BlueCross BlueShield of Oklahoma

Dental PPO

1/1/2027

This information only provides a summary of the benefits for this Dental Plan. Please refer to your Dental Benefit Booklet for additional benefit information. The Deductibles, Coinsurance and Benefit Period Maximum shown below are subject to change as permitted by applicable law.

Summary of Dental Benefits

Program Basics	In Network	Out of Network*
Benefit Period Maximum	$1,500	$1,000
Deductible	$50 Individual/$150 Family	$75 Individual/$225 Family

Covered Services

Diagnostic Evaluations Periodic oral evaluations Problem focused oral evaluations Comprehensive oral evaluations	100% (Deductible does not apply)	80% (Deductible does not apply)
Preventive Services Prophylaxis (cleanings) Topical fluoride applications	100% (Deductible does not apply)	80% (Deductible does not apply)
Diagnostic Radiographs Full-mouth and panoramic films Bitewing films Periapical films	100% (Deductible does not apply)	80% (Deductible does not apply)
Miscellaneous Preventive Services Sealants Space maintainers	100% (Deductible does not apply)	80% (Deductible does not apply)
Basic Restorative Dental Services Amalgams Resin-based composite restorations	80%	60%
Non-Surgical Extractions Removal of retained coronal remnants Removal of erupted tooth or exposed root	80%	60%
Non-Surgical Periodontal Services Periodontal scaling and root planing Full-mouth debridement Periodontal maintenance procedures	80%	60%
Adjunctive Services Palliative treatment (emergency) Deep sedation / general anesthesia	80%	60%
Endodontic Services Therapeutic pulpotomy and pulpal debridement Root canal therapy Apexification/recalcification	80%	60%

	In Network	Out of Network*
Covered Services (continued)		
Oral Surgery Services Surgical tooth extractions Alveoloplasty and vestibuloplasty Excision of benign odontogenic tumor/cyst Excision of bone tissue Incision and drainage of an intraoral abscess	80%	60%
Surgical Periodontal Services Gingivectomy or gingivoplasty and gingival flap procedures Clinical crown lengthening Osseous surgery Osseous grafts Soft tissue grafts/allografts Distal or proximal wedge procedure Anatomical crown exposures	80%	60%
Major Restorative Services Single crown restorations Gold foil and inlay/onlay restorations Labial veneer restorations Crowns placed over implants	50%	50%
Prosthodontic Services Complete and removable partial dentures Denture reline/rebase procedures Fixed bridgework Prosthetics placed over implants Implants	50%	50%
Miscellaneous Restorative and Prosthodontic Services Prefabricated crowns Recementations Post and core, pin retention and crown/bridge repairs Adjustments	50%	50%
Orthodontic Services		
Orthodontic Services Orthodontic Diagnostic Procedures and Treatment Lifetime Maximum per Participant Adult coverage and dependent children to age 19	50% $1,500 (Deductible does not apply)	

The above is a listing of common services available through your network of Participating Dentists.
The Member's share of the cost is determined by whether care is received from a Participating or Non-Participating Dentist.

***Services from non-participating providers will be subject to reasonable and customary allowances, as determined by the Company. Amounts in excess of these allowances will be the full responsibility of the insured.**

This plan includes BlueCare Dental Enhanced Benefit℠. The Enhanced Benefit provides additional dental benefits, such as an extra cleaning and 100% coverage for periodontal cleanings to members with specific health issues at no additional cost. Please refer to your Dental Benefit Booklet for additional benefit information.

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