# Summary of dental benefits

Oregon Homecare Workers Supplemental Fund  
Oregon Preferred Provider Dental Plan FV  
January 1, 2014 through December 31, 2014

<table>
<thead>
<tr>
<th></th>
<th>In-network benefit</th>
<th>Out-of-network benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Benefit Maximum</strong> per Calendar Year (covered Services subject to either Benefit Maximum count toward both Benefit Maximums)</td>
<td></td>
<td>$1,500</td>
</tr>
<tr>
<td><strong>Deductible</strong> (applies to all services unless otherwise indicated)</td>
<td><strong>You Pay</strong></td>
<td></td>
</tr>
<tr>
<td>For one Member</td>
<td>$50 per Calendar Year</td>
<td></td>
</tr>
<tr>
<td>For an entire Family</td>
<td>$150 per Calendar Year</td>
<td></td>
</tr>
<tr>
<td><strong>Preventive and Diagnostic Services</strong> (oral exam, x-rays, teeth cleaning, fluoride) (Not subject to the Deductible)</td>
<td>No additional charge</td>
<td>No additional charge</td>
</tr>
<tr>
<td><strong>Basic Restoration Services</strong> (routine fillings, plastic and steel crowns, simple extractions)</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td><strong>Oral Surgery Services</strong> (surgical tooth extractions)</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td><strong>Periodontics</strong> (treatment of gum disease, scaling and root planing)</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td><strong>Endodontics</strong> (root canal therapy)</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td><strong>Major Restoration Services</strong> (gold or porcelain crowns, bridges)</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Removable Prosthetic Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full and partial dentures</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Relines</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Rebases</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Nitrous oxide</strong> (Not subject to the Deductible or the Benefit Maximum)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adults and children age 13 years and older</td>
<td>$15</td>
<td>$15</td>
</tr>
<tr>
<td>Children age 12 years and younger</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Orthodontics</strong></td>
<td>Not a covered benefit</td>
<td>Not a covered benefit</td>
</tr>
<tr>
<td><strong>Implants</strong></td>
<td>50% in-network</td>
<td>50% out-of-network</td>
</tr>
</tbody>
</table>

*“MAC” means Maximum Allowable Charge. "UCC" means Usual and Customary Charges. See your Evidence of Coverage (EOC) for details.*

**Exclusions**

- Cosmetic Services.
- Dental conditions for which Service or reimbursement is required by law to be provided at or by a government agency.
- Dental implants unless coverage for dental implants as an additional benefit has been purchased.
- Dental services not listed on the “Schedule of Covered Procedures” section, located at the back of your EOC.
- Drugs obtainable with or without a prescription.
- Experimental or investigational treatments.
- Fees a provider may charge for an Emergency Dental Care or Urgent Dental Care visit.
- Full mouth reconstruction and occlusal rehabilitation.
• Genetic testing.
• Hospital call fees.
• Medical or Hospital Services, unless otherwise specified in this Summary.
• Missed appointment fees.
• Orthodontic Services unless orthodontic coverage as an additional benefit has been purchased.
• Procedures, appliances, or fixed crown and bridge for periodontal splinting of teeth.
• Prosthetic devices following your decision to have a tooth (or teeth) extracted for nonclinical reasons or when a tooth is restorable.
• Replacement of prefabricated, noncast crowns, including noneast stainless steel crowns.
• Services covered by workers' compensation or that are the employer's responsibility.
• Services furnished by a family member.
• Services provided or arranged by criminal justice institutions for Members confined therein, unless care would be covered as Emergency Dental Care.
• Speech aid prosthetic devices and follow up modifications.
• Surgery to correct malocclusion or temporomandibular joint disorders.
• Treatment to restore tooth structure lost due to attrition, erosion, or abrasion.

Limitations
• Amalgams and composites are allowed one restoration per surface every 36 months.
• All relines and rebases of existing removable dentures are limited to once per 36-month period.
• Benefits for prophylaxis will not be covered if performed on the same date of Service with periodontal cleaning treatment.
• Dentures, bridges, crowns (per tooth) and replacement of fixed or removable prosthetic devices are limited to once every five years.
• Examination and prophylaxis, including scaling and polishing is limited to twice every 12 months.
• Extraction of asymptomatic or nonpathologic third molars (wisdom teeth) are not covered unless performed in conjunction with orthodontic or periodontal treatment and prescribed by an orthodontist or periodontist.
• Full mouth gross debridement is limited to a frequency of once every 36 months. Subsequent debridement within this period will require Prior-Authorization.
• Interim complete dentures and interim partial dentures may not be replaced for a 12-month period.
• Periodontal scaling and root planning is limited to once per quadrant every 24 months and requires Prior-Authorization before the initiation of Services.
• Removable prosthetic adjustments, repair, and relines within six months of the initial placement is not covered.
• Root canals are covered once per tooth per lifetime and re-treatment of root canal is limited to not more than once in 24 months for the same tooth.
• Sealant coverage is limited to once every three years for treatment of the occlusal surfaces of permanent molars for persons 15 years and younger.
• Sedation and general anesthesia are not covered, except nitrous oxide.
• Services performed by someone other than a Dentist are not covered. This exclusion does not apply to dental hygienists who are supervised by a Dentist.
• Use of alternative materials for removal and replacement of clinically acceptable material or restorations for any reason, except the pathological condition of the tooth (or teeth).
• When there are two or more professionally acceptable dental treatments for a dental condition, Plan bases the reimbursement on the least costly treatment alternative.
• Works-in-Progress started prior to effective date of coverage.
• X-rays are limited to one full mouth set of X-rays every three years, one bite wing series per year, and those that are necessary to document the need for oral surgery.

Questions? Call Dental Choice Customer Care  (M-F, 6:30 am-5 pm) 1-866-498-7912 or visit kp.org/dental/nw
Language Interpretation Services, all areas. 1-800-324-8010
This is not a contract. This benefit summary does not fully describe your benefit coverage with Kaiser Foundation Health Plan of the Northwest. For more details on your benefit coverage, claims
review, and adjudication procedures, please see your EOC or call Membership Services. In the case of conflict between this summary and the EOC, the EOC will prevail.