

Summary of dental benefits

10/01/2006 through 09/30/2007

HILLSBORO SCHOOL DISTRICT - CLASSIFIED

01404

Dental office visit charge

\$10¹

Annual deductible

None

Annual benefit maximum

None

Benefit (when provided, prescribed, or authorized by a Kaiser Permanente Plan dentist)

You pay

Preventive and diagnostic services

Oral exams and X-rays, teeth cleaning, fluoride treatments, instruction in care of your teeth and gums, and prescribed space maintainers

No additional charge

Basic restorative services

Routine fillings, plastic and stainless steel crowns

No additional charge

Simple extractions

No additional charge

Oral surgery

Surgical tooth extractions, including diagnosis and evaluation

No additional charge

Periodontics

Diagnosis, evaluation, and treatment of gum disease, including scaling and root planing

20%

Endodontics

Root canal and related therapy, including diagnosis and evaluation

20%

Major restorative services

Gold or porcelain crowns, inlays, and bridge abutments and pontics

50%

Removable prosthetic services

Full and partial dentures, relines and rebases

50%

Emergency treatment

From Plan providers:

\$25 for emergency and urgent care visits on the same or next business day plus any other charges that normally apply.

From non-Plan providers:

Balance after you are reimbursed up to \$100 for qualifying claims outside the service area

Orthodontics

50% up to \$2,000; you pay 100% thereafter.

Please note:

- ◆ You pay \$15 for nitrous oxide for adults and children 13 and older.
- ◆ You pay 10 percent of charges for nightguards.

Exclusions

The following are not covered:

- ◆ Care for conditions that are covered by workers' compensation or that are the employer's responsibility.
- ◆ Conditions for which care or reimbursement is required by law to be provided at or by a government agency.
- ◆ Cosmetic services.
- ◆ Dental implants, including bone augmentation and fixed or removable prosthetic devices attached to or covering the implants and all related services.
- ◆ Experimental or investigational treatments, procedures, and services.
- ◆ Full mouth reconstruction and occlusal rehabilitation.
- ◆ General anesthesia.
- ◆ Genetic testing.
- ◆ Intravenous sedation.
- ◆ Medical, hospital, and certain dental services.
- ◆ More than two visits for routine teeth cleaning (oral prophylaxis) treatments in any 12 consecutive month period.
- ◆ Orthodontic services, unless coverage purchased by your group.
- ◆ Prescription drugs.
- ◆ Prosthetic devices when necessary or desired following your decision to have a tooth (or teeth) extracted for nonclinical reasons or when a tooth is restorable.
- ◆ Removal and replacement, with alternative materials, of clinically acceptable material or restorations for any reason, except the pathological condition of the tooth or teeth.
- ◆ Repair or replacement of fixed prosthetics or removable prosthetic appliances that are less than five years old.
- ◆ Replacement of prefabricated, noncast crowns, including noncast stainless steel crowns, that were not placed by a Kaiser Permanente dentist.
- ◆ Replacement of temporary removable appliances within five years of the date you received the appliance.
- ◆ Restorative or reconstructive treatment for specific congenital or developmental malformations.
- ◆ Services not approved by a Kaiser Permanente dentist, except as described under "Emergency Treatment."
- ◆ Surgery to correct malocclusion or temporomandibular joint disorders.
- ◆ Work-in-progress before your coverage became effective.

Dependent age limits: Your group plan covers enrolled dependents to age 26.

Questions? Call Membership Services (M-F, 8 am-6 pm)

Portland area...503-813-2000. All other areas...1-800-813-2000. TTY...1-800-735-2900.

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 A Guide to Your Benefits (or EOC) or call Membership Services. In the case of conflict between this summary and the EOC, the EOC will prevail.

Footnotes: ¹Applies to each dental office visit. For plans with a deductible, this charge applies only to preventive and diagnostic services.