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

Summary of Dental Benefits

11/1/2016 - 10/31/2017

Dollar Park & Fly, Inc. **Group Number: 8636**

Benefit Maximum per Calendar Year	$1,000
	You Pay
Dental Office Visit Charge – Applies to all visits	$10
Deductible (Per Calendar Year; applies to all services unless otherwise indicated)	
For one Member	$0
For an entire Family	$0
Preventive and Diagnostic Services (oral exam, x-rays, teeth cleaning, fluoride) (Not subject to or counted toward the Deductible or counted toward the Benefit Maximum)	No additional charge
Basic Restoration Services (routine fillings, plastic and steel crowns, simple extractions)	20% Coinsurance
Oral Surgery Services (surgical tooth extractions)	50% Coinsurance
Periodontics (treatment of gum disease, scaling and root planing)	50% Coinsurance
Endodontics (root canal therapy)	50% Coinsurance
Major Restoration Services (gold or porcelain crowns, bridges)	50% Coinsurance
Removable Prosthetic Services	
Full and partial dentures	50% Coinsurance
Relines	50% Coinsurance
Rebases	50% Coinsurance
Emergency Dental Care	
From Participating Providers	Copayments or Coinsurance that normally apply for non-emergency dental care Services.
From Non-Participating Providers outside the Service Area	All Charges over $100
Nitrous oxide (Not subject to or counted toward the Deductible or Benefit Maximum)	
Adults and children age 13 years and older	$15
Children age 12 years and younger	$0
Orthodontics	Not a covered benefit

Exclusions and Limitations
The Services listed below are either completely excluded from coverage or partially limited. This applies to all Services that would otherwise be covered and is in addition to the exclusions and limitations that apply only to a particular Service as listed in the description of that Service in the *Evidence of Coverage (EOC)*. For a complete list and description of Exclusions and Limitations please refer to *EOC*.

Continuation of Services performed or started prior to your coverage becoming effective and/or after your membership terminates. **Cosmetic Services, supplies, or prescription drugs** intended primarily to improve

appearance, repair, and/or replace cosmetic dental restorations. **Dental implants**. **Experimental or investigational treatments, procedures, and other Services** that are not commonly considered standard dental practice or that require governmental approval. **Fees** a provider may charge for an Emergency Dental Care or Urgent Dental Care visit. **Full mouth reconstruction and occlusal rehabilitation**, including appliances, restorations, and procedures needed to alter vertical dimension, occlusion, or correct attrition or abrasion. **Genetic testing**. **Medical or Hospital Services**, unless otherwise specified in the EOC. **Maxillofacial surgery**. **Missed appointment fees** a provider may charge for a missed appointment. **Myofunctional therapy**. **Orthodontic Services**, unless your Group has purchased a plan with orthodontic coverage as an additional benefit. **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 noncast stainless steel crowns that were not placed by a Participating Provider. **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 for problems of the jaw joint, including temporomandibular joint syndrome and craniomandibular disorders**; and treatment of conditions of the joint linking the jaw bone and skull and of the complex of muscles, nerves, and other tissues related to that joint. Treatment of micrognathia. Treatment of micrognathia. **Treatment to restore tooth structure lost due to attrition, erosion, or abrasion. Repair or replacement** needed due to normal wear and tear of fixed and removable prosthetic devices that are less than five years old is not covered. **Sedation and general anesthesia** (including, but not limited to, intramuscular IV sedation, non-IV sedation, and inhalation sedation) are not covered, except nitrous oxide.

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 Membership Services. In the case of conflict between this summary and the *EOC*, the *EOC* will prevail.