

## 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)	
<b>Class I - Preventive Care Services</b>			<b>Amount Paid by the Member</b>			
Preventive Care Routine Cleanings Sealants Space Maintainers		\$0 \$12/tooth \$20	In-Network	Out-of-Network**	In-Network	Out-of-Network**
			Deductible waived			
Diagnostic Exams Evaluations & Consultations X-rays		\$0 \$0 - \$55 \$0	\$0	20%	\$0	\$0
			Deductible waived			
Emergency Palliative Treatment Treatment for the relief of pain		\$5 - \$45	\$0	20%	\$0	\$0
			Deductible waived			
<b>Class II - Basic Restorative Services</b>			<b>Amount Paid by the Member</b>			
Restorative Fillings		Amalgam \$9 - \$21 Resin \$22 - \$70	Amalgam 20%	Amalgam 40%	Amalgam 20%	Amalgam 20%
			Resin 50%	Resin 50%	Resin 50%	Resin 50%
Oral Surgery Extractions		\$35 - \$120	20%	40%	20%	20%
Endodontics Root Canal Treatment Pulpotomy		\$170 - \$265 \$30 - \$85	20%	40%	20%	20%
			Deductible waived			
Periodontics Treatment of gum disease Periodontal Maintenance		Debridement: \$80 Root Planing: \$90/quadrant	20%	40%	20%	20%
			Deductible waived			
Bridge & Denture Repair		\$10	20%	40%	20%	20%
<b>Class III - Major Restorative Services</b>			<b>Amount Paid by the Member</b>			
Prosthodontics Bridges per pontic Partial Dentures Complete Dentures (upper or lower)		\$235 - \$250 \$375 - \$400 \$325 - \$350	50%		50%	
			Deductible waived			
			50%		50%	
Restorative Cast Crowns & Jackets Onlays & Inlays		\$250 - \$260 \$135 - \$170	50%		50%	
			Deductible waived			
<b>Class IV - Orthodontic Services</b>			<b>Amount Paid by the Member</b>			
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, or [contact the vendor](#) (on the "Vendor Contact Page" in the Resources section of the website.)