Dental Plans Rate Chart

Your dental plan may limit the number of visits and/or services (frequency)

		Prepaid Dental Plans (In-Network Only)					Dental PPO Plan		Indemnity with Dental PPO Plans		Indemnity Plan
		Humana Network Plus (formerly CompBenefits)	UnitedHealthcare Solstice $700	Assurant Employee Benefits Prepaid Dental 225 Plan (formerly Heritage Plus)	CIGNA Dental	Humana Select 15 (formerly CompBenefits)	Humana Preferred Plus (formerly CompBenefits)		Ameritas Dental	Assurant Employee Benefits Freedom Advance	Humana Schedule B (formerly CompBenefits)
	People First Plan Code	4004	4014	4025	4034	4044	4054		4064	4074	4084
	MONTHLY PREMIUM										
	Employee Only	$23.58	$10.91	$14.93	$27.38	$12.64	$31.76		$10.20	$41.48	$14.74
	Employee + Spouse	$46.48	$23.95	$25.17	$49.22	$21.20	$58.76		$20.76	$79.63	$21.96
	Employee + Child or Children	$55.42	$29.90	$33.26	$57.92	$23.00	$65.66		$27.00	$93.84	$23.30
	Employee + Family	$70.80	$41.98	$43.54	$70.26	$32.98	$95.32		$37.56	$124.14	$37.10
	Calendar Year Deductible	$0	$0	$0	$0	$0	In Network Employee: $25 Family: $50 Waved on Type 1	Out-of-Network Employee: $50 Family: $100	$50 Calendar Year Waived on Type 1	$50/Person per Calendar Year; Waived on Type I and IV	Employee: $50 Family: $150 Waved on Type 1
	Calendar Year Maximum	$0	$0	$0	$0	$0	$1,200/person		$1,000/person	$1,250/person	$1000/person
							In Network	**Out-of-Network**			
ADA Code	**EXAMS**	**You Pay**	**You Pay**	**You Pay**	**You Pay**	**You Pay**	**You Pay**	**You Pay**	**You Pay**	**You Pay**	**You Pa**
D0120	Periodic Checkup	$0[1]	$0	$0	$0	$0	$0[1]	20%[1]	Cost above $14	$0[1]	Cost Above $11.70[1]
D0140	Limited	$0[1]	$0	$0	$0	$0	$0[1]	20%[1]	Cost above $15	$0	Cost Above $15.30[1]
D0150	Comprehensive Initial	$0[1]	$0	$0[1]	$0	$0	$0	20%	Cost above $22	$0	Cost Above $15.30[1]
	X-RAYS										
D0230	Additional Intraoral	$0	$2	$0	$0	$0	$0	20%	Cost above $6	20%	Cost Above $6.30
D0272	2 Bite Wings	$0[1]	0	$0	$0	$0	$0	20%	Cost above $13	$0	Cost Above $12.60
D0330	Panoramic	$0	$50	$0	$0	$0	$0	20%	Cost above $36	20%	Cost Above $23.40
	PREVENTIVE SERVICES										
D1110	Prophy (adult cleaning)	$0[1]	$0[1]	$0[1]	$0	$0[1]	$0[1]	20%[1]	Cost above $30	$0[1]	Cost Above $18.90[1]
D1120	Prophy (child cleaning)	$0[1]	$0[1,2]	$0[1]	$0	$0[1]	$0[1]	20%[1]	Cost above $21	$0[1]	Cost Above $18.00
D1203	Fluoride, child	$0	$0[2]	$0	$0	$0[2]	$0[2]	20%[2]	Cost above $11	$0[3]	Cost Above $15.30[2]
D1351	Sealant	$0[3]	$0[2]	$0	$11	$7	$0[2]	20%[2]	Cost above $17	$0[2]	Cost Above $6.30[4]
	SILVER FILLINGS										
D2140	Amalgam, 1 surface	$6	$0	$10	$0	$0	20%	50%	Cost above $25	20%	Cost Above $11.70
D2150	Amalgam, 2 surfaces	$8	$0	$15	$0	$0	20%	50%	Cost above $32	20%	Cost Above $18.00
	WHITE FILLINGS, FRONT TEETH										
D2330	Anterior Composite, 1 surface	$8	$30	$25	$0	$30	20%	50%	Cost above $30	20%	Cost Above $15.30
D2331	Anterior Composite, 2 surfaces	$10	$37	$35	$0	$37	20%	50%	Cost above $38	20%	Cost Above $22.50
	WHITE FILLINGS, BACK TEETH										
D2391	Posterior Composite, 1 surface	$6	$65	$60	$45	75%	20%	50%	Cost above $33	20%	Cost Above $11.70
D2392	Posterior Composite, 2 surfaces	$8	$75	$70	$57	75%	20%	50%	Cost above $42	20%	Cost Above $18.80
	ONLAYS AND CROWNS										
D2740	Crown, All Porcelain	$280	$245[5]	$225[5]	$490 (all inclusive)	75%	50%	70%	Cost above $161	75% or 50%[7]	Cost Above $95.40
