All plans offered and underwritten by Kaiser Foundation Health Plan of the Northwest. 500 NE Multnomah St., Suite 100, Portland, OR 97232

Summary of Dental Benefits

KP WA Adult Traditional - $2000/$50 Ded - Voluntary

2025 Contract

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

	You pay
Benefit Maximum	
Per Member per Year	$2,000
Deductible	
For one Member per Year	$50
For an entire Family per Year	$150
Dental Office Visit	$10 plus any Cost Share shown below for specific Services
Preventive and Diagnostic Services (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
Minor Restoration Services	
Routine fillings	20% Coinsurance after Deductible
Simple extractions	20% Coinsurance after Deductible
Restorations (composite / acrylic and steel)	20% Coinsurance after Deductible
Oral Surgery Services	
Major oral surgery	20% Coinsurance after Deductible
Surgical tooth extractions	20% Coinsurance after Deductible
Periodontics	
Scaling and root planing	20% Coinsurance after Deductible
Periodontal surgery	20% Coinsurance after Deductible
Treatment of gum disease	20% Coinsurance after Deductible
Endodontics (Root canal and related therapy)	
Anterior tooth	20% Coinsurance after Deductible
Bicuspid tooth	20% Coinsurance after Deductible
Molar tooth	20% Coinsurance after Deductible
Major Restoration Services	
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	Not covered
Orthodontic Services (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**.

Questions? Call Member Services (M-F, 8 am-6 pm) or visit **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.

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