Kaiser Foundation Health Plan, Inc. – Hawaii
Kaiser Permanente – Small Group Dental 2995 (Bundled Dental)

This rider is included in the *Benefit Summary* in the front of the *Guide to Your Health Plan* (Guide). The provisions of this Guide and the Evidence of Coverage (EOC) apply to this rider.

For Senior Advantage members, this rider is included in the Medical Benefits Chart in the front of the *Evidence of Coverage* (EOC).

The following amends part of *Chapter 4: Services Not Covered:*

Dental Care: You are not covered for dental care Services, except as described in this rider.

All benefits are governed by the provisions of Kaiser Foundation Health Plan, Inc.'s (Kaiser) Agreement with Hawaii Dental Service (herein referred to as "HDS") and HDS's procedure code guidelines. If there are inconsistencies, then the agreement between Kaiser and HDS shall govern. All dental claims must be filed within 12 months of the date of service for HDS claims payment.

A description of the HDS dental benefits covered under the "Kaiser Permanente Small Group Dental: HDS Group Number 2995" stand-alone dental plan was provided to Kaiser Permanente directly from HDS and is on the following page *"Summary of Dental Benefits"*.

DELTA DENTAL

HDS
Hawaii Dental Service

Summary of Dental Benefits
Kaiser Small Group Plan - Group No. 2995
Effective: 01/01/2021

This summary is a brief description of a Hawaii Dental Service (HDS) member's dental benefits. Some limitations, restrictions, and exclusions may apply. Plan benefits are governed by the provisions detailed in the group's and/or subscriber's agreement with HDS, HDS's Procedure Code Guidelines and Delta Dental National Policies when applicable. Certain provisions may vary across group agreements such as waiting periods, frequency and age limitations, etc. and may not be included in this summary. For additional information, please contact HDS Customer Service. As an HDS member, you may visit any licensed dentist, but your out-of-pocket costs may be lower when visiting an HDS participating dentist. All dental claims must be filed within 12 months of the date of service to be eligible for HDS claims payment.

Small Group Over 18	Small Group 18 and Under
PLAN MAXIMUM $1200 per person per calendar year. The most HDS will pay for each person for all covered dental services performed during the calendar year.	**MAXIMUM OUT OF POCKET (MOOP)** $350 per child or $700 for 2 or more children, per calendar year. The most you will pay before your dental plan begins to pay 100% of your benefit. Out-of-pocket payments made for non-covered services, alternate benefits and non-medically necessary orthodontics will not count toward the MOOP.

	HDS PLAN PAYS	
DIAGNOSTIC	Small Group 18 and Under	Small Group Over 18
Examinations	**100%** 2x/yr	**100%** 2x/yr
Bitewing X-rays	**100%** 2x/yr	**100%** 1x/yr
Other X-rays	**70%** Full mouth X-rays 1x/5 yrs	**70%** Full mouth X-rays 1x/5 yrs
PREVENTIVE		
Cleanings	**100%** 2x/yr	**100%** 2x/yr
Fluoride	**100%** 2x/yr Through age 18	**Not Covered** N/A
Silver Diamine Fluoride	**100%**	**100%**
Space Maintainers	**100%** Through age 18	**Not Covered**
Sealants One treatment per tooth per lifetime to permanent molar teeth when there are no prior fillings on biting surfaces.	**100%** Through age 18	**Not Covered**
TOTAL HEALTH PLUS BENEFITS		
If the member has multiple conditions, they will only be eligible for the benefit with the most cleaning(s) and/or gum maintenance treatments of a single condition. All benefits are covered at 100% unless otherwise noted.		
Diabetes • Cleanings/Gum Maintenance	Additional 2x/yr	Additional 2x/yr
Cancer (other than Oral) • Cleanings/Gum Maintenance • Fluoride Treatments	Additional 2x/yr Additional 2x/yr	Additional 2x/yr Additional 2x/yr

Oral Cancer • Cleanings/Gum Maintenance • Fluoride Treatments	 Additional 2x/yr Additional 4x/yr	 Additional 2x/yr Additional 4x/yr
Sjogren's Syndrome • Cleanings/Gum Maintenance • Fluoride Treatments	 Additional 2x/yr Additional 4x/yr	 Additional 2x/yr Additional 4x/yr
Stroke • Cleanings/Gum Maintenance	 Additional 2x/yr	 Additional 2x/yr
Heart Attack, Congestive Heart Failure • Cleanings/Gum Maintenance	 Additional 2x/yr	 Additional 2x/yr
Kidney Failure • Cleanings/Gum Maintenance	 Additional 2x/yr	 Additional 2x/yr
Organ Transplant • Cleanings/Gum Maintenance	 Additional 2x/yr	 Additional 2x/yr
Pregnancy (Expectant Mothers) • Cleanings/Gum Maintenance	 Additional 1x/yr	 Additional 1x/yr
Medical Risk for Cavities • Fluoride Treatments	 Additional 3x/yr	 Additional 3x/yr
BASIC CARE		
Fillings Once every two years per tooth per surface.	**70%** White-colored fillings limited to front teeth.	**70%** White-colored fillings limited to front teeth.
Root Canals	**70%**	**70%**
Gum/Bone Surgeries & Maintenance (non-medical risk factors) Once every three years per quad.	**70%**	**70%**
Oral Surgeries	**70%**	**70%**
MAJOR CARE		
Crowns	**50%** 1x/7yrs per tooth White crowns limited to front teeth and bicuspids.	**50%** 1x/7yrs per tooth White crowns limited to front teeth and bicuspids.
Fixed Bridges & Dentures	**50%** 1x/7yrs per tooth	**50%** 1x/7yrs per tooth
Implants	**Not Covered**	**50%**
OTHER SERVICES		
Adjunctive General Services	**70%**	**70%**
Emergency Treatment of Dental Pain (Palliative Treatment) Once per visit per dental office for relief of pain but not to cure	**70%** Nitrous Oxide, IV sedation and hospital care is covered.	**70%**
Athletic Mouth Guards	**70%** 1x/24-months Through age 18	**70%** 1x/24-months Through age 18

ORTHODONTICS		
	50% For children. $1000 lifetime maximum amount paid (eight quarterly payments)	**50%** For children. $1000 lifetime maximum amount paid (eight quarterly payments)
Medically Necessary Ortho Limited to dependent children for those cases involving repair of the cleft lip and/or cleft palate, severe facial birth defects, or an incurred injury that affects the function of speech, swallowing, and/or chewing.	**50%** Through age 18	**Not Covered**

Small Group 18 and Under - Special Consideration: Assessment of salivary flow is covered. Orthodontic services are not covered if services were started prior to the date the patient became eligible under this employer's plan. If a patient's eligibility ends prior to the completion of the orthodontic treatment, payments will not continue. If your employer elects to remove the orthodontic benefit, coverage will end on the last day of the month that the change occurred. Self-administered or at-home applications (or any type of "do it yourself") orthodontics is not a covered benefit. Orthodontics must be performed by a licensed dentist or supervised staff.

Small Group Over 18 - Special Consideration: Assessment of salivary flow is covered. Orthodontic services are not covered if services were started prior to the date the patient became eligible under this employer's plan. If a patient's eligibility ends prior to the completion of the orthodontic treatment, payments will not continue. If your employer elects to remove the orthodontic benefit, coverage will end on the last day of the month that the change occurred. Self-administered or at-home applications (or any type of "do it yourself") orthodontics is not a covered benefit. Orthodontics must be performed by a licensed dentist or supervised staff.