



# Covered California Family Dental Plans

## ADULT DENTAL BENEFIT COMPARISON

COVERED SERVICES	Carrier A	Carrier B	Carrier C
① in a <b>six month</b> period	oral exam	oral exam	oral exam
① in a <b>twelve month</b> period	denture reline	denture reline	denture reline
② in a <b>twelve month</b> period	routine prophylaxis	routine prophylaxis	routine prophylaxis
① in a <b>twenty-four month</b> period	full mouth debridement	full mouth debridement	full mouth debridement
① in a <b>thirty-six month</b> period	osseous surgery per quad	osseous surgery per quad	osseous surgery per quad
① in a <b>five year</b> period	complete dentures	crowns	complete dentures
EXCLUDED SERVICES	implants orthodontics posterior composites	implants orthodontics bone grafting	implants orthodontics

Please see the plan's Schedule of Benefits and Evidence of Coverage documents for complete information on limitations and excluded services.

**DRAFT FOR DISCUSSION**