

City of Oklahoma City

Effective: 1/1/2026

The following is a listing of common services available through your BlueCare Dental PPO network. The member's share of the cost is determined by whether care is received from a contracted or non-contracted provider. Your plan allows you to see any licensed dentist, but using an in-network provider may minimize your out-of-pocket expenses.

This information only provides highlights of this program. Please refer to the BlueCare Dental Certificate for additional detailed benefit information.

Summary of Dental Benefits		
PROGRAM BASICS	In-Network Dentist	Out-of-Network Dentist MAC
Benefit Period Maximum: Calendar Year	\$1,000	\$1,000
Deductible: Calendar Year	\$50 Individual \$150 Family	\$50 Individual \$150 Family
Three Month Deductible Carryover Applies	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Prior Carrier Deductible Credit Applies	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
COVERED SERVICES		
Class 1: Preventive Services (Deductible applies) Problem Focused Oral Evaluations Sealants Space maintainers Palliative Treatment (emergency care to relieve pain)	100%	100%
Class 1: Preventive Services (Deductible does <u>not</u> apply) Periodic Oral Evaluations Comprehensive Oral Evaluations Prophylaxis/routine cleanings X-rays Full-Mouth, Pano, Bitewing, Periapical Topical Fluoride	100%	100%
Class 2: Basic Restorative Services Amalgam & Composite Fillings Deep Sedation/General Anesthesia Non-surgical Extractions	80%	60%
Class 3: Major Restorative Services Perio Maintenance Full Mouth Debridement Scaling & Root Planning Denture Reline/Rebase Bridges & Dentures Implants: Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Crowns, Inlays, Onlays Repairs – Crown & Bridge Oral Surgery & Surgical Extractions Endodontics (root canal) Major Periodontics	50%	30%
Class 4: Orthodontics Orthodontic Diagnostic Procedures & Treatment Coverage for Adults & Dependent Children (to age 26)	50%	30%
Lifetime Maximum Ortho Benefit per Participant	\$1,000	\$1,000

Benefit Limitations & Frequencies:

Oral Evaluations	2 per year
Comprehensive Evaluations	1 per 36 months
X-rays: Bitewings	2 per year
X-rays Full mouth panoramic	1 per 36 months
Prophy/Cleanings	2 per year
Fluoride Application	2 per year for children up to age 19
Sealants (per tooth)	1 every 5 years up to age 16
Space Maintainers	1 per lifetime up to age 16
Amalgam & Composite Fillings	1 per tooth per 24 months
Crowns/Dentures/Bridges	Replacement every 7 years
Denture Reline/Rebase	1 per 36 months
Perio Maintenance	2 per year

Included Plan Features:

Missing Tooth Exclusion: This plan covers replacement of tooth/teeth missing prior to your effective date under this policy.

No Benefit Waiting Period: There is no required period of time a member must be covered under the plan before receiving coverage for dental procedures.

Preventive Services: Costs for preventive procedures do not apply toward the plan benefit period maximum.

Enhanced Dental Benefit: Participants diagnosed and receiving active medical care for cardiovascular disease, diabetes, prediabetes or pregnancy qualify for one of the following enhanced dental benefits after standard benefits are exhausted: one additional cleaning, periodontal scaling and root planing or periodontal maintenance. Enhanced benefit services will apply toward your individual annual maximum.

Finding a Provider: For a list of in-network general and specialty dentists, go to bcbsok.com and click on **Find Care** and then on **Find a Dentist** on the left side of the page. You can search for a dentist near your home, school or office.

QR Code to Provider Finder site



Graduated Annual Maximum: Incremental annual increase in Benefit Period Maximum. Only applicable to members that remain enrolled in this dental plan year after year until the maximum benefit increase has been met.

- **Start Date:** 1/1/2026
- **Increment Amount:** \$100
- **# of Increments:** Three (3)
- **Graduated Benefit Maximum:** \$1300 for both In-Network & Out-of-Network benefits

Predetermination of benefits is recommended, but not required, for services in excess of \$300

This summary is intended to highlight the most common services and frequencies under the dental plan. For complete and detailed descriptions of services, limitations, and exclusions, please refer to the certificate of coverage.