DENTAL PLAN COMPARISON

**BASE PLAN** | **PREFERRED PLAN** | **DHMO**
---|---|---
**CALCULATED DEDUCTIBLE**<br>Individual | $50 | $50 | $50 | None
Family | $150 | $150 | $150 | None

**CALCULATED MAXIMUM**<br>$1,000 | $2,000 | None

**PREVENTIVE & DIAGNOSTIC SERVICES**
Exams, Cleanings, Bitewing X-rays (each twice in a calendar year), Fluoride Treatment (twice per calendar year, children to age 19)

| Benefit Description | IN-NETWORK | OUT-OF-NETWORK* | IN-NETWORK | OUT-OF-NETWORK* | IN-NETWORK ONLY |
|---------------------|-------------|------------------|-------------|------------------|----------------
| Exams, Cleanings, Bitewing X-rays | Plan pays 100% no deductible | Plan pays 100% no deductible | Plan pays 100% no deductible | Plan pays 100% no deductible | Flat copay amounts. See Schedule of Benefits. |
| Preventive Care | Plan pays 100% no deductible | Plan pays 100% no deductible | Plan pays 100% no deductible | Plan pays 100% no deductible | Flat copay amounts. See Schedule of Benefits. |

**BASIC SERVICES**
Fillings, Extractions, Endodontics (root canal), Periodontics, Oral Surgery, Sealants

| Benefit Description | IN-NETWORK | OUT-OF-NETWORK* | IN-NETWORK | OUT-OF-NETWORK* | IN-NETWORK ONLY |
|---------------------|-------------|------------------|-------------|------------------|----------------
| Fillings, Extractions, Endodontics (root canal), Periodontics, Oral Surgery, Sealants | Plan pays 50% after deductible | Plan pays 50% after deductible | Plan pays 90% after deductible | Plan pays 80% after deductible | Flat copay amounts. See Schedule of Benefits. |

**MAJOR SERVICES**
Crowns, Gold Restorations, Bridges, Dentures, Inlays, Onlays, Prosthesis, Implants

| Benefit Description | IN-NETWORK | OUT-OF-NETWORK* | IN-NETWORK | OUT-OF-NETWORK* | IN-NETWORK ONLY |
|---------------------|-------------|------------------|-------------|------------------|----------------
| Crowns, Gold Restorations, Bridges, Dentures, Inlays, Onlays, Prosthesis, Implants | Plan pays 50% after deductible | Plan pays 50% after deductible | Plan pays 60% after deductible | Plan pays 50% after deductible | Flat copay amounts. See Schedule of Benefits. |

**ORTHODONTIA**
Coverage for all eligible children and adults

| Benefit Description | IN-NETWORK | OUT-OF-NETWORK* | IN-NETWORK | OUT-OF-NETWORK* | IN-NETWORK ONLY |
|---------------------|-------------|------------------|-------------|------------------|----------------
| Orthodontia | Not Covered | Not Covered | Plan pays 50% no deductible | Plan pays 50% no deductible | Flat copay amounts. See Schedule of Benefits. |

**LIFETIME ORTHODONTIA MAXIMUM**
N/A | $1,000 | None

*Note that out of network providers may balance bill and additional out of pocket charges may apply.*

**FIND A DENTAL PROVIDER:**
If you have a MyCigna.com account login to find a provider in either the PPO or DHMO network.

If you currently do not have an account, you can search for dental providers at [www.cigna.com](http://www.cigna.com).

Click on “find a doctor, dentist, facility” in the top right corner of the website.

**DHMO PLAN**

- Procedures listed on the Patient Charge Schedule are subject to the plan limitations and exclusions described in your plan book/certificate of coverage.
- All patient charges must correspond to the Patient Charge Schedule in effect on the date the procedure is initiated.
- See the Patient Charge Schedule located in the enrollment system for a full list of services.