Summary of dental benefits

01/01/2008 through 12/31/2008

CITY OF VANCOUVER	01959-155
Dental office visit charge	$10[1]
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	20%
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	20%
Removable prosthetic services	
Full and partial dentures, relines and rebases	20%
Emergency treatment -You must use a Kaiser Permanente facility unless you are out of the service area or unless the extra travel time required to reach a Kaiser Permanente facility could cause serious adverse consequences or you nor your family member have any control over where you are taken for care.	
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:	Any charges that normally apply plus amounts that exceed reasonable and customary charges for qualifying claims.
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 services in conjunction with any covered dental procedure performed in a dental office, except when medically necessary for members who are under the age of seven, or physically or developmentally disabled.
- Genetic testing.
- Intravenous sedation except when medically necessary for members who are under the age of seven, or physically or developmentally disabled.
- 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 when less expensive professionally appropriate treatment is available, as determined by your Kaiser Permanente dentist.
- Services not approved by a Kaiser Permanente dentist, except as described under "Emergency Treatment."
- Orthognathic surgery to correct malocclusion or temporomandibular joint disorders. This exclusion does not apply to orthognathic surgical services performed by a dentist for treatment of a congenital anomaly such as cleft palate when the services are required for a covered dependent child and the dependent is not enrolled under a KPHA medical plan that covers these services.
- Work-in-progress before your coverage became effective.

Dependent age limits: Your group plan covers enrolled dependents to age 23.

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 Permanente Health Alternatives. 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: [1]Applies to each dental office visit. For plans with a deductible, this charge applies only to preventive and diagnostic services.