

# Summary of Dental Benefits

**KP OR Family Traditional - \$1500/\$100 Ded**

**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	\$1,500
<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)	Not covered
<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.