Dental Plan Comparison Chart

The chart below provides an overview of covered dental services in the PPO and DMO plans. For a complete list of benefits, a participant should refer to the plans' Certificate of Coverage.

Dental Benefits				
	Delta Dental PPO (Plus Premier) Low Plan	**Delta Dental PPO (Plus Premier) High Plan**	**Aetna DMO**	**Cigna International Dental**
Group Number:	700273	700273	698685-51	0666A
Member Services Phone:	800-237-6060	800-237-6060	877-238-6200	800-441-2668 or 302-797-3100 (collect)
Plan Website	www.DeltaDentalVA.com	www.DeltaDentalVA.com	www.aetna.com	www.cignaenvoy.com
Availability:	Nationwide. Also available in Puerto Rico, Guam and U.S. Virgin Islands	Nationwide	Nationwide except for Alabama, Alaska, Arkansas, Louisiana, Maine, Mississippi, Montana, New Hampshire, North Dakota, South Carolina, South Dakota Vermont and Wyoming. Service area based on dental plan's zip code eligibility criteria. ****	Available for participants on international assignments of 6 months or more
Choice of Dentist:	Any dentist	Any dentist	Select a dentist from a list of participating dentists in your area. ****	Any Dentist – Online directory available to search for Dentists in 450+ countries
Annual Deductible	$50 per person	$50 per person	No deductible	$25 per person $75 per family
Annual Maximum Benefit	$1,000 per person	$1,500 per person	N/A	$1,500 per person

	Delta Dental PPO (Plus Premier) Low Plan		Delta Dental PPO (Plus Premier) High Plan		Aetna DMO (Plan 58)	Cigna International Dental
Preventive Services* **	**Plan pays:**				**Plan pays 100% After**	
	In-Network*	**Out-of-Network****	**In-Network***	**Out-of-Network****		
Periodic Oral Examination (2 per participant per calendar year)	100% Not subject to deductible	100% Not subject to deductible	100% Not subject to deductible	100% Not subject to deductible	$0 Copay	$0 copay
Prophylaxis / Cleaning, including scaling and polishing (2 per year)	100% Not subject to deductible (2 per participant per calendar year)	100% Not subject to deductible (2 per participant per calendar year)	100% Not subject to deductible (2 per participant per calendar year)	100% Not subject to deductible (2 per participant per calendar year)	$0 copay (Limit 2 per calendar year)	$0 copay (2 per participant per calendar year)
X-rays – Complete Series	100% Not subject to deductible (1 per participant every 5 years)	100% Not subject to deductible (1 per participant every 5 years)	100% Not subject to deductible (1 per participant every 5 years)	100% Not subject to deductible (1 per participant every 5 years)	$0 copay	$0 copay (1 per participant every 3 years)
X-rays – Bitewings **(One Set)**	100% Not subject to deductible (2 per participant per calendar year)	100% Not subject to deductible (2 per participant per calendar year)	100% Not subject to deductible (2 per participant per calendar year)	100% Not subject to deductible (2 per participant per calendar year)	$0 copay	$0 copay (2 per participant per calendar year)
Topical application of fluoride	100% Not subject to deductible (ages 18 and younger; 2 per participant per calendar year)	100% Not subject to deductible (ages 18 and younger; 2 per participant per calendar year)	100% Not subject to deductible (ages 18 and younger; 2 per participant per calendar year)	100% Not subject to deductible (ages 18 and younger; 2 per participant per calendar year)	$0 copay	$0 copay (Up to age 18; 1 per participant per calendar year)

	Delta Dental PPO (Plus Premier) Low Plan		Delta Dental PPO (Plus Premier) High Plan		Aetna DMO (Plan 58)	Cigna International Dental
Diagnostic Services	**Plan pays:**				**Plan pays 100% After**	
	In-Network*	**Out-of-Network****	**In-Network***	**Out-of-Network****		
Diagnostic X-rays	100%	100%	100%	100%	$0 Copay	$0 Copay
Single Film	100%	100%	100%	100%	$0 Copay	$0 Copay
Fissure Sealant (per tooth; once every 3 calendar years)	100% (under age 16)	100% (under age 16)	100% (under age 16)	100% (under age 16)	$5 copay (under age 16)	$0 Copay
Oral Surgery	**Plan pays:**				**You pay:**	
	In-Network*	**Out-of-Network****	**In-Network***	**Out-of-Network****		
Simple Extraction	80%	70%	90%	80%	$0 Copay	Plan pays 80%
Surgical Extraction	80%	70%	90%	80%	$28 Copay	Plan pays 80%
Impactions	80%	70%	90%	80%	$46 soft tissue; $58 partially bony; $100 completely bony	Plan pays 80%
General Anesthesia (only for Surgical Extraction)	80%	70%	90%	80%	General Anesthesia (deep sedation) or Conscious IV Sedation (first 15 min): $104 copay; $83 copay for each additional 15 min	Plan pays 80% when determined to be medically necessary
Fillings	**Plan pays:**				**You pay:**	
	In-Network*	**Out-of-Network****	**In-Network***	**Out-of-Network****		
Amalgam Restoration of Primary Teeth/Permanent Teeth	80%	70%	90%	80%	$0 Copay	Plan pays 80%
Composite Restoration	80%	70%	90%	80%	$0-50 Copay	Plan pays 80%

