

# Summary of Dental Benefits

**KP OR Family Traditional - \$3000/\$100 Ded + Ortho**

**2025 Contract**

| You pay                                                                                                                                |                                                                       |
|----------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|
| <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                                                                                                                    | \$3,000                                                               |
| <b>Deductible</b>                                                                                                                      |                                                                       |
| For one Member per Year                                                                                                                | \$100                                                                 |
| For an entire Family per Year                                                                                                          | \$300                                                                 |
| <b>Out-of-Pocket Maximum</b> (Applies to covered Services you receive until the end of the month which you turn 19 years of age)       |                                                                       |
| For one Member per Year                                                                                                                | \$425                                                                 |
| For two or more members per Year                                                                                                       | \$850                                                                 |
| <b>Dental Office Visit</b>                                                                                                             | \$10 per visit, 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                                                                   |
| Fluoride treatments                                                                                                                    | \$0                                                                   |
| Teeth cleaning                                                                                                                         | \$0                                                                   |
| Sealants                                                                                                                               | \$0                                                                   |
| Space maintainers                                                                                                                      | \$0                                                                   |
| X-rays                                                                                                                                 | \$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                                                                                                                     | 20% Coinsurance after Deductible                                      |
| Surgical tooth extractions                                                                                                             | 20% Coinsurance after Deductible                                      |
| <b>Periodontics</b>                                                                                                                    |                                                                       |
| Scaling and root planing                                                                                                               | 20% Coinsurance after Deductible                                      |
| Periodontal surgery                                                                                                                    | 20% Coinsurance after Deductible                                      |
| Treatment of gum disease                                                                                                               | 20% Coinsurance after Deductible                                      |
| <b>Endodontics</b> (Root canal and related therapy)                                                                                    |                                                                       |
| Anterior tooth                                                                                                                         | 20% Coinsurance after Deductible                                      |
| Bicuspid tooth                                                                                                                         | 20% Coinsurance after Deductible                                      |
| Molar tooth                                                                                                                            | 20% Coinsurance after Deductible                                      |

| You pay                                                                                                                                                |                                                                                                         |
|--------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|
| <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                                                                        |
| <b>Removable Prosthetic Services</b>                                                                                                                   |                                                                                                         |
| 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                                                                        |
| <b>Emergency Dental Care</b>                                                                                                                           |                                                                                                         |
| 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                                                                                  |
| <b>Other Dental Services</b> (Not subject to or counted toward the Deductible or Benefit Maximum)                                                      |                                                                                                         |
| Nightguards (limit one every five years)                                                                                                               | 35% Coinsurance                                                                                         |
| Nitrous oxide                                                                                                                                          |                                                                                                         |
| Members age 13 years and older                                                                                                                         | \$25                                                                                                    |
| Members age 12 years and younger                                                                                                                       | \$0                                                                                                     |
| <b>Teledentistry Services</b> - Telephone and video visits                                                                                             | \$0                                                                                                     |
| <b>Medically Necessary orthodontics</b> (diagnosis of cleft palate/lip) (Covered until the end of the month in which the Member turns 19 years of age) | 50% Coinsurance after Deductible                                                                        |
| <b>Orthodontics</b> (Orthodontic treatment for abnormally aligned or positioned teeth)                                                                 | All Members: 50% of Charges up to the \$1,500 Lifetime Benefit Maximum, and 100% of Charges thereafter. |
| <b>Dental Implant Services</b> (for Members age 19 years and older)                                                                                    | 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.