LACERA

Effective July 1, 2024

DENTAL PLAN

	Cigna Indemnity Dental	Cigna Dental HMO
Individual annual deductible	$25	None
Family annual deductible	$50	None
Individual annual maximum benefit	$1,500	Unlimited
Exams & Cleanings:		
Two exams and cleanings per year, not subject to the plan deductible	20%	$0**
Additional two cleanings are subject to the plan deductible/co-pay	20%*	$45**
Amalgam – 1 surface, permanent	20%*	$0**
Amalgam – 2 surface, permanent	20%*	$0**
Amalgam – 3 surface, permanent	20%*	$0**
Amalgam – 4 surface, permanent	20%*	$0**
Resin or composite – anterior	20%*	$0**
Anterior root canal – permanent	20%*	$10**
Scaling/root planing – per quad	20%*	$35**
Simple extraction	20%*	$10**
Surgical extraction	20%*	$15 – $50**
Crown – porcelain to high noble metal	20%*	$220**
Crown – stainless steel	20%*	$10**
Post – prefab or crown buildup	20%*	$40/$55/$65**
Orthodontic therapy – child	Not covered	$2,240**
Orthodontic therapy – adult	Not covered	$2,840**

* Cigna network dentists are reimbursed according to a Fee Schedule or Discount Schedule. For non-network dentist, plan will reimburse according to the Maximum Reimbursable Charge for the procedure, in the geographic area. The dentist may balance bill up to their usual fees. Procedure with high noble metal are covered at 50%. Services are subject to the plan deductible and plan maximum.

** Member pays this amount, plus additional charges specified in the plan brochure. For post/crown buildup work, the copay amounts apply to different steps in the procedure.

VISION PLAN

Benefit	In-Network Benefits	Out-of-Network Benefits
Spectacle exam*** (Once every 12 months)	$20 copay; then covered in full. For contact lens fitting and professional services, member pays additional charges	$25 reimbursement maximum
Lenses (Once every 12 months)		
■ Single vision	$40 copay; then covered in full	$35 reimbursement maximum
■ Bifocal	$40 copay; then covered in full	$45 reimbursement maximum
■ Trifocal	$40 copay; then covered in full	$70 reimbursement maximum
■ Lenticular	$40 copay; then covered in full	$130 reimbursement maximum
■ Progressive	$40 copay; then up to $70 allowance	$70 reimbursement maximum
Frames (Once every 24 months)	$50 allowance	$35 reimbursement maximum
Contact lenses (one pair or single purchase up to allowed amount with one lifetime maximum)		
■ Hard lenses	$180 allowance	$150 reimbursement maximum
■ Soft lenses	$230 allowance	$225 reimbursement maximum

*** Spectacle exam includes routine exam, including dilation and refraction.

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