

# Summary of Dental Benefits

**KP OR Family Choice - \$1000/\$50 Ded**

**2025 Contract**

|                                                                                                                                        | In-network benefit<br>(reimbursement is based<br>on MAC) * | Out-of-network benefit<br>(reimbursement is based<br>on 90%UCC) * |
|----------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|-------------------------------------------------------------------|
| <b>You pay</b>                                                                                                                         |                                                            |                                                                   |
| <b>Benefit Maximum</b> (Applies to covered Services you receive on or after the first day of the month after you turn 19 years of age) |                                                            |                                                                   |
| Per Member per Year                                                                                                                    | \$1,000                                                    | \$1,000                                                           |
| <b>Deductible</b>                                                                                                                      |                                                            |                                                                   |
| For one Member per Year                                                                                                                | \$50                                                       |                                                                   |
| For an entire Family per Year                                                                                                          | \$150                                                      |                                                                   |
| <b>Out-of-Pocket Maximum</b> (Applies to covered Services you receive until the end of the month in which you turn 19 years of age)    |                                                            |                                                                   |
| For one Member per Year                                                                                                                | \$425                                                      | None                                                              |
| For an entire Family per Year                                                                                                          | \$850                                                      | None                                                              |
| <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                                                        | \$0                                                               |
| Fluoride treatment                                                                                                                     | \$0                                                        | \$0                                                               |
| Teeth cleaning                                                                                                                         | \$0                                                        | \$0                                                               |
| Sealants                                                                                                                               | \$0                                                        | \$0                                                               |
| Space maintainers                                                                                                                      | \$0                                                        | \$0                                                               |
| X-rays                                                                                                                                 | \$0                                                        | \$0                                                               |
| <b>Minor Restoration Services</b>                                                                                                      |                                                            |                                                                   |
| Routine fillings                                                                                                                       | 20% Coinsurance after Deductible                           | 20% Coinsurance after Deductible                                  |
| Simple extractions                                                                                                                     | 20% Coinsurance after Deductible                           | 20% Coinsurance after Deductible                                  |
| Restorations (composite / acrylic and steel)                                                                                           | 20% Coinsurance after Deductible                           | 20% Coinsurance after Deductible                                  |
| <b>Oral Surgery Services</b>                                                                                                           |                                                            |                                                                   |
| Major oral surgery                                                                                                                     | 20% Coinsurance after Deductible                           | 20% Coinsurance after Deductible                                  |
| Surgical tooth extractions                                                                                                             | 20% Coinsurance after Deductible                           | 20% Coinsurance after Deductible                                  |
| <b>Periodontics</b>                                                                                                                    |                                                            |                                                                   |
| Scaling and root planing                                                                                                               | 20% Coinsurance after Deductible                           | 20% Coinsurance after Deductible                                  |
| Periodontal surgery                                                                                                                    | 20% Coinsurance after Deductible                           | 20% Coinsurance after Deductible                                  |
| Treatment of gum disease                                                                                                               | 20% Coinsurance after Deductible                           | 20% Coinsurance after Deductible                                  |

|                                                                                                                                                       | In-network benefit<br>(reimbursement is based<br>on MAC) *                  | Out-of-network benefit<br>(reimbursement is based<br>on 90%UCC) * |
|-------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|-------------------------------------------------------------------|
| You pay                                                                                                                                               |                                                                             |                                                                   |
| Endodontics                                                                                                                                           |                                                                             |                                                                   |
| Root canal and related therapy                                                                                                                        | 20% Coinsurance after<br>Deductible                                         | 20% Coinsurance after<br>Deductible                               |
| Major Restoration Services                                                                                                                            |                                                                             |                                                                   |
| Bridges abutments                                                                                                                                     | 50% Coinsurance after<br>Deductible                                         | 50% Coinsurance after<br>Deductible                               |
| Noble metal gold or porcelain crowns                                                                                                                  | 50% Coinsurance after<br>Deductible                                         | 50% Coinsurance after<br>Deductible                               |
| Inlays & Pontics                                                                                                                                      | 50% Coinsurance after<br>Deductible                                         | 50% Coinsurance after<br>Deductible                               |
| Removable Prosthetic Services                                                                                                                         |                                                                             |                                                                   |
| Full upper and lower dentures                                                                                                                         | 50% Coinsurance after<br>Deductible                                         | 50% Coinsurance after<br>Deductible                               |
| Partial dentures                                                                                                                                      | 50% Coinsurance after<br>Deductible                                         | 50% Coinsurance after<br>Deductible                               |
| Rebases                                                                                                                                               | 50% Coinsurance after<br>Deductible                                         | 50% Coinsurance after<br>Deductible                               |
| Relines                                                                                                                                               | 50% Coinsurance after<br>Deductible                                         | 50% Coinsurance after<br>Deductible                               |
| Emergency Dental Care or Urgent Dental Care                                                                                                           | The Cost Share that normally applies for non-emergency dental care Services |                                                                   |
| Other Dental Services (Not subject to or counted toward the Deductible or Benefit Maximum)                                                            |                                                                             |                                                                   |
| Nightguards (limit one every five years)                                                                                                              | 35% Coinsurance                                                             | 35% Coinsurance                                                   |
| Nitrous oxide                                                                                                                                         |                                                                             |                                                                   |
| Members age 13 years and older                                                                                                                        | \$25                                                                        | \$25                                                              |
| Members age 12 years and younger                                                                                                                      | \$0                                                                         | \$0                                                               |
| Teledentistry Services - Telephone and video visits                                                                                                   | \$0                                                                         | \$0                                                               |
| Medically Necessary orthodontics (diagnosis of cleft palate/lip)<br>(Covered until the end of the month in which the Member turns 19<br>years of age) | 50% Coinsurance after<br>Deductible                                         | 50% Coinsurance after<br>Deductible                               |
| Orthodontics (Orthodontic treatment for abnormally aligned or<br>positioned teeth)                                                                    | Not covered                                                                 |                                                                   |
| Dental Implant Services (for Members age 19 years and older)                                                                                          | Not covered                                                                 |                                                                   |

\* "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.

**Questions? Call Customer Service** at 1-866-653-0338 (M-F, 7 am-7 pm) or visit [kp.org](https://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.