

Dental Schedule of Coverage



BlueCross BlueShield
of Texas

Plan Overall Payment Provisions	Dental Benefits
Deductibles <ul style="list-style-type: none"> • Calendar Year Deductible • Three month Deductible carryover applies 	\$50 – per individual \$150 – per family
Maximum Calendar Year Benefits per Participant for Categories I, II, III, IV, V, VI, VII, VIII, IX Does not apply to Orthodontic	\$2,000
I. Diagnostic & Preventive Care Services Calendar Year Deductible does not apply	100% of Allowable Amount
II. Miscellaneous Services	100% of Allowable Amount after Calendar Year Deductible
III. Restorative Services	80% of Allowable Amount after Calendar Year Deductible
IV. General Services	80% of Allowable Amount after Calendar Year Deductible
V. Endodontic Services	80% of Allowable Amount after Calendar Year Deductible
VI. Periodontal Services	80% of Allowable Amount after Calendar Year Deductible
VII. Oral Surgery Services	80% of Allowable Amount after Calendar Year Deductible
VIII. Crowns, Inlays/Onlays Services	80% of Allowable Amount after Calendar Year Deductible
IX. Prosthodontic Services	80% of Allowable Amount after Calendar Year Deductible
OPTIONAL COVERAGE	
X. Orthodontic Services <ul style="list-style-type: none"> • Limiting age: 26 • \$1,000 maximum lifetime benefit 	50% of Allowable Amount
Predetermination Amount	\$300
Dependent Child Age Limit	Age 26