

# Summary of Dental Benefits

**KP WA Adult Traditional - \$1500**

**2025 Contract**

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

| You pay                                                                                                        |                                                            |
|----------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|
| <b>Benefit Maximum</b>                                                                                         |                                                            |
| Per Member per Year                                                                                            | \$1,500                                                    |
| <b>Deductible</b>                                                                                              |                                                            |
| For one Member per Year                                                                                        | \$0                                                        |
| For an entire Family per Year                                                                                  | \$0                                                        |
| <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                                            |
| Simple extractions                                                                                             | 20% Coinsurance                                            |
| Restorations (composite / acrylic and steel)                                                                   | 20% Coinsurance                                            |
| <b>Oral Surgery Services</b>                                                                                   |                                                            |
| Major oral surgery                                                                                             | 20% Coinsurance                                            |
| Surgical tooth extractions                                                                                     | 20% Coinsurance                                            |
| <b>Periodontics</b>                                                                                            |                                                            |
| Scaling and root planing                                                                                       | 20% Coinsurance                                            |
| Periodontal surgery                                                                                            | 20% Coinsurance                                            |
| Treatment of gum disease                                                                                       | 20% Coinsurance                                            |
| <b>Endodontics</b> (Root canal and related therapy)                                                            |                                                            |
| Anterior tooth                                                                                                 | 20% Coinsurance                                            |
| Bicuspid tooth                                                                                                 | 20% Coinsurance                                            |
| Molar tooth                                                                                                    | 20% Coinsurance                                            |
| <b>Major Restoration Services</b>                                                                              |                                                            |
| Bridges abutments                                                                                              | 50% Coinsurance                                            |
| Noble metal gold or porcelain crowns                                                                           | 50% Coinsurance                                            |
| Inlays & Pontics                                                                                               | 50% Coinsurance                                            |

**You pay**

**Removable Prosthetic Services**

|                               |                 |
|-------------------------------|-----------------|
| Full upper and lower dentures | 50% Coinsurance |
| Partial dentures              | 50% Coinsurance |
| Rebases                       | 50% Coinsurance |
| Relines                       | 50% Coinsurance |

**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 |
|------------------------------------------------------------------------------------------------|-------------|

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.