BlueCross BlueShield of Texas Brownsville ISD - 01/01/2023	Low Plan		Mid Plan		High Plan	
Dental Plan Pays	**In-Network**	**Out-of-Network***	**In-Network**	**Out-of-Network***	**In-Network**	**Out-of Network***
DIAGNOSTIC/PREVENTIVE SERVICES						
Diagnostic Services Periodic Oral Evaluations	100% No deductible	100% No deductible	100% No deductible	100% No deductible	100% No deductible	100% No deductible
Preventive Services Prophylaxis (cleanings) Topical Fluoride Appliations	100% No deductible	100% No deductible	100% No deductible	100% No deductible	100% No deductible	100% No deductible
Diagnostic Radiographs X-Rays	100% No deductible	100% No deductible	100% No deductible	100% No deductible	100% No deductible	100% No deductible
Miscellaneous Preventive Services Sealants Space Maintainers	100% No deductible	100% No deductible	100% No deductible	100% No deductible	100% No deductible	100% No deductible
BASIC SERVICES						
Restorative Dental Services Fillings, Simple Tooth Extractions	80%	80%	50%	50%	80%	80%
Adjunctive Services Palliative treatment (emergency) Deep sedation / general anesthesia	80%	80%	50%	50%	80%	80%
Endodontic Services Root canals	Not Covered	Not covered	50%	50%	80%	80%
Non-Surgical Extractions Removal of erupted tooth or exposed root	Not Covered	Not covered	50%	50%	50%	50%
Oral Surgery Services Surgical tooth extractions	Not Covered	Not covered	50%	50%	50%	50%
Periodontal Services Periodontal maintenance procedures Gum treatment	Not Covered	Not covered	50%	50%	50%	50%
MAJOR SERVICES						
Major Restorative Services Single crown, Inlay/onlay restorations	Not Covered	Not covered	50%	50%	50%	50%
Prosthodontic Services Bridges, dentures	Not Covered	Not covered	50%	50%	50%	50%
ORTHODONTIA SERVICES						
Orthodontics (Dependent Children - age 19) Lifetime Orthodontia Maximum	Not covered	Not covered	30% Dependents Only $1,000	30% Dependents Only $1,000	50% Dependents/Adults $1,000	50% Dependents/Adults $1,000

Calendar Year Deductible	N/A	N/A	$50 Individual $150 Family	$50 Individual $150 Family	$50 Individual $150 Family	$50 Individual $150 Family
Calendar Year Maximum (Services other than Orthodontia)	$1,000 per person	$1,000 per person	$1,000 per person	$1,000 per person	$1,000 per person	$1,000 per person
*Out-of-Network reimbursement 80% of UCR		*		*		*

Rates		Rates		Rates	
12 Pay Periods		**12 Pay Periods**		**12 Pay Periods**	
Employee Only	$16.51	Employee Only	$22.82	Employee Only	$25.74
Employee + One	$38.02	Employee + One	$45.01	Employee + One	$55.87
Employee + Family	$71.04	Employee + Family	$87.36	Employee + Family	$90.99
18 Pay Periods		**18 Pay Periods**		**18 Pay Periods**	
Employee Only	$11.01	Employee Only	$15.21	Employee Only	$17.16
Employee + One	$25.35	Employee + One	$30.01	Employee + One	$37.25
Employee + Family	$47.36	Employee + Family	$58.24	Employee + Family	$60.66
24 Pay Periods		**24 Pay Periods**		**24 Pay Periods**	
Employee Only	$ 8.26	Employee Only	$11.41	Employee Only	$12.87
Employee + One	$19.01	Employee + One	$22.51	Employee + One	$27.94
Employee + Family	$35.52	Employee + Family	$43.68	Employee + Family	$45.50