Compare Plans

Comparing 2 dental plan(s) for **1 person(s)** living in FL, **33990** starting **12/01/2017**.

Selected Plans You have selected the following plans to compare	Delta Dental PPO Individual - Basic Plan Monthly Premium **$21.57** Enroll	DeltaCare® USA FLA70 Individual/Family Dental Program Annual Premium **$107.04** Enroll
Summary		
Deductible per calendar year per person	$50.00	$0
Maximum per calendar year per person	$1,000.00	$0
	You Pay	This is only a summary of benefits subject to the limitations and exclusions of the plan. Actual copayment amounts vary by specific procedure(s). You Pay
Office visit	0%	$10
Exams	0%	$0
X-rays	0%	$0
Cleanings	0%	$20
Fillings	50%	$25-$120
Root canals	100%	$240-$400
Gum treatment	100%	$64-$650
Extractions	100%	$30-$230
Denture repair	100%	$40-$75
Crowns	100%	$125-$495
Orthodontics	NA	75%
Deductibles		
Deductible per calendar year per person	$50	$0
Deductible per calendar year per family	$150.00	$0
Temporomandibular Joint Dysfunction (TMJ) per person	NA	Not a covered benefit
Accident injury per person	NA	Subject to procedures, copayments, limitations and exclusions as defined in the Disclosure Form/Contract.
Maximums		
Maximum per calendar year per person (excludes orthodontic maximum)	$1,000	$0
Maximum per calendar year per family (excludes orthodontic maximum)	NA	$0
Orthodontic benefits per lifetime per person	NA	$0
Orthodontic benefits per lifetime per family	NA	$0
Temporomandibular Joint Dysfunction (TMJ) per lifetime per person	NA	Not a covered benefit
Diagnostic (exams, x-rays)		
	You Pay	This is only a summary of benefits subject to the limitations and exclusions of the plan. Actual copayment amounts vary by specific procedure(s). You Pay
Exam - periodic	0%	$0
Exam - comprehensive	0%	$0
X-ray - full mouth	0%	$0
X-ray - intraoral (first image)	0%	$0
X-ray - intraoral (each additional image)	0%	$0
X-ray - bitewing (two images)	0%	$0
X-ray - bitewing (four images)	0%	$0
Waiting period	NA	$0
Preventive (cleanings)		
	You Pay	This is only a summary of benefits subject to the limitations and exclusions of the plan. Actual copayment amounts vary by specific procedure(s). You Pay
Teeth cleaning - adult	0%	$20
Teeth cleaning - child	0%	$20
Fluoride	0%	$20
Sealant	0%	$22
Waiting period	NA	None
Basic Services (fillings)		
	You Pay	This is only a summary of benefits subject to the limitations and exclusions of the plan. Actual copayment amounts vary by specific procedure(s). You Pay
Filling - silver-colored (one surface)	50%	$25
Filling - silver-colored (two surfaces)	50%	$40
Filling - tooth-colored/composite (one surface, front)	50%	$65
Filling - tooth-colored/composite (one surface, back)	50%	$70
Filling - tooth-colored/composite (two surfaces, back)	50%	$80
Waiting period	6 Months	None
Endodontics (root canal)		
	You Pay	This is only a summary of benefits subject to the limitations and exclusions of the plan. Actual copayment amounts vary by specific procedure(s). You Pay
Root canal (front)	100%	$240
Root canal (molar)	100%	$400
Waiting period	NA	None
Periodontics (gum treatment)		
	You Pay	This is only a summary of benefits subject to the limitations and exclusions of the plan. Actual copayment amounts vary by specific You Pay
Gum disease treatment	100%	$150-$260
Gum cleanings	100%	$65
Waiting period	NA	None
Oral Surgery (extractions)		
	You Pay	This is only a summary of benefits subject to the limitations and exclusions of the plan. Actual copayment amounts vary by specific procedure(s). You Pay
Simple tooth extraction	50%	$40
Surgical removal of erupted tooth	100%	$70
Waiting period	6 Months	None
Major Services (dentures, crowns)		
	You Pay	This is only a summary of benefits subject to the limitations and exclusions of the plan. Actual copayment amounts vary by specific procedure(s). You Pay
Full denture	100%	$495
Denture repair	100%	$40-$55
Crown	100%	$125-$495
Implants	100%	Not a covered benefit
Waiting period	NA	None
Orthodontics (braces)		
	You Pay	This is only a summary of benefits subject to the limitations and exclusions of the plan. Actual copayment amounts vary by specific procedure(s). You Pay
Orthodontics - child	NA	75%
Orthodontics - adult	NA	75%
Waiting period	NA	None
General Services		
	You Pay	This is only a summary of benefits subject to the limitations and exclusions of the plan. Actual copayment amounts vary by specific procedure(s). You Pay
Teeth whitening	Not a covered benefit	$125
Waiting period	NA	None