

# 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

Washington Voluntary Deductible PPO 3

1/1/2025 - 12/31/2025

|                                                                                                                                                                                                                          | In-network benefit<br>(reimbursement is based on MAC) * | Out-of-network benefit<br>(reimbursement is based on UCC) * |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|-------------------------------------------------------------|
| <b>Benefit Maximum</b> per Calendar Year (Covered Services that are subject to either Benefit Maximum and that are received in the same Year will count toward both the in-network and out-of-network Benefit Maximums.) |                                                         |                                                             |
| Per Member per Year                                                                                                                                                                                                      | \$1,500                                                 | \$1,500                                                     |
| <b>You pay</b>                                                                                                                                                                                                           |                                                         |                                                             |
| <b>Deductible</b> (Per Calendar Year; applies to all services unless otherwise indicated)                                                                                                                                |                                                         |                                                             |
| For one Member                                                                                                                                                                                                           | \$25 / \$50 / \$75 / \$100                              |                                                             |
| For an entire Family                                                                                                                                                                                                     | \$75 / \$150 / \$225 / \$300                            |                                                             |
| <b>Preventive and Diagnostic Services</b> (Not subject to or counted toward the Deductible)                                                                                                                              |                                                         |                                                             |
| Oral exam                                                                                                                                                                                                                | \$0                                                     | \$0                                                         |
| X-rays                                                                                                                                                                                                                   | \$0                                                     | \$0                                                         |
| Teeth cleaning                                                                                                                                                                                                           | \$0                                                     | \$0                                                         |
| Fluoride                                                                                                                                                                                                                 | \$0                                                     | \$0                                                         |
| <b>Minor Restoration Services</b>                                                                                                                                                                                        |                                                         |                                                             |
| Routine fillings                                                                                                                                                                                                         | 20% Coinsurance after Deductible                        | 20% Coinsurance after Deductible                            |
| Plastic and steel crowns                                                                                                                                                                                                 | 20% Coinsurance after Deductible                        | 20% Coinsurance after Deductible                            |
| Simple extractions                                                                                                                                                                                                       | 20% Coinsurance after Deductible                        | 20% Coinsurance after Deductible                            |
| <b>Oral Surgery Services</b>                                                                                                                                                                                             |                                                         |                                                             |
| Surgical tooth extractions                                                                                                                                                                                               | 20% Coinsurance after Deductible                        | 20% Coinsurance after Deductible                            |
| <b>Periodontics</b>                                                                                                                                                                                                      |                                                         |                                                             |
| Treatment of gum disease                                                                                                                                                                                                 | 20% Coinsurance after Deductible                        | 20% Coinsurance after Deductible                            |
| Scaling and root planing                                                                                                                                                                                                 | 20% Coinsurance after Deductible                        | 20% Coinsurance after Deductible                            |
| <b>Endodontics</b>                                                                                                                                                                                                       |                                                         |                                                             |
| Root canal therapy                                                                                                                                                                                                       | 20% Coinsurance after Deductible                        | 20% Coinsurance after Deductible                            |
| <b>Major Restoration Services</b>                                                                                                                                                                                        |                                                         |                                                             |
| Gold or porcelain crowns                                                                                                                                                                                                 | 50% Coinsurance after Deductible                        | 50% Coinsurance after Deductible                            |
| Bridges                                                                                                                                                                                                                  | 50% Coinsurance after Deductible                        | 50% Coinsurance after Deductible                            |

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**Removable Prosthetic Services**

|                           |                                  |                                  |
|---------------------------|----------------------------------|----------------------------------|
| Full and partial dentures | 50% Coinsurance after Deductible | 50% Coinsurance after Deductible |
| Relines                   | 50% Coinsurance after Deductible | 50% Coinsurance after Deductible |
| Rebases                   | 50% Coinsurance after Deductible | 50% Coinsurance after Deductible |

**Nitrous oxide** (Not subject to or counted toward the Deductible or Benefit Maximum)

|                                            |      |      |
|--------------------------------------------|------|------|
| Adults and children age 13 years and older | \$25 | \$25 |
| Children age 12 years and younger          | \$25 | \$25 |

**Teledentistry**

|                            |     |     |
|----------------------------|-----|-----|
| Telephone and video visits | \$0 | \$0 |
|----------------------------|-----|-----|

**Orthodontics**

|  |                              |  |
|--|------------------------------|--|
|  | Rider Available for Purchase |  |
|--|------------------------------|--|

**Implants**

|  |                              |  |
|--|------------------------------|--|
|  | Rider Available for Purchase |  |
|--|------------------------------|--|

\* "UCC" means Usual and Customary Charge. "MAC" means Maximum Allowable Charge. For the Services that are subject to a Benefit Maximum, it is your responsibility to pay the full amount of any Charges (MAC) or Usual and Customary Charges (UCC) incurred above the applicable Benefit Maximum.

Your dentist must submit a request for prior authorization for any procedure over \$500. 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, or you may go to [kp.org/plandocuments](https://kp.org/plandocuments).

Visit: [kp.org/dental/nw/ppo](https://kp.org/dental/nw/ppo) for a searchable provider directory.

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**Questions? Call Customer Service** at 1-866-653-0338 (M-F, 8 am-6 pm) or visit **kp.org**. TTY, all areas: 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.