

DENTAL COPAY/CO-INSURANCE COMPARISON CHART

Benefit Provision		Cigna (DHMO) *	Cigna Dental (PPO) ***	Delta Dental (PPO)		
		In-Network coverage only	In and Out-of-Network coverage			
Deductible	Individual	\$0	\$50	\$50		
	Family	\$0	\$100	\$100		
Annual Individual Benefit Maximum	Standard	None/Unlimited	\$2,000	\$2,000		
	Orthodontic	None/Unlimited	\$3,000	\$3,000		
Pre-existing Condition Limitation		Procedures in progress at time of enrollment are not covered, excluding orthodontic services	5 year waiting period for replacement (major services)	5 year waiting period for replacement (major services)		
Dental Provider Network		DHMO Provider Network	Cigna DPPO Advantage	Delta Dental PPO		
Class I - Preventive Care Services			Amount Paid by the Member			
Preventive Care Routine Cleanings Sealants Space Maintainers		\$0 \$12/tooth \$20	In-Network	Out-of-Network**	In-Network	Out-of-Network**
			Deductible waived			
			\$0	20%	\$0	\$0
Diagnostic Exams Evaluations & Consultations X-rays		\$0 \$0 - \$55 \$0	Deductible waived			
			\$0	20%	\$0	\$0
Emergency Palliative Treatment Treatment for the relief of pain		\$5 - \$45	Deductible waived			
			\$0	20%	\$0	\$0
Class II - Basic Restorative Services			Amount Paid by the Member			
Restorative Fillings		Amalgam \$9 - \$21 Resin \$22 - \$70	Amalgam 20%	Amalgam 40%	Amalgam 20%	Amalgam 20%
			Resin 20%	Resin 40%	Resin 50%	Resin 50%
Oral Surgery Extractions		\$35 - \$120	Resin 20%	Resin 40%	20%	20%
Endodontics Root Canal Treatment Pulpotomy		\$170 - \$265 \$30 - \$85	20%	40%	20%	20%
Periodontics Treatment of gum disease Periodontal Maintenance		Debridement: \$80 Root Planing: \$90/quadrant	20%	40%	20%	20%
Bridge & Denture Repair		\$10	20%	40%	20%	20%
Class III - Major Restorative Services			Amount Paid by the Member			
Prosthodontics Bridges per pontic Partial Dentures Complete Dentures (upper or lower)		\$235 - \$250 \$375 - \$400 \$325 - \$350	50%		50%	
			50%		50%	
Restorative Cast Crowns & Jackets Onlays & Inlays		\$250 - \$260 \$135 - \$170	50%		50%	
Class IV - Orthodontic Services			Amount Paid by the Member			
Orthodontic maximum is separate from annual benefit maximum		Banding: \$448 - \$1,125 24 month treatment: \$3,264 - \$3,936 adults and children	50% adults & children		50% adults & children age 8 + older	

*Office visit fee \$3.00 (per patient, per office visit, in addition to any other applicable patient charges.) These amounts are only applicable to the selected network general dentist.

**If the dentist charges more than the reasonable & customary allowance, you will be liable for the difference between the allowance and the billed amount, in addition to the applicable deductible and co-insurance.

***Progressive/Regressive Base Plan. If you enroll in this plan and you or your covered dependents receive a preventive service during the plan year, the level of coverage is increased for that person by 5% for Class II and Class III services for the next plan year up to a 10% maximum. If you don't receive a preventive service during the plan year, the level of coverage is decreased by 5% for these services for the next plan year. However, level of coverage will not go below that listed above.

For more detail, review the dental plan documents on the Employee Benefits Dental Page.