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Endodontics	**Plan pays:**				**You pay:**	
	In-Network *	**Out-of-Network****	**In-Network ***	**Out-of-Network****		
Root Canal Therapy	80%	70%	90%	80%	Anterior: $70 Copay; Bicuspid: $85 Copay; Molar: $240 Copay	Plan pays 80%
Pulpotomy	80%	70%	90%	80%	$14 Copay	Plan pays 80%
Apicoectomy and Retro Fill	80%	70%	90%	80%	Anterior $85 copay; Bicuspid (1st root) $85 copay; Molar (1st root) $90 Copay; each additional root $55 copay	Plan pays 80%
Periodontics	**Plan pays:**				**You pay:**	
	In-Network *	**Out-of-Network****	**In-Network ***	**Out-of-Network****		
Periodontal Planning and Root Scaling	80%	70%	90%	80%	$55 Copay 4 separate quadrants per calendar year	Plan pays 80%
Gingivectomy (per quadrant)	80%	70%	90%	80%	$100 Copay	Plan pays 80%
Restorative Services	**Plan pays:**				**You pay:**	
	In-Network *	**Out-of-Network****	**In-Network ***	**Out-of-Network****		
Crowns (per unit)	50%	40%	60%	50%	$176 - $220 copay depending on type	Plan pays 50%
Bridges (per unit)	50%	40%	60%	50%	$210 copay per unit	Plan pays 50%
Stainless Steel Crowns	80%	70%	90%	80%	$35-$50 copay	Plan pays 50%
Recementation	**Plan pays:**				**You pay:**	
	In-Network *	**Out-of-Network****	**In-Network ***	**Out-of-Network****		
Inlay	80%	70%	90%	80%	$10 copay	Plan pays 50%
Crown	80%	70%	90%	80%	$10 copay	Plan pays 50%
Bridge	80%	70%	90%	80%	$15 copay	Plan pays 50%

	Delta Dental PPO (Plus Premier) Low Plan		Delta Dental PPO (Plus Premier) High Plan		Aetna DMO (Plan 58)	Cigna International Dental
Prosthetics (Dentures)	**Plan pays:**				**You pay:**	
	In-Network*	**Out-of-Network****	**In-Network***	**Out-of-Network****		
Complete Upper or Lower Denture	50%	40%	60%	50%	$275 Copay	Plan pays 50% (1 per participant every 5 years)
Partial Upper or Lower Denture	50%	40%	60%	50%	$275 - $403 Copay	Plan pays 50%
Denture and Partial Adjustment	80%	70%	90%	80%	$10 Copay	Plan pays 50%
Denture Reline	50%	40%	60%	50%	$45 Copay (Chair Side) $85 Copay (Laboratory)	Plan pays 50%
Denture Duplication	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not covered
Denture and Partial Repairs	80%	70%	90%	80%	$20 - $86 Copay	Plan pays 80%
Adding Teeth or Clasps to Partial Denture (per unit)	80%	70%	90%	80%	$35 - $40 Copay	Plan pays 80%
Orthodontia	**Plan pays:**				**You pay:**	
	In-Network*	**Out-of-Network****	**In-Network***	**Out-of-Network****		
Full-Banded Case	Not covered	Not Covered	50% up to a separate $1,500 lifetime max per participant; includes invisible braces; Not subject to deductible	50% up to a separate $1,500 lifetime max per participant; includes invisible braces; Not subject to deductible	$1,545 Copay, plus $30 orthodontic screening exam; $150 diagnostic records; $275 retention fee. Other fees may apply per Aetna's Dental Care Schedule	Plan pays 50% after separate $50 lifetime deductible; $1,500 lifetime max coverage; includes invisible braces
Partial-Banded Case	Not Covered	Not Covered	50% up to a separate $1,500 lifetime max per participant Not subject to deductible	50% up to a separate $1,500 lifetime max per participant Not subject to deductible	Not covered	Plan pays 50% after separate $50 lifetime deductible; $1,500 lifetime max includes invisible braces

* Covered services received from a network provider will be paid based on the negotiated rate.
** Covered services received from an out-of-network provider will be paid based on Non-Participating Provider Allowance.
*** Preventive services are not subject to the annual deductible.
**** Services provided by a non-participating dental provider may be available in the case of an emergency condition.