic & Preventive Services (check-ups, teeth cleaning, x-rays, maintenance therapy)	0-10%	0-10%
Basic Services (cavity repair, tooth extractions, general anesthesia/sedation, restoration of decayed or fractured teeth, routine oral surgery)	20-30%	20-30%
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
Corrective Orthodontia Benefit & Lifetime Maximum (up to age 19)	50% copay and $1,500 lifetime maximum	50% copay and $1,500 lifetime maximum

C = Corrective Orthodontia
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.

2019 Plan Comparison | PPO plus Premier – Plan C Prime

DELTA DENTAL

For 2019, the plan you are currently enrolled in will no longer be offered. Your group 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.

If you would like to look at other plan options, contact your broker, or view the 2019 Small Group Product Guide.

	New 2019 Plan	Current 2018 Plan
SUMMARY OF COVERAGE	**PPO Plus Premier Plan C Prime**	**PPO Plus Premier Plan Standard** (Plan 413)
Deductible per person per calendar year	$50*-$75	Individual – $50**-75 Family – $150**-225
Annual Benefit Maximum with To Go SM* **	$1,000	$1,000
Diagnostic & Preventive Services (check-ups, teeth cleaning, x-rays, maintenance therapy)	0-10%	0-10%
Basic Services (cavity repair, tooth extractions, general anesthesia/sedation, restoration of decayed or fractured teeth, routine oral surgery)	20-30%	20-30%
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 Go SM 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.

2019 Plan Comparison | PPO plus Premier – Plan C Prime - C

For 2019, the plan you are currently enrolled in will no longer be offered. Your group will be automatically enrolled in the **Delta Dental PPO Plus Premier - Plan C Prime – C** (with orthodontia). Below is a comparison of your new plan and your 2018 plan.

If you would like to look at other plan options, contact your broker, or view the 2019 Small Group Product Guide.

	New 2019 Plan	Current 2018 Plan
SUMMARY OF COVERAGE	**PPO plus Premier Plan C Prime – C** (with orthodontia)	**PPO plus Premier Plan Standard** (Plan 412 with orthodontia)
Deductible per person per calendar year	$50*-75	Individual – $50**-75 Family – $150**-225
Annual Benefit Maximum with To GoSM***	$1,000	$1,000
Diagnostic & Preventive Services (check-ups, teeth cleaning, x-rays, maintenance therapy)	0-10%	0-10%
Basic Services (cavity repair, tooth extractions, general anesthesia/sedation, restoration of decayed or fractured teeth, routine oral surgery)	20-30%	20-30%
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
Corrective Orthodontia Benefit & Lifetime Maximum (up to age 19)	50% copay and $1,500 lifetime maximum	50% copay and $1,500 lifetime maximum

C = Corrective Orthodontia
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.

2019 Plan Comparison | Premier – Plan A Prime

For 2019, the plan you are currently enrolled in will no longer be offered. Your group will be automatically enrolled in the **Delta Dental Premier - Plan A Prime** Below is a comparison of your new plan and your 2018 plan.

If you would like to look at other plan options, contact your broker, or view the 2019 Small Group Product Guide.

	New 2019 Plan	Current 2018 Plan
SUMMARY OF COVERAGE	**Premier Plan A Prime**	**Premier Plan A** (Plan 205)
Deductible per person per calendar year	$25*	Individual – $25** Family – $75**
Annual Benefit Maximum with To Go℠* **	$1,500	$1,500
Diagnostic & Preventive Services (check-ups, teeth cleaning, x-rays, maintenance therapy)	20%	20%
Basic Services (cavity repair, tooth extractions, general anesthesia/sedation, restoration of decayed or fractured teeth, routine oral surgery)	50%	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%
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 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.

2019 Plan Comparison | Premier – Plan A Prime - C

DELTA DENTAL

For 2019, the plan you are currently enrolled in will no longer be offered. Your group will be automatically enrolled in the **Delta Dental Premier - Plan A Prime – C** (with orthodontia). Below is a comparison of your new plan and your 2018 plan.

If you would like to look at other plan options, contact your broker, or view the 2019 Small Group Product Guide.

