BLUECARE DENTAL℠ 52

BlueCross BlueShield of Montana

To learn more, call Blue Cross and Blue Shield of Montana at 800.447.7828 or your local agent.

www.bcbsmt.com

Outline of Coverage | 2021

Benefit Period	Calendar Year
Annual Maximum Benefit Amount	$1,500 per Participant, per benefit period
Deductible	Individual: $50 Family: $150

BCBSMT Contracting Provider Networks

Contracting Dentists (In-Network) – Dentists in the BCBSMT participating dental network accept the BCBSMT allowable fee, in addition to the Deductible and Coinsurance Amount, as payment in full for covered services. These Dentists will submit claims for you.

Non-Contracting Dentists (Out-of-Network) – Non-Contracting Dentists have not contracted with BCBSMT and are under no obligation to submit claims for you. They may also bill you the difference between the allowable fee and their charge (balance billing), in addition to any Deductible and Coinsurance Amount.

Finding Contracting Dentists - To locate Contracting Dentists in Montana, check our on-line Provider directory at www.bcbsmt.com, or contact Customer Service at 1-866-739-4090.

Participants Rights: When requested by the Participant or the Participant's agent, BCBSMT is required to provide a summary of a Participant's coverage for a specific dental care service or Course of Treatment when an actual charge or estimate of charges by a dental care Provider exceeds $500.

Covered Services	The Plan will pay Contracting Dentists	The Plan will pay Non-Contracting Dentists
Diagnostic Evaluations *(Deductible Waived)*	100%	100%
Preventive Services *(Deductible Waived)*	100%	100%
Diagnostic Radiographs *(Deductible Waived)*	100%	100%
Miscellaneous Preventive Services *(Deductible Waived)*	100%	100%
Basic Restorative Services	80%	80%
Non-Surgical Extractions	80%	80%
Non-Surgical Periodontal Services	80%	80%
Adjunctive Services	80%	80%
Endodontic Services	80%	80%
Oral Surgery Services	80%	80%
Surgical Periodontal Services *	80%	80%
Major Restorative Services *	50%	50%
Prosthodontic Services *	50%	50%
Miscellaneous Restorative and Prosthodontic Services *	50%	50%

Important Information

Annual Maximum Benefit Amount: The maximum amount the Plan will pay in one benefit period. Any balance owed above this amount is the Participant's responsibility.

Deductible: The dollar amount each Participant must pay for covered dental expenses incurred during the benefit period before BCBSMT will make payment for any covered dental expense to which the Deductible applies.

Coinsurance Amount: The percentage of the allowable fee payable by the Participant.

Rating Factors and Trend: The following factors are used in setting rates: the income and claims experience for the 12 months prior to rating calculations for the category of product being rated, the benefit difference for the deductible and coinsurance relationship for the specific products in a product category, the projected claims, income and enrollment for the next 12-month rating period, projected expenses for the plan of the next rating period, and/or age of the application or subscriber, industry, and risk characteristics. The trend of premium increases during the preceding five years is: 2016 – 0%, 2017 – 0 %, 2018 – 2%, 2019 - 2%, 2020 - 5%.

Your estimated premium will be_____.

*A 12-month waiting period applies to these services only.

This information is only a summary of benefits. For more detailed information, refer to your Certificate of Coverage. Benefits and general provisions described herein are subject to the terms of the Group Contract and Certificate of Coverage.