COMPARISON OF BENEFITS FOR DENTAL PLANS

Allowable Amounts Apply for All Benefits	BCBSOK – BlueCare Dental High Plan	BCBSOK – BlueCare Dental Low Plan
Annual Deductible	Network: $25 individual/$75 family Basic and Major services combined Non-network: $25 individual/$75 family Preventive, basic and major services combined plus amounts above allowable fees	Network: $50 individual/$150 family Basic and Major services combined Non-network: $50 individual/$150 family Preventive, basic and major services combined plus amounts above allowable fees
Diagnostic and Preventive Care (cleanings, routine oral exams)	Network: 0% Non-Network 0% after charges above the allowable amounts	Network: 0% Non-Network 0% after maximum allowed charge
Basic Care (extractions, oral surgery)	Network: 15% in-network after deductible Non-Network: 30% after deductible and charges above the allowable amounts	Network: 15% in-network after deductible Non-Network: 30% after deductible and maximum allowed charge

This is only a sample of the services covered by each plan. For services not listed in this comparison chart, contact each plan. Refer to the Contact Information at the back of this guide.

Allowable Amounts Apply for All Benefits	Cigna Prepaid High (K1I09)	Cigna Prepaid Low (OKIV9)
Annual Deductible	No deductible $0 office copay applies	No deductible $5 office copay applies
Diagnostic and Preventive Care (cleanings, routine oral exams)	There is a $0 office visit fee (per patient, per office visit in addition to any other applicable patient charge as described in the patient charge schedule K1I09) Example Services/Copays: Sealant per tooth: $12 Copay Routine cleaning (once every 6 months): No charge Topical Fluoride Application (up to age 18): No charge Periodic Oral Evaluations: No charge	There is a $5 office visit fee (per patient, per office visit in addition to any other applicable patient charge as described in the patient charge schedule OKIV9) Example Services/Copays: Sealant per tooth: $17 Copay Routine cleaning (once every 6 months): No charge Topical Fluoride Application (up to age 18): No charge Periodic Oral Evaluations: No charge
Basic Care (extractions, oral surgery)	There is a $0 office visit fee (per patient, per office visit in addition to any other applicable patient charge as described in the patient charge schedule K1I09) Example Services/Copays Amalgam – one surface, permanent teeth: $0 copay	There is a $5 office visit fee (per patient, per office visit in addition to any other applicable patient charge as described in the patient charge schedule OKIV9) Example Services/Copays Amalgam – one surface, permanent teeth: $23 copay

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Allowable Amounts Apply for All Benefits	Delta Dental PPO	Delta Dental PPO – Choice	HealthChoice Dental
Annual Deductible	In-Network and Out-of-Network: $25 per person, per year. Applies to Basic and Major services only	In-Network and Out-of-Network: $100 per person per year. Applies to only Major Restorative (Level 4) services	Network: $25 individual $75 family Basic and major services combined Non-network: $25 individual $75 family Preventive, basic and major services combined Separate network and non-network deductibles A family is 3 or more covered individuals.
Diagnostic and Preventive Care (cleanings, routine oral exams)	In-Network and Out-of-Network: Plan pays 100% of allowable amounts No deductible applies	In-Network and Out-of-Network: Member pays on a service by services basis with co-payments for all tiers of service (Levels 1-5) based on a fee table No deductible applies	Network: You pay $0 Non-network: You pay $0 after deductible plus charges above the allowable amounts
Basic Care (extractions, oral surgery)	In-Network and Out-of-Network: Plan pays 85% of allowable amounts after deductible is met	In-Network and Out-of-Network: Member pays on a service by services basis with co-payments for all tiers of service (Levels 1-5) based on a fee table No deductible applies	Network: You pay 15% after deductible Non-network: You pay 30% after deductible plus charges above the allowable amounts

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Allowable Amounts Apply for All Benefits	MetLife High Classic MAC	MetLife Low Classic MAC	Sun Life Preferred Active PPO
Annual Deductible	Network and Non- Network: $25 individual/$75 family Basic and Major Care combined	Network and Non- Network: $50 individual/$150 family Basic and Major Care combined	$25 per person, waived for Network preventive services
Diagnostic and Preventive Care (cleanings, routine oral exams)	You pay Network: $0 Non-network: Amounts above maximum allowed charge	You pay Network: $0 Non-network: Amounts above maximum allowed charge	Network: Plan pays 100% of allowable amounts Non-network: Plan pays 100% of usual and customary after deductible
Basic Care (extractions, oral surgery)	You pay Network: 15% Non-network: 15% plus amounts above maximum allowed charge Deductible applies	You pay Network: 30% Non-network: 30% plus amounts above maximum allowed charge Deductible applies	Network: Plan pays 85% of allowable amounts after deductible Non-network: Plan pays 70% of usual and customary after deductible

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Allowable Amounts Apply for All Benefits	BCBSOK – BlueCare Dental High Plan	BCBSOK – BlueCare Dental Low Plan
Major Care (dentures, bridge work)	Network: 40% after deductible Non-Network: 50% after deductible and charges above the allowable amounts	Network: 50% after deductible Non-Network: 50% after deductible and maximum allowed charge
Orthodontic Care	Network: 50%. Deductible waived. Non-Network: 50% after charges above the allowable amounts $5,000 Lifetime maximum Dependents covered up to age 19. No waiting period for orthodontic benefits	Member Pays Network: 50%. Deductible waived. Non-Network: 50% after maximum allowed charge $1,500 Lifetime maximum Dependents covered up to age 19. No waiting period for orthodontic benefits
Plan Year Maximum	$2,500	$1,500
Filing Claims	Network: No claims to file Non-Network: You may file claims, provider may file claims .	Network: No claims to file Non-Network: You may file claims, provider may file claims.

