2024 Dental Plans	Prepaid Dental Plans (DHMO)			Preferred Provider Organization (PPO) Plans		Indemnity with PPO Plans		Indemnity Plans
	Cigna Prepaid Dental (4034)	**Sun Life Prepaid Dental (4025)**	**Humana HD 205 Prepaid Dental (4044)**	**Ameritas, Humana, Metlife Preventive PPO (4023, 4094, 4033)**	**Ameritas, Humana, Metlife Standard PPO (4022, 4092, 4032)**	**Ameritas, Humana, Metlife Indemnity w/PPO (4021, 4090, 4031)**	**Sun Life Indemnity w/ PPO (4074)**	**Humana Indemnity (4084)**
Type I: Preventative Services (Routine cleanings, X-rays, etc.)	See benefit schedule: Fixed copayments	See benefit schedule: Fixed copayments	See benefit schedule: Fixed copayments	100% in-network: 80% out of network	100% in-network: 80% out of network	100% in or out of network	100% in or out of network	See benefit schedule: Reimbursement amounts
Type II: Basic Services (Fillings, root canals,etc.)	See benefit schedule: Fixed copayments	See benefit schedule: Fixed copayments	See benefit schedule: Fixed copayments	80% in-network 50% out of network	80% in-network 50% out of network	80% in or out of network	80% in or out of network	See benefit schedule: Reimbursement amounts
Type III: Major Services (Crown, bridges, etc.)	See benefit schedule: Fixed copayments	See benefit schedule: Fixed copayments	See benefit schedule: Fixed copayments	No coverage	50% in-network: 30% out of network	50% in or out of network	50% in or out of network	See benefit schedule: Reimbursement amounts
Annual Deductible	No Deductible	No Deductible	No Deductible	**Type I**: No deductible **Type II only:** Individual: $50 EE+Spouse: $100 EE + Children: $100 Family: $150	**Type I:** No deductible **Type II & III:** Individual: $50 EE + Spouse: $100 EE + Children: $100 Family: $150	**Type I:** No deductible **Type II & III:** Individual: $50 EE + Spouse: $100 EE + Children $100 Family: $150	**Type I:** No deductible **Type II & III:** Individual: $50 Family: $100	No Deductible
Annual Maximum	None	None	None	$1,000	$1,500	$2,000	$2,000 in-network: $1,500 out of network	$1,000
Orthodontia	Yes, No age limit	Yes, No age limit	No age limit: Eligible for 25% discount at provider's discretion	No coverage	Yes, No age limit	Yes, No age limit	Yes, Only dependants under 19	No Coverage
Waiting period for Orthodontic Services	None	None	None	No Coverage	12 month waiting period (may be satisfied w/ prior creditable coverage)	None	None	No Coverage
Othordontia Maximum	None	None	None	No Coverage	$2,000 in-network; $1,500 out of network	$2,500 in or out of network	$1,500	No Coverage