



Blue Cross and Blue Shield of New Mexico

SCHEDULE OF BENEFITS

Your dental benefits are highlighted below. To fully understand all the terms, conditions, limitations, and exclusions which apply to your benefits, please read your entire Benefit Booklet.

The Deductibles, Coinsurance, Annual Maximum and/or Out-of-Pocket Limits below are subject to change as permitted by applicable law.

Plan Basics	Participating Dentist	Out-of-Network Dentist**
Annual Maximum Benefit (In/Out-of-Network accumulate together)	\$1,000	\$1,000
Out-of-Pocket Maximum	None	None
Deductible (In/Out-of-Network accumulate together)	\$75 Individual/\$225 Family	\$75 Individual/\$225 Family

Covered Services

Diagnostic Evaluations	10% (Deductible waived)	30% (Deductible waived)
Preventive Services	10% (Deductible waived)	30% (Deductible waived)
Diagnostic Radiographs	10%, after Deductible	30%, after Deductible
Miscellaneous Preventive Services	10%, after Deductible	30%, after Deductible
Basic Restorative Services	30%, after Deductible	50%, after Deductible
Non-Surgical Extractions	30%, after Deductible	50%, after Deductible
Non-Surgical Periodontal Services	30%, after Deductible	50%, after Deductible
Adjunctive Services	30%, after Deductible	50%, after Deductible
Endodontic Services	50%, after Deductible	70%, after Deductible
Oral Surgery Services	50%, after Deductible	70%, after Deductible
Surgical Periodontal Services	50%, after Deductible	70%, after Deductible
Major Restorative Services	50%, after Deductible	70%, after Deductible
Prosthodontic Services	50%, after Deductible	70%, after Deductible
Miscellaneous Restorative and Prosthodontic Services	50%, after Deductible	70%, after Deductible
Orthodontic Services	Not Covered	Not Covered

**For Out-of-Network Dental Provider services, the Allowable Charge is the Dental Provider's usual charge, not to exceed the amount that the Dental Plan would reimburse a Participating Dentist for the same services. The Subscriber will be responsible for the full amount by which the actual charges of an Out-of-Network Dental Provider exceed the Allowable Charge.



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Plan Basics	Participating Dentist	Out-of-Network Dentist**
Annual Maximum Benefit	Unlimited	Unlimited
Out-of-Pocket Maximum	1 child = \$ 350 2 or more children = \$ 700	None
Deductible (In/Out-of-Network accumulate together)	\$75 Individual/\$225 Family	\$75 Individual/\$225 Family

Covered Services

Diagnostic Evaluations	20%, after Deductible	40%, after Deductible
Preventive Services	20%, after Deductible	40%, after Deductible
Diagnostic Services	20%, after Deductible	40%, after Deductible
Miscellaneous Preventive Services	20%, after Deductible	40%, after Deductible
Basic Restorative Services	50%, after Deductible	70%, after Deductible
Non-Surgical Extractions	50%, after Deductible	70%, after Deductible
Non-Surgical Periodontal Services	50%, after Deductible	70%, after Deductible
Adjunctive Services	50%, after Deductible	70%, after Deductible
Endodontic Services	50%, after Deductible	70%, after Deductible
Oral Surgery Services	50%, after Deductible	70%, after Deductible
Surgical Periodontal Services	50%, after Deductible	70%, after Deductible
Major Restorative Services	50%, after Deductible	70%, after Deductible
Prosthodontic Services	50%, after Deductible	70%, after Deductible
Miscellaneous Restorative and Prosthodontic Services	50%, after Deductible	70%, after Deductible
Orthodontic Services		
Pediatric Orthodontic Services: Coverage limited to children under age 19 with an orthodontic condition meeting Medical Necessity criteria (e.g., severe dysfunctional malocclusion) established by a Provider, in consultation with BCBSNM.	50% of Allowable Charge, after Deductible to Unlimited Lifetime Maximum	70% of Allowable Charge, after Deductible to Unlimited Lifetime Maximum

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