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Allowable Amounts Apply for All Benefits	Cigna Prepaid High (K1I09)	Cigna Prepaid Low (OKIV9)
Major Care (dentures, bridge work)	There is a $0 office visit fee (per patient, per office visit in addition to any other applicable patient charge as described in the patient charge schedule K1I09) Example Services/Copays Root Canal, Anterior: $210 copay Periodontal Scaling/Root planing 1-3 teeth (per quadrant): $42 copay	There is a $5 office visit fee (per patient, per office visit in addition to any other applicable patient charge as described in the patient charge schedule OKIV9) Example Services/Copays Root Canal, Anterior: $375 copay Periodontal Scaling/Root planing 1-3 teeth (per quadrant): $75 copay
Orthodontic Care	There is a $0 office visit fee (per patient, per office visit in addition to any other applicable patient charge as described in the patient charge schedule K1I09) $2,040 out-of-pocket child; $2,376 out-of-pocket adult (24 month treatment) Excludes orthodontic treatment plan and banding No waiting period for orthodontic benefits	There is a $5 office visit fee (per patient, per office visit in addition to any other applicable patient charge as described in the patient charge schedule OKIV9) $2,472 out-of-pocket child; $3,384 out-of-pocket adult (24 month treatment) Excludes orthodontic treatment plan and banding No waiting period for orthodontic benefits
Plan Year Maximum	Plan year maximum is unlimited No plan year dollar maximum	Plan year maximum is unlimited No plan year dollar maximum
Filing Claims	If services are rendered by a participating dentist, the Prepaid dentist is contractually obligated to file the claim on the patient's behalf If a claim must be filed by the member, the member can obtain a claim form by logging into **www.mycigna.com** Customer Service can also assist in filing a claim by dialing 800-244-6224 24 hours a day/7 days a week	If services are rendered by a participating dentist, the Prepaid dentist is contractually obligated to file the claim on the patient's behalf If a claim must be filed by the member, the member can obtain a claim form by logging into **www.mycigna.com** Customer Service can also assist in filing a claim by dialing 800-244-6224 24 hours a day/7 days a week

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Allowable Amounts Apply for All Benefits	Delta Dental PPO	Delta Dental PPO – Choice	HealthChoice Dental
Major Care (dentures, bridge work)	In-Network and Out-of-Network: Plan pays 60% of allowable amounts after deductible is met	In-Network and Out-of-Network: Member pays on a service by services basis with co-payments for all tiers of service (Levels 1-5) based on a fee table Deductible applies to Major Restorative (Level 4) services	Network: You pay 40% after deductible Non-network: You pay 50% after deductible plus charges above the allowable amounts
Orthodontic Care	In-Network and Out-of-Network: Plan pays 60% of allowable amounts, up to the $2,000 lifetime maximum per person Orthodontic benefits are available to eligible employees, spouses and dependent children No waiting period for orthodontic benefits	In-Network and Out-of-Network: Plan pays up to the $1,800 lifetime maximum per person Orthodontic (Level 5) service co-payments are based on a fee table Orthodontic benefits are available to eligible employees, spouses and dependent children No waiting period for orthodontic benefits	Network: You pay 50% of allowable amounts; no deductible applies Non-network: You pay 50% of the allowable amounts, plus charges above the allowable amounts; no deductible applies Covered for members age 18 and under Covered for treatment of TMD at any age No lifetime maximum 12-month waiting period for orthodontic benefits (some exceptions apply)
Plan Year Maximum	In-Network and Out-of-Network: $2,500 per person per year for Diagnostic, Preventive, Basic and Major services	In-Network and Out-of-Network: $2,000 per person per year for Levels 1, 2, 3 and 4 services	Network and non- network: $2,500 per person You are responsible for all charges billed by provider after plan year maximum is met
Filing Claims	Claims are filed by participating dentists Members must file claims for reimbursement for non-participating providers	Claims are filed by participating dentists Members must file claims for reimbursement for non-participating providers	Network: No claims to file Non-network: You file claims

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Allowable Amounts Apply for All Benefits	MetLife High Classic MAC	MetLife Low Classic MAC	Sun Life Preferred Active PPO
Major Care (dentures, bridge work)	You pay Network: 40% Non-network: 40% plus amounts above maximum allowed charge Deductible applies	You pay Network: 50% Non-network: 50% plus amounts above maximum allowed charge Deductible applies	Network: Plan pays 60% of allowable amounts after deductible Non-network: Plan pays 50% of usual and customary after deductible
Orthodontic Care	You pay Network: 40% Non-network: 40% plus amounts above maximum allowed charge $2,000 lifetime maximum per person No waiting period for orthodontic benefits	You pay Network: 50% Non-network: 50% plus amounts above maximum allowed charge $2,000 lifetime maximum per person No waiting period for orthodontic benefits	Network: Plan pays 60% Non-network: Plan pays 50% up to lifetime maximum of $2,000 for dependents under age 19 12-month waiting period applies
Plan Year Maximum	Network and non- network: $5,000 per person	Network and non-network: $1,500 per person	$2,000 per person
Filing Claims	Claims are filed by network and non- network dentists	Claims are filed by network and non-network dentists	Member/provider must file claims

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