

# Summary of Dental Benefits

All plans offered and underwritten by Kaiser Foundation Health Plan of the Northwest. 500 NE Multnomah St., Suite 100, Portland, OR 97232

Membership Services: 1-800-813-2000

Oregon R446

1/1/2021 - 12/31/2021

Carewell SEIU 503

Group Number: 19581-005

|  | <b>In-network benefit<br/>(reimbursement is<br/>based on MAC) *</b> | <b>Out-of-network benefit<br/>(reimbursement is<br/>based on UCC) *</b> |
|--|---|---|
| <b>Benefit Maximum</b> per Calendar Year (covered Services subject to either Benefit Maximum count toward both Benefit Maximums) | \$2,500   | \$2,500   |
| <b>You pay</b>   |   |   |
| <b>Deductible</b> (Per Calendar Year; applies to all services unless otherwise indicated)  |   |   |
| For one Member   |   | \$0   |
| For an entire Family   |   | \$0   |
| <b>Preventive and Diagnostic Services</b> (Not subject to or counted toward the Deductible or Benefit Maximum)                   |   |   |
| Oral exam  | \$0   | \$0   |
| X-rays   | \$0   | \$0   |
| Teeth cleaning   | \$0   | \$0   |
| Fluoride   | \$0   | \$0   |
| <b>Minor Restoration Services</b>  |   |   |
| Routine fillings   | \$0   | \$0   |
| Plastic and steel crowns   | \$0   | \$0   |
| Simple extractions   | \$0   | \$0   |
| <b>Oral Surgery Services</b>   |   |   |
| Surgical tooth extractions   | 10% Coinsurance   | 10% Coinsurance   |
| <b>Periodontics</b>  |   |   |
| Treatment of gum disease   | \$0   | \$0   |
| Scaling and root planing   | \$0   | \$0   |
| <b>Endodontics</b>   |   |   |
| Root canal therapy   | 10% Coinsurance   | 10% Coinsurance   |
| <b>Major Restoration Services</b>  |   |   |
| Gold or porcelain crowns   | 30% Coinsurance   | 30% Coinsurance   |
| Bridges  | 30% Coinsurance   | 30% Coinsurance   |
| <b>Removable Prosthetic Services</b>   |   |   |
| Full and partial dentures  | 30% Coinsurance   | 30% Coinsurance   |
| Relines  | 30% Coinsurance   | 30% Coinsurance   |
| Rebases  | 30% Coinsurance   | 30% Coinsurance   |
| <b>Nitrous oxide</b> (Not subject to or counted toward the Deductible or Benefit Maximum)  |   |   |
| Adults and children age 13 years and older   | \$25  | \$25  |

SSOB ORLGPPDental0121

|                                   |   |                       |
|-----------------------------------|---|-----------------------|
| Children age 12 years and younger | \$0   | \$0                   |
| <b>Orthodontics</b>               | Not a covered benefit   | Not a covered benefit |
| <b>Implants</b>                   | 30% Coinsurance up to the Benefit Maximum and 100% of charges thereafter. |                       |

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

Plan is subject to exclusions and limitations. A complete list of the exclusions and limitations is included in the Evidence of Coverage (EOC). Sample EOCs are available upon request.

---

**Questions? Call Member Services** (M-F, 8 am-6 pm) or visit **kp.org** Portland area: 503-813-2000  
 All other areas: 1-800-813-2000 TTY.711. 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 benefit coverage, claims review, and adjudication procedures, please see your EOC or call Member Services. In the case of a conflict between this summary and the EOC, the EOC will prevail.