	New 2019 Plan	Current 2018 Plan
SUMMARY OF COVERAGE	**Premier Plan A Prime – C** (with orthodontia)	**Premier Plan A** (Plan 204 with orthodontia)
Deductible per person per calendar year	$25*	Individual – $25** Family – $75**
Annual Benefit Maximum with To Go℠* **	$1,500	$1,500
Diagnostic & Preventive Services (check-ups, teeth cleaning, x-rays, maintenance therapy)	20%	20%
Basic Services (cavity repair, tooth extractions, general anesthesia/sedation, restoration of decayed or fractured teeth, routine oral surgery)	50%	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%
Implants	60%	50% Implants limited to the amount paid for a bridge
Corrective Orthodontia Benefit & Lifetime Maximum (up to age 19)	50% copay and $1,500 lifetime maximum	50% copay and $1,500 lifetime maximum

C = Corrective Orthodontia
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 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.

2019 Plan Comparison | Premier – Plan B Prime

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

If you would like to look at other plan options, contact your broker, or view the 2019 Small Group Product Guide.

	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.

2019 Plan Comparison | Premier – Plan B Prime - C

For 2019, the plan you are currently enrolled in will no longer be offered. Your group will be automatically enrolled in the **Delta Dental Premier - Plan B Prime – C** (with orthodontia). Below is a comparison of your new plan and your 2018 plan.

If you would like to look at other plan options, contact your broker, or view the 2019 Small Group Product Guide.

	New 2019 Plan	Current 2018 Plan
SUMMARY OF COVERAGE	**Premier Plan B Prime – C** (with orthodontia)	**Premier Plan B** (Plan 206 with orthodontia)
Deductible per person per calendar year	$25*	Individual – $25** Family – $75**
Annual Benefit Maximum with To Go^{SM***}	$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
Corrective Orthodontia Benefit & Lifetime Maximum (up to age 19)	50% copay and $1,500 lifetime maximum	50% copay and $1,500 lifetime maximum

C = Corrective Orthodontia
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 Go^{SM} 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.

2019 Plan Comparison | Premier – Plan B Prime - C

DELTA DENTAL

For 2019, the plan you are currently enrolled in will no longer be offered. Your group will be automatically enrolled in the **Delta Dental Premier - Plan B Prime – C** (with orthodontia). Below is a comparison of your new plan and your 2018 plan.

If you would like to look at other plan options, contact your broker, or view the 2019 Small Group Product Guide.

	New 2019 Plan	Current 2018 Plan
SUMMARY OF COVERAGE	**Premier Plan B Prime – C** (with orthodontia)	**Premier Plan C** (Plan 208 with orthodontia)
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
Corrective Orthodontia Benefit & Lifetime Maximum (up to age 19)	50% copay and $1,500 lifetime maximum	50% copay and $2,500 lifetime maximum

C = Corrective Orthodontia
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.

2019 Plan Comparison | Premier – Plan C Prime

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

If you would like to look at other plan options, contact your broker, or view the 2019 Small Group Product Guide.

	New 2019 Plan	Current 2018 Plan
SUMMARY OF COVERAGE	**Premier Plan C Prime**	**Premier Plan Standard** (Plan 213)
Deductible per person per calendar year	$50*	Individual – $50** Family – $150**
Annual Benefit Maximum with To Go℠* **	$1,000	$1,000
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 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.

2019 Plan Comparison | Premier – Plan C Prime - C

DELTA DENTAL

For 2019, the plan you are currently enrolled in will no longer be offered. Your group will be automatically enrolled in the **Delta Dental Premier - Plan C Prime – C** (with orthodontia). Below is a comparison of your new plan and your 2018 plan.

If you would like to look at other plan options, contact your broker, or view the 2019 Small Group Product Guide.

	New 2019 Plan	Current 2018 Plan
SUMMARY OF COVERAGE	**Premier Plan C Prime – C** (with orthodontia)	**Premier Plan Standard** (Plan 212 with orthodontia)
Deductible per person per calendar year	$50*	Individual – $50** Family – $150**
Annual Benefit Maximum with To Go℠***	$1,000	$1,000
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
Corrective Orthodontia Benefit & Lifetime Maximum (up to age 19)	50% copay and $1,500 lifetime maximum	50% copay and $1,500 lifetime maximum

C = Corrective Orthodontia
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 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.

