

State of Oregon  
Public Employees' Benefit Board Summary Plan Description

## Kaiser Permanente Dental Full-time Benefit Summary

This Benefit Summary, which is part of the Evidence of Coverage (EOC), is a summary of answers to the most frequently asked questions about benefits. This chart does not fully describe benefits, the benefit limitations, or exclusions in full. To see what is covered for each benefit (including exclusions and limitations), for complete explanations, and for additional benefits that are not included in this summary, please refer to the “Copayments, Coinsurance, and Benefits” and “Exclusions and Limitations” sections of this Evidence of Coverage, which is listed in the same order as in the “Benefit Summary.” Exclusions and limitations that apply to all benefits are described in the “Exclusions and Limitations” section of this Evidence of Coverage.

Some works-in-progress may be reduced to a 50% payment of the Usual and Customary Charges. Please refer to the “Exclusions and Limitations” section of the Evidence of Coverage for details.

<b>Benefit</b>	<b>You Pay</b>
<b>Dental Office Visit Charge</b>	\$0
<b>Benefit Maximum</b>	\$1,750
<b>Preventive and Diagnostic Services</b>	<b>You Pay</b>
Oral Exam	No additional charge
X-rays	No additional charge
Teeth cleaning	No additional charge
Fluoride treatments	No additional charge
Space maintainers	No additional charge
<b>Basic Restorative Services</b>	<b>You Pay</b>
Routine fillings	20%
Crowns (plastic/acrylic and steel)	20%
Simple extractions	20%
<b>Oral Surgery</b>	<b>You Pay</b>
Surgical tooth extractions including diagnosis and evaluation	20%
Major Oral Surgery	20%
<b>Periodontics</b>	<b>You Pay</b>
Diagnosis and evaluation	20%
Treatment of gum disease	20%
Scaling and root planing	20%
Periodontal Maintenance (Current Dental Terminology Code 4910)	No additional charge
<b>Endodontics</b>	<b>You Pay</b>
Root canal, related therapy, including diagnosis and evaluation	20%
<b>Major Restoration Services</b>	<b>You Pay</b>

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Gold or porcelain crowns	25%
Inlays	50%
Bridge abutments	50%
Pontics	50%
Dental Implants	50% up to Benefit Maximum
<b>Removable Prosthetic Services</b>	<b>You Pay</b>
Full and partial dentures	50%
Relines	50%
Rebases	50%
<b>Emergency Care</b>	<b>You Pay</b>
From Dental Group Providers	\$25 for Emergency and Urgent Care visits on the same or next business day plus any other Charges that normally apply.
From non-Dental Group providers	All Charges over \$100
<b>Other Benefits</b>	<b>You Pay</b>
Nightguards	10%
Nitrous oxide	
Adults and children age 13 years and older	\$15.00
Children age 12 years and younger	No Charge
<b>Questions? Call Membership Services (M-F, 8am – 6pm)</b>	
Portland: 503-813-2000, outside Portland: 1-800-813-2000. TTY...1-800-735-2900. 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 of your benefit coverage, claims review, and adjudication procedures, please see your evidence of coverage (or EOC) or call Membership Services. In the case of a conflict between this summary and the EOC, the EOC will prevail.	

## Kaiser Permanente Dental Part-time and Retiree Benefit Summary

This Benefit Summary, which is part of this Evidence of Coverage (EOC), is a summary of answers to the most frequently asked questions about benefits. This chart does not fully describe benefits, the benefit limitations, or exclusions in full. To see what is covered for each benefit (including exclusions and limitations), for complete explanations, and for additional benefits that are not included in this summary, please refer to the “Copayments, Coinsurance, and Benefits” and “Exclusions and Limitations” sections of this Evidence of Coverage, which is listed in the same order as in the “Benefit Summary.” Exclusions and limitations that apply to all benefits are described in the “Exclusions and Limitations” section of this Evidence of Coverage.

Some works-in-progress may be reduced to a 50% payment of the Usual and Customary Charges. Please refer to the “Exclusions and Limitations” section of this EOC for details.

<b>Benefit</b>	<b>You Pay</b>
<b>Dental Office Visit Charge</b>	\$0
<b>Benefit Maximum</b>	\$1,250
<b>Preventive and Diagnostic Services</b>	<b>You Pay</b>
Oral Exam	No additional charge
X-rays	No additional charge
Teeth cleaning	No additional charge
Fluoride treatments	No additional charge
Space maintainers	No additional charge
<b>Basic Restorative Services</b>	<b>You Pay</b>
Routine fillings	50%
Crowns (plastic/acrylic and steel)	50%
Simple extractions	50%
<b>Oral Surgery</b>	<b>You Pay</b>
Surgical tooth extractions including diagnosis and evaluation	50%
Major Oral Surgery	50%
<b>Periodontics</b>	<b>You Pay</b>
Diagnosis and evaluation	50%
Treatment of gum disease	50%
Scaling and root planing	50%
Periodontal Maintenance (Current Dental Terminology Code 4910)	No additional charge
<b>Endodontics</b>	<b>You Pay</b>
Root canal, related therapy, including diagnosis and evaluation	50%
<b>Major Restoration Services</b>	<b>You Pay</b>
Gold or porcelain crowns	50%