D2750	Crown, Porcelain fused to High Noble	$300 (includes metal)	$245[5]	$225[5]	$450 (all inclusive)	$240 (plus metal)	50%	70%	Cost above $156	75% or 50%[7]	Cost Above $180.00
D2950	Core Build Up	$59	$70	$75	$130	$40	50%	70%	Cost above $32	75% or 50%[7]	Cost Above $36.00
	PERIODONTAL CARE (for gums)										
D4341	Periodontal Therapy, 4+ teeth/quadrant	$14[9]	$50	$75[9]	$83	$45	20%	50%	Cost above $52	75% or 50%[7]	Cost Above $14.40[1]
D4910	Periodontal Maintenance	$9[1]	$50	$45	$50	$45	20%	50%	Cost above $32	75% or 50%[7]	Cost Above $19.80[1]
	EXTRACTIONS										
D7140	Extraction, Erupted Tooth or Exposed Root	$8	$20	$18	$12	$0	20%	50%	Cost above $28	20%	Cost Above $14.40
D7210	Extraction, Surgical	$14[9]	$30	$65[9]	$50	$25	20%	50%	Cost above $54	75% or 50%[7]	Cost Above $26.10
	ORTHODONTIA CARE[6]										
D8080	Comprehensive orthodontic treatment of adolescent dentition (full treatment case up to 24 months - including fixed/removable appliances)	$1,580	$2,250	$2,000	$2,045	75%	50%; $1,500 lifetime max benefit	Not Covered	Not Covered	50% (lifetime maximum reimbursement $1,000 per child)	Not Covered
D8090	Comprehensive orthodontic treatment of adult dentition (full treatment case up to 24 months - including fixed/removable appliances)	$1,580	$2,350	$2,200	$2,385	75%	50%; $1,500 lifetime max benefit	Not Covered	Not Covered	Not Covered	Not Covered
None	Bracketing (for above procedures D8080 or D8090)	Included	Included	$300	$515	Included	Included	Not Covered	Not Covered	Subject to limits in Code D8080	Not Covered
D8660	Pre-orthodontic treatment visit (consult/records/exam)	$80	$35	$100	$67	75%	50%; $1,500 lifetime max benefit	Not Covered	Not Covered	Subject to limits in Code D8080	Not Covered
D8680	Orthodontic retention (removal of applicances, construction and placement of retainer(s))	$250	$300	$250	$345	75%	50%; $1,500 lifetime max benefit	Not Covered	Not Covered	Subject to limits in Code D8080	Not Covered
D8999	Unspecified Orthodontic Procedure - By Report (Orthodontic Treatment Plan and Records)	Included	$250	Included under D8660	$195	Included	Included	Not Covered	Not Covered	Subject to limits in Code D8080	Not Covered

Use this rate chart to compare dental plan costs. The rows show the monthly premium and the amount or percentage you pay for the common dental services listed. The columns list the costs by plan. "Cost above" means you pay any dollar amount that is higher than the amount shown. Use the online cost estimator to compare your likely total costs under each plan at www.myflorida.com/mybenefits

All fees listed here are approximate and are based on the services of a general dentist. **Please review the dental plan documents available to you which include all plan benefits, features, exclusions, limitations, and restrictions.** Where plan documents differ from the information on this chart, the plan documents control all benefit determinations.

[1] Limited to once every six months

[2] Only for children under age 16

[3] Only for children under age 14

[4] Only for children under age 13

[5] Services require separate payment of laboratory charges

[6] Copays do not include pre-exam and retention

[7] 75% during first year; 50% for 2nd and subsequent years of continuous coverage

[8] Plan payments for covered preventive procedures are not deducted from your annual maximum benefit.

[9] Copayment for General Dentist or Specialist is the same