



# BlueCare Dental PPO<sup>SM</sup> Voluntary

Plan ID: DONHR53

*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                                                                                                                                   | Contracting Dentist                 | Non-Contracting Dentist*            |
|--------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|-------------------------------------|
| <b>Benefit Period Maximum</b>                                                                                                                    | \$1,500                             |                                     |
| <b>Deductible</b>                                                                                                                                | \$50 Individual/\$150 Family        | \$50 Individual/\$150 Family        |
| <b>Covered Services</b>                                                                                                                          |                                     |                                     |
| <b>Diagnostic Evaluations</b><br>Periodic oral evaluations<br>Problem focused oral evaluations<br>Comprehensive oral evaluations                 | 100%<br>(Deductible does not apply) | 100%<br>(Deductible does not apply) |
| <b>Preventive Services</b><br>Prophylaxis (cleanings)<br>Topical fluoride applications                                                           | 100%<br>(Deductible does not apply) | 100%<br>(Deductible does not apply) |
| <b>Diagnostic Radiographs</b><br>Full-mouth and panoramic films<br>Bitewing films<br>Periapical films                                            | 100%<br>(Deductible does not apply) | 100%<br>(Deductible does not apply) |
| <b>Miscellaneous Preventive Services</b><br>Sealants<br>Space maintainers                                                                        | 100%<br>(Deductible does not apply) | 100%<br>(Deductible does not apply) |
| <b>Basic Restorative Services</b><br>Amalgams<br>Resin-based composite restorations                                                              | 80%                                 | 80%                                 |
| <b>Non-Surgical Extractions</b><br>Removal of retained coronal remnants<br>Removal of erupted tooth or exposed root                              | 80%                                 | 80%                                 |
| <b>Non-Surgical Periodontal Services</b><br>Periodontal scaling and root planing<br>Full-mouth debridement<br>Periodontal maintenance procedures | 80%                                 | 80%                                 |
| <b>Adjunctive Services</b><br>Palliative treatment (emergency)<br>Deep sedation / general anesthesia                                             | 80%                                 | 80%                                 |
| <b>Endodontic Services</b><br>Therapeutic pulpotomy and pulpal debridement<br>Root canal therapy<br>Apexification/recalcification                | 80%                                 | 80%                                 |

## Covered Services (continued)

|                                                                                                                                                                                                                                              |             |     |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|-----|
| <b>Oral Surgery Services</b><br>Surgical tooth extractions<br>Alveoloplasty and vestibuloplasty<br>Excision of benign odontogenic tumor/cyst<br>Excision of bone tissue<br>Incision and drainage of an intraoral abscess                     | 80%         | 80% |
| <b>Surgical Periodontal Services</b><br>Gingivectomy or gingivoplasty and gingival flap procedures<br>Clinical crown lengthening<br>Osseous surgery<br>Osseous grafts<br>Soft tissue grafts/allografts<br>Distal or proximal wedge procedure | 80%         | 80% |
| <b>Major Restorative Services</b><br>Single crown restorations<br>Inlay/onlay restorations<br>Labial veneer restorations<br>Crowns placed over implants                                                                                      | 50%         | 50% |
| <b>Prosthodontic Services</b><br>Complete and removable partial dentures<br>Denture relining/rebase procedures<br>Fixed bridgework<br>Prosthetics placed over implants                                                                       | 50%         | 50% |
| <b>Miscellaneous Restorative and Prosthodontic Services</b><br>Prefabricated crowns<br>Recementations<br>Post and core, pin retention and crown/bridge repairs<br>Adjustments                                                                | 50%         | 50% |
| <h2>Orthodontic Services</h2>                                                                                                                                                                                                                |             |     |
| <b>Orthodontic Services</b><br><br>Orthodontic Diagnostic Procedures and Treatment<br><br>Lifetime Maximum per Participant                                                                                                                   | Not Covered |     |

Dental implants are not covered.

The above is a listing of common services available through your network of Contracting Dentists.

The Member's share of the cost is determined by whether care is received from a Contracting or Non- Contracting Dentist.

\* Benefits for covered services received from a Contracting Dentist are based on the Allowable Amount, and such Dentist cannot balance bill for charges in excess of this Allowable Amount. Benefits for covered services received from a Non-Contracting Dentist will be based upon an Allowable Amount determined by BCBSOK, where non-contracting Allowable Amount will be not less than the amount BCBSOK would have paid, for the same covered service, supply, or procedure if performed or provided by a Contracting Dentist, and it is possible that such Dentist will balance bill for amounts above this.

This plan includes BlueCare Dental Enhanced Benefit<sup>SM</sup>. The Enhanced Benefit provides additional dental benefits, such as an extra cleaning for members with specific health issues. Please refer to your Dental Benefit Booklet for additional benefit information.

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