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BlueCross BlueShield of Kansas
Blue Choice Network

KICF POOLED EMPLOYEE HEALTH INSURANCE PROGRAM

Comprehensive Dental

Effective Jan 01, 2020

This Dental Care Program offers coverage for preventive services, along with additional coverage for primary and major dental services. Employees and each eligible dependent will receive a maximum of $1,500 in benefits for all covered services each anniversary year.

Covered Services	
PREVENTIVE **No deductible** **100% payment**	Oral examinations Dental imaging services required to treat or diagnose diseases or abnormalities of the teeth, surrounding tissue and cavity detection Fluoride (under age of 21) Prophylaxis, including cleaning, scaling and polishing Space maintainers Sealants limited to one application per tooth per lifetime per eligible insured between 5 and 17 years of age inclusive, and limited to permanent molars and bicuspids (20 teeth).
PRIMARY **Primary and Major Dental benefits have a combined deductible maximum of $25/individual, $75/family.** **80% payment**	Inlays Simple extractions Repair of dentures Fillings (except gold) Emergency treatment for pain Endodontics General anesthesia when the dental treatment is covered Periodontics, non-surgical Non-surgical care of acute oral infection and oral lesions Oral surgery, consisting of diagnosis and treatment of fractures, dislocations, cysts, and abscesses; and surgical extractions (including impacted teeth)
MAJOR **Primary and Major Dental benefits have a combined deductible maximum of $25/individual, $75/family.** **50% payment**	Periodontal surgery Surgery of the bony structure supporting the teeth Bridges Onlays (not part of a bridge) Crowns (not part of a bridge) Dentures, full or partial Dental implant services ($1,000 lifetime max per insured, per arch).
ORTHODONTIC RIDER (under age of 21) **100% payment up to a 3-year maximum of $1,500**	Retention treatment Active treatment, including necessary appliances Diagnosis including study models and facial photographs
Benefits are not provided for denture or bridge replacement within five years after receiving dentures or bridges under this program. Benefits are limited to standard procedures for prosthodontic services.	
**** Any charges for the replacement and/or repair of any appliance previously furnished under this plan shall not be covered by Blue Cross and Blue Shield of Kansas.**	

Monthly Premium

	Employee	Emp/Child(ren)	Emp/Spouse	Family
Dental Total	$37.41	$80.54	$80.24	$122.51

Contracting Dentists: Payment will be the maximum allowable charge for covered dental services. Payment will be sent directly to the dentist. The member will only be responsible for any coinsurance amounts and any charges for non-covered services.

Non-Contracting Dentists In Company Service Area: The member will be responsible for any difference between the payment allowance and the provider's charge, in addition to any coinsurance amounts and any charges for non-covered services. Payment will be sent directly to the member.

Non-Contracting Dentists Outside Company Service Area: Payment is based on usual, customary and reasonable charges. If the member does not sign payment over to the dentist, or the dentist does not submit the claim on the member's behalf, payment will be sent directly to the member.

Coinsurance: The coinsurance will be applied to the payments of a contracting dentist or a non-contracting dentist as described.

Out-of-State Dentists: As a BCBSKS member, you may go to any dentist located outside the state of Kansas that contracts with the local Blue Cross Plan. Payment amount is based on the local Blue Cross allowance arrangement with their contracting dentists. If the out-of-state Blue plan does not provide their discounted rates to BCBSKS, then the BCBSKS allowance is used. The member may be responsible for the difference between the allowed amount and the BCBSKS paid amount. BCBSKS payments will be sent directly to the member.

Exclusions: Services not listed as eligible dental services in the certificate; duplicate benefits provided under federal, state or local laws, regulations or programs (except for Medicaid); patient education services; hospital calls and consultations; lab work; occlusal adjustments; dental implants (except limited coverage under Prosthodontics); services for diseases or injuries caused by or arising out of acts of war or aggression; services for cosmetic purposes; payments under any provision of a Blue Cross and Blue Shield of Kansas certificate when the payment would duplicate payment for coverage made under another provision of the dental certificate (but only to the extent that such payment would exceed the charge for the service); services provided by a dentist for which there would customarily be no charge; medically unnecessary services; services related to alveolar ridge augmentations; services related to temporomandibular joint dysfunction syndrome over the amount specified in the certificate; services covered and payable by any medical expense payment provision of any automobile insurance policy; services performed by immediate relatives or by members of the household of the employee; benefits received when a patient transfers during treatment, or if more than one dentist provides services for the same, payment for that benefit will not exceed the amount payable for one service.

This is a brief summary of the coverage available under this program. It is not a legal document.
The exact provisions of the benefits and exclusions are contained in the certificate.