Comparison of NC Flex Dental PPO and BCBS Dental Plans				
NC Flex			BCBS	
Benefit Category	**Hi Option**	**Low Option**	**Benefit Category**	**One Option**
Type I — Diagnostic and Preventive			**Diagnostic and Preventive**	
Oral Examinations (2 per calendar year)			Routine Oral Exams	
Cleanings (2 per calendar year)	100% - All Type I services are excluded from annual max	100%	Cleanings	100%
X -rays (bitewing x-rays — 1 per calendar year; full-mouth radiograph series or panoramic series - 1 every 5 years			X-rays	
Topical Fluoride (2 per calendar year under age 19)			Flouride Application	
Sealants for Permanent First and Second Molars (under age 16)			Sealants	
Space Maintainers (under age 19)				
Type II — Basic Services (Supporting documentation required for Periodontal Services*)			**Basic Care**	
Fillings (amalgam, synthetic or composite; replacements limited to once every 24 months			Routine fillings	
Simple Extractions			Simple extractions	
Endodontics (root canal treatment)	80%	50%	Endodontics	80%
Oral Surgery (wisdom teeth extractions)			Oral surgery	
Re-cement Crowns, Inlays, Bridges			Space maintainers	
Repair of Removable Dentures				
Periodontal Services* (gingivectomy, gingivoplasty, osseous surgery, scaling and root planing)	50%			
Periodontal Maintenance after Therapy* (2 per consecutive 12 months)				
Type III—Major Services			**Major Care**	
Crowns, including Single Implant Crowns* (Not eligible for dependent children under age 14; replacements limited to every 7 years. Single Prosthetic procedures are considered completed on the date they are inserted, not the date of impression)			Crowns	
General Anesthesia				50%
Dentures* (replacements limited to every 7 years	50%	Not covered	Periodontics	
Bridges* (replacements limited to every 7 years			Inlays & onlays	
Fixed Bridge Repairs*			Dentures	
Denture Adjustments/Relining* (within 6 months of initial denture placement)			Fixed bridges	
Implants*				
Type IV — Orthodontics (High Option PPO Plan only-Dependent children up to age 19)			**Orthodontics**	50%
Orthodontic treatment in progress	50%	Not covered		
Maximums/Deductibles			**Maximums/Deductibles**	

Calendar-Year Maximum(per covered person; excludes Orthodontics services under the High Option PPO Plan)	$5,000	$1,000	Calendar-Year Maximum(excludes Orthodontics)	$1,000
Lifetime Orthodontic Maximum (per covered person) (The Lifetime maximum will include any reimbursement received from the prior carrier)	$1,500	N/A	Lifetime Orthodontic Maximum (per covered person)	$1,500
Calendar-Year Deductible (per person/per family)	$50/$150 Type II and Type III	$25/$75 Types I and II		$25/$75
Monthly Premiums - Pre-Tax			**Monthly Premiums - Post-Tax**	
Employee	$35.90	$21.22	Employee	$35.40
Employee & Spouse	$72.00	$42.78	Employee & Spouse	$70.62
Employee & Child(ren)	$78.00	$45.94	Employee Child(ren)	$75.30
Family	$123.00	$73.22	Family	$121.90