

Your Dental Benefits at a Glance

CIGNA DHMO		CIGNA PPO	
		In-Network	Out-of-Network
General Information	You must select a Primary Care General Dentist from CIGNA's Dental HMO provider list.	You may go to any provider you choose. In-network dentists have agreed to lower rates, so you will generally pay less if you visit an in-network dentist.	
Allowable Charges	The dollar amounts listed on the Patient Charge Schedule are only applicable to treatment performed by your selected Network General Dentist. If you receive care from a Network Specialty Dentist, you are responsible to pay for that care. You are entitled to pay at the Contract Fees negotiated by CIGNA Dental rather than the Network Specialty Dentists' usual fees. Under this plan, referrals and preauthorization for payment by CIGNA Dental are not necessary for care received at a Network Specialty Dentist. CIGNA Dental will not make payments toward this treatment.	If you visit an out-of-network dentist, you are responsible for coinsurance (percentage of charges) PLUS any non-allowable charges. Your total cost may exceed the percentages listed below.	
Deductible	N/A	\$25 Individual \$75 Family	\$50 Individual \$150 Family
Plan Year Maximum	N/A	\$2,000	\$1,500
Lifetime Maximum	N/A	N/A	N/A
Diagnostic	YOU PAY THIS AMOUNT***	THE PLAN PAYS THIS PERCENTAGE	
Visit	\$5	100%, No deductible	80%, No deductible
Exam/X-rays	\$0	100%, No deductible	80%, No deductible
Preventive			
Cleaning	\$0	100%, No deductible	80%, No deductible
Fluoride Application	\$0	100%, No deductible	80%, No deductible
Basic/Restorative			
Routine Fillings	\$16 - \$32	90%, After deductible*	80%, After deductible**
Oral Surgery			
Routine Extractions	\$100	90%, After deductible*	80%, After deductible**
Impactions – Soft Tissue	\$110	90%, After deductible*	80%, After deductible**
Impactions – Complete Bony	\$220	90%, After deductible*	80%, After deductible**
Periodontics			
Perio Prophy – Partial	\$78	90%, After deductible*	80%, After deductible**
Perio Scaling – Complete	\$61 - \$110 per quadrant	90%, After deductible*	80%, After deductible**
Gingival Care/Quadrant	\$120 - \$240 per quadrant	90%, After deductible*	80%, After deductible**
Surgical Treatment of Gums	\$155 - \$295 per quadrant	90%, After deductible*	80%, After deductible**
Osseous Surgery	\$310 - \$595	90%, After deductible*	80%, After deductible**
Missed Appointment	Not covered	Not covered	Not covered
Prosthetics			
Full Upper or Lower Dentures	\$550 each	60%, After deductible*	50%, After deductible**
Partial Upper or Lower Dentures	\$410 - \$640	60%, After deductible*	50%, After deductible**
Adjustments to Dentures	\$33	60%, After deductible*	50%, After deductible**
Inlays	\$410 - \$460	60%, After deductible*	50%, After deductible**

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Porcelain Crown	\$405 - \$505	60%, After deductible*	50%, After deductible**
Bridgework	\$405 - \$460	60%, After deductible*	50%, After deductible**
Denture Repair	\$65 - \$82	60%, After deductible*	50%, After deductible**
Implants	Not covered	60%, No deductible	50%, No deductible****
Endodontics			
Root Canal – One Root	\$315 - \$505	90%, After deductible*	80%, After deductible**
Root Canal – Two Roots	\$315 - \$505	90%, After deductible*	80%, After deductible**
Root Canal – Three Roots	\$315 - \$505	90%, After deductible*	80%, After deductible**
Apicoectomy with Retrograde Fill	\$375 - \$430, first root \$145 each additional root \$100 per root for retrograde filling	90%, After deductible*	80%, After deductible**
Orthodontics			
Orthodontics	\$2,304 for children up to 19 th birthday; paid out in 24 monthly payments of \$96.00. \$3,120 for adults; paid out in 24 monthly payments of \$130.00.	60%, No ortho deductible. Coverage for both eligible adults and children.	60%, No ortho deductible. Coverage for both eligible adults and children.
Lifetime Maximum	N/A	\$2,000	\$1,500
Nitrous Oxide Analgesia			
Nitrous Oxide Analgesia	\$73 - \$160	90%, After deductible*	80%, After deductible**

*The plan pays the percentage shown after you meet the plan deductible.

**The plan pays the percentage shown after you meet the plan deductible. Percentages are based on reasonable and customary charges. You are responsible for the applicable percentage plus any charges the plan considers in excess of "reasonable and customary." As such, the percentage you pay may exceed the amount shown.

*** Please refer to your Dental HMO Patient Charge Schedule for full detailed copayment listing.

**** Percentages are based on reasonable and customary charges. You are responsible for the applicable percentage plus any charges the plan considers in excess of "reasonable and customary." As such, the percentage you pay may exceed the amount shown.