2022 Delta Dental Premier Plan Benefit Summary

Delta Dental of Oregon & Alaska

METRO

Group ID: 10001772

Calendar year costs	
Calendar year maximum, per member (Class 2 and Class 3)	$2,000
Calendar year deductible, per member	$50
Calendar year maximum deductible, per family	$150
Class 1* (Services do not apply to the calendar year max)	
Periodic examinations / X-rays	100%
Prophylaxis (cleanings) / periodontal maintenance	100%
Sealants	100%
Topical application of fluoride	100%
Class 2 - A	
Restorative fillings	100%
Space maintainers	100%
Oral surgery (extractions & certain minor surgical procedures)	100%
Endodontics (treatment of teeth with diseased or damaged nerves)	100%
Periodontics (treatment of diseases of the gums and supporting structures of the teeth)	100%
Class 2 - B	
Crowns and other cast restorations	80%
Bridges (construction or repair of fixed bridges)	80%
Class 3	
Implants	50%
Dentures (construction or repair of partial and complete dentures)	50%
Orthodontics	
Adult & Child orthodontic services	50% up to $1,500 lifetime maximum

* Deductible waived for Class 1 and Orthodontic services.

This is a benefit summary only. For a more detailed description of benefits, refer to your member handbook.

How to use this dental plan

When you visit your dental provider, tell him or her you are a Delta Dental member.

When the member visits:

Delta Dental Premier Dentist:

Members are held harmless from balance billing (will not be billed for the difference between the dentist's billed charge and the Delta Dental negotiated fee).

Non Participating Dentists:

Members may be held liable for the difference between the dentist's billed charge and the non-participating allowable.

Limitations

If a more expensive treatment than is functionally adequate is performed, Delta Dental Plan of Oregon will pay the applicable percentage of the maximum plan allowance for the least costly treatment.

Preventive (Class 1 services)

- **Diagnostic** Routine or comprehensive examinations or consultations covered twice per year. Supplementary bitewing x-rays are covered once per year. Complete series x-rays or a panoramic film are covered once in any 5-year period.
- **Preventive** Prophylaxis (cleaning) or periodontal maintenance is covered twice per year. Additional periodontal maintenance is covered for members with periodontal disease, up to a total of 2 additional periodontal maintenances per year. Topical application of fluoride is covered twice per year for members until age 19. For members age 19 and older, topical application of fluoride is covered twice per year if there is a recent history of periodontal surgery or high risk of decay due to medical disease or chemotherapy or similar type of treatment. Sealant benefits are limited to the unrestored, occlusal surfaces of permanent molars. Benefits will be limited to one sealant, per tooth, during any 5-year period except for evidence of clinical failure.

Basic (Class 2-A services)

- **Oral Surgery** Limited to extractions and other minor surgical procedures.
- **Restorative** Amalgam and composite fillings are covered for all teeth. A separate charge for general anesthesia and/or IV sedation is not covered when used for non-surgical procedures.
- **Periodontic** Scaling and root planing is limited to once per quadrant in any 2-year period.

Major (Class 2-B & Class 3 services)

- **Implants** and implant removal are limited to once per lifetime per tooth space. A crown over an implant is covered once per lifetime of the implant.
- **Restorative** Cast restorations (including pontics) are covered once in a seven (7) year period on any tooth.
- **Prosthodontic** A bridge or denture (full or partial, including alternate benefits) will be covered once in a seven (7) year period only if the tooth, tooth site, or teeth involved have not received a cast restoration benefit in the past seven (7) years. Specialized or personalized prosthetics are limited to the cost of standard devices.
- **Occlusal Guard** (night guard) covered at 100% once in a five year period, up to $150 maximum. Over-the-counter night guards are excluded.
- **Athletic mouth guard** covered at 50%, once in any 12-month period for members age 15 and under and once in any 24-month period age 16 and over. Over-the-counter athletic mouth guards are excluded.

Exclusions

- Services covered under worker's compensation or employer's liability laws and services covered by any federal, state, county, municipality or other governmental agency, except Medicaid.
- Services with respect to congenital (hereditary) or developmental (following birth) malformations or cosmetic reasons; including, but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis and disturbance of the temporomandibular joint.
- Services for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth except for occlusal guards.
- Services started prior to the date the individual became eligible for services under the program.
- Hypnosis, prescribed drugs, premedications or analgesia (e.g. nitrous oxide) or any other euphoric drugs.
- Hospital costs or any additional fees charged by the dentist because the patient is hospitalized.
- General anesthesia and/or IV sedation except when administered by a dentist in conjunction with covered oral surgery in his or her office.
- Plaque control and oral hygiene or dietary instructions.
- Experimental procedures.
- Missed or broken appointments.
- Precision attachments.
- Services for cosmetic reasons.
- Claims submitted more than 12 months after the date of service are not covered.
- All other services or supplies, not specifically covered.

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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 R125

1/1/2022 - 12/31/2022

Metro

Group Number: 1543-044

Benefit Maximum per Calendar Year	None
	You pay
Dental Office Visit Charge – Per visit	$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 (Not subject to or counted toward the Deductible)	
Oral exam	$0
X-rays	$0
Teeth cleaning	$0
Fluoride	$0
Minor Restoration Services	
Routine fillings	$0
Plastic and steel crowns	$0
Simple extractions	$0
Oral Surgery Services	
Surgical tooth extractions	20% Coinsurance
Periodontics	
Treatment of gum disease	20% Coinsurance
Scaling and root planing	20% Coinsurance
Endodontics	
Root canal therapy	20% Coinsurance
Major Restoration Services	
Gold or porcelain crowns	20% Coinsurance
Bridges	20% Coinsurance
Removable Prosthetic Services	
Full upper and lower dentures	20% Coinsurance
Partial dentures	20% Coinsurance
Relines	20% Coinsurance
Rebases	20% Coinsurance
Nitrous oxide (Not subject to or counted toward the Deductible or Benefit Maximum)	
Adults and children age 13 years and older	$25
Children age 12 years and younger	$0

Orthodontics	Members age 17 years and younger: 50% of Charges up to Lifetime Benefit Maximum of $1,000, and 100% of Charges thereafter. Members age 18 years and older: No Coverage.

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.