

THIS SUMMARY COVERS DENTAL OPTIONS DISCUSSED ON PAGE 6. Please note important exclusions and limitations on pages 11-12. You may want to detach these pages at the perforated lines and make copies for your employees if you have added dental coverage to your Benefits. This summary is printed in English on one side and Spanish on the other; Chinese and Korean versions are available at [www.bluecrossca.com](http://www.bluecrossca.com) - ask your agent or call Customer Service for assistance (800) 627-8797.



Blue Cross of California (BCC) is a health care service plan regulated by the Department of Managed Health Care

# Dental Plan Options



BC Life & Health (BCL&H) is an insurance company regulated by the Department of Insurance

Note:  
The Dental Benefits Plan is included with Hospital Benefits Preferred Plan.

	Dental Benefits Plan		Dental Net Plan*	
	PPO coverage offered by BCL&H		HMO coverage offered by BCC	
	PLAN pays amounts shown		MEMBER pays amounts shown	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Maximum paid by Plan	\$500		Unlimited	
Annual Deductible <i>Member must pay this amount first, before plan benefits begin</i>	\$25 Deductible waived for In-Network Preventive & Diagnostic procedures		None	
<b>Preventive &amp; Diagnostic Services</b>				
Teeth Cleaning - Adult	100%	\$39	No Charge	Not Covered
Teeth Cleaning - Child		\$30		
Child Fluoride with Cleaning		\$35		
<b>Oral Exams</b>				
Periodic Oral Exam	100%	\$18	No Charge	Not Covered
Comprehensive Oral Exam		\$25		
<b>X-rays</b>				
Intraoral - complete series	100%	\$60	No Charge	Not Covered
Bitewing - single film		\$16		
<b>Minor Services</b>				
Fillings - Amalgam (two surfaces)	80%	\$55	\$16	Not Covered
Fillings - Resin (two surfaces)				
<b>Oral Surgery</b>				
Extraction - Impacted tooth, complete bony	Not Covered		\$85	Not Covered
<b>Endodontic Services</b>				
Root canal therapy - molar	Not Covered		\$120	Not Covered
<b>Periodontic Services</b>				
Scaling (root planing)	Not Covered		\$34	Not Covered
<b>Removable Prosthodontics</b>				
Dentures - Complete (maxillary)	Not Covered		\$280	Not Covered
<b>Fixed Prosthodontics</b>				
Crowns - porcelain (high noble)	Not Covered		\$190	Not Covered
<b>Orthodontics</b>				
Adult (age 18 and over)	Not Covered		\$1,850	Not Covered
Child (through age 17)			\$1,450	

\*These copays apply only when services are rendered by a participating dentist. Specialty services provided by a specialty dentist are included on a separate schedule in your Evidence of Coverage and Disclosure Form/Certificate.

**This is an overview only; refer to the Evidence of Coverage and Disclosure Form/Certificate for a comprehensive description of coverage, frequency and benefit limitations.**