2019 Plan Comparison | Premier – Plan A Prime

For 2019, the plan you are currently enrolled in will no longer be offered. Your group will be automatically enrolled in the **Delta Dental Premier - Plan A Prime**. Below is a comparison of your new plan and your 2018 plan.

If you would like to look at other plan options, contact your broker, or view the 2019 Small Group Product Guide.

	New 2019 Plan	Current 2018 Plan
SUMMARY OF COVERAGE	**Premier Plan A Prime**	**Premier Plan 868**
Deductible per person per calendar year	$25*	Individual – $25** Family – $75**
Annual Benefit Maximum	$1,500 Includes To Go℠ carryover benefit***	$500
Diagnostic & Preventive Services (check-ups, teeth cleaning, x-rays, maintenance therapy)	20%	20%
Basic Services (cavity repair, tooth extractions, general anesthesia/sedation, restoration of decayed or fractured teeth, routine oral surgery)	50%	50%
Major Services (gum and bone diseases, complex procedures, cast restorations – crowns, inlays, onlays, posts, cores, bridges and dentures)	50%	Not covered
Root Canal (root canals and therapy, apicoectomy, direct pulp cap and retrograde fillings)	50%	50%
Implants	60%	Not covered

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 Go℠ annual maximum carryover – see Benefits Certificate for details.

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2395-F10144 09/2018

2019 Plan Comparison | PPO plus Premier – Preferred Prime

DELTA DENTAL

For 2019, the plan you are currently enrolled in will no longer be offered. Your group will be automatically enrolled in the **Delta Dental Employee Choice PPO plus Premier – Preferred Prime**. Below is a comparison of your new plan and your 2018 plan.

If you would like to look at other plan options, contact your broker, or view the 2019 Small Group Product Guide.

	New 2019 Plan	Current 2018 Plan
SUMMARY OF COVERAGE	**PPO plus Premier Preferred Prime**	**PPO plus Premier Voluntary Catastrophic**
Deductible per person per calendar year	$50*-150*	$0-100
Annual Benefit Maximum	$1,000	$1,250
Diagnostic & Preventive Services (check-ups, teeth cleaning, x-rays, maintenance therapy)	0%	100%
Basic Services (cavity repair, tooth extractions, general anesthesia/sedation, restoration of decayed or fractured teeth, routine oral surgery)	50%	40-50%
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%	40-50%

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

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2395-F10154 09/2018

2019 Plan Comparison | PPO plus Premier – Preferred Prime

For 2019, the plan you are currently enrolled in will no longer be offered. Your group will be automatically enrolled in the **Delta Dental Employee Choice PPO plus Premier – Preferred Prime**. Below is a comparison of your new plan and your 2018 plan.

If you would like to look at other plan options, contact your broker, or view the 2019 Small Group Product Guide.

	New 2019 Plan	Current 2018 Plan
SUMMARY OF COVERAGE	**PPO plus Premier Preferred Prime**	**PPO plus Premier Voluntary Comprehensive**
Deductible per person per calendar year	$50*-150*	$50-150
Annual Benefit Maximum	$1,000	$1,250
Diagnostic & Preventive Services (check-ups, teeth cleaning, x-rays, maintenance therapy)	0%	20-30%
Basic Services (cavity repair, tooth extractions, general anesthesia/sedation, restoration of decayed or fractured teeth, routine oral surgery)	50%	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%	40-50%

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

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2395-F10155 09/2018

For 2019, the plan you are currently enrolled in will no longer be offered. Your group will be automatically enrolled in the **Delta Dental PPO plus Premier – Preventive Prime**. Below is a comparison of your new plan and your 2018 plan.

If you would like to look at other plan options, contact your broker, or view the 2019 Small Group Product Guide.

	New 2019 Plan	Current 2018 Plan
SUMMARY OF COVERAGE	**PPO plus Premier Preventive Prime**	**PPO plus Premier Voluntary Preventive**
Deductible per person per calendar year	$50	$50
Annual Benefit Maximum	Unlimited	Unlimited
Diagnostic & Preventive Services (check-ups, teeth cleaning, x-rays, maintenance therapy)	20-30%	20-30%
Basic Services (cavity repair, tooth extractions, general anesthesia/sedation, restoration of decayed or fractured teeth, routine oral surgery)	50%	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)	Not covered	Not covered

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

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2395-F10156 09/2018