

# Summary of Dental Benefits

**KP WA Adult Traditional - \$1000/\$100 Ded + Ortho**

**2025 Contract**

Dental Services are only covered for Members age 19 years and older.

You pay	
<b>Benefit Maximum</b>	
Per Member per Year	\$1,000
<b>Deductible</b>	
For one Member per Year	\$100
For an entire Family per Year	\$300
<b>Dental Office Visit</b>	\$10 plus any Cost Share shown below for specific Services
<b>Preventive and Diagnostic Services</b> (Not subject to or counted toward the Deductible or Benefit Maximum)	
Oral exam, including evaluations and diagnostic exams	\$0
X-rays	\$0
Teeth cleaning	\$0
Fluoride treatments	\$0
Space maintainers	\$0
<b>Minor Restoration Services</b>	
Routine fillings	20% Coinsurance after Deductible
Simple extractions	20% Coinsurance after Deductible
Restorations (composite / acrylic and steel)	20% Coinsurance after Deductible
<b>Oral Surgery Services</b>	
Major oral surgery	50% Coinsurance after Deductible
Surgical tooth extractions	50% Coinsurance after Deductible
<b>Periodontics</b>	
Scaling and root planing	50% Coinsurance after Deductible
Periodontal surgery	50% Coinsurance after Deductible
Treatment of gum disease	50% Coinsurance after Deductible
<b>Endodontics</b> (Root canal and related therapy)	
Anterior tooth	50% Coinsurance after Deductible
Bicuspid tooth	50% Coinsurance after Deductible
Molar tooth	50% Coinsurance after Deductible
<b>Major Restoration Services</b>	
Bridges abutments	50% Coinsurance after Deductible
Noble metal gold or porcelain crowns	50% Coinsurance after Deductible
Inlays & Pontics	50% Coinsurance after Deductible

**You pay****Removable Prosthetic Services**

Full upper and lower dentures	50% Coinsurance after Deductible
Partial dentures	50% Coinsurance after Deductible
Rebases	50% Coinsurance after Deductible
Relines	50% Coinsurance after Deductible

**Emergency Dental Care**

From Participating Providers	The Cost Share that normally applies for nonemergency dental care Services
From Non-Participating Providers outside the Service Area (coverage is limited to \$100 per incident)	All Charges over \$100

**Other Dental Services** (not subject to or counted toward the Deductible or Benefit Maximum)

Nightguards (limit one every five years)	35% Coinsurance
Nitrous oxide	\$25

**Dental Implant Services**

<b>Orthodontic Services</b> (Orthodontic treatment for abnormally aligned or positioned teeth)	Not covered
	All Members: 50% of Charges up to the \$1,500 Lifetime Benefit Maximum, and 100% of Charges thereafter.

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).

**Questions? Call Member Services** (M-F, 8 am-6 pm) or visit [kp.org](https://kp.org) All areas: 1-800-813-2000. 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.