KAISER PERMANENTE®

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 OR Family Choice - $2500/$100 Ded + Ortho + Implants

2027 Contract

Benefit maximum (applies to covered services you receive on or after the first day of the month after you turn 19 years of age)	**In-network benefit (reimbursement is based on MAC)***	**Out-of-network benefit (reimbursement is based on 90% UCC)***
Per member per year	$2,500	$2,500

Deductible	**In-network benefit (reimbursement is based on MAC)***	**Out-of-network benefit (reimbursement is based on 90% UCC)***
For one member per year	$100	$100
For an entire family per year	$300	$300

Out-of-pocket maximum (applies to covered services you receive until the end of the month in which you turn 19 years of age)	**In-network benefit (reimbursement is based on MAC)***	**Out-of-network benefit (reimbursement is based on 90% UCC)***
For one member per year	$450	None
For an entire family per year	$900	None

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Dental care	In-network benefit (reimbursement is based on MAC)* You Pay	Out-of-network benefit (reimbursement is based on 90% UCC)* You Pay
Preventive and diagnostic services (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
Minor restoration services		
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
Oral surgery services		
Major oral surgery	20% coinsurance after deductible	20% coinsurance after deductible
Surgical tooth extractions	20% coinsurance after deductible	20% coinsurance after deductible
Periodontics		
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
Endodontics		
Root canal and related therapy	20% coinsurance after deductible	20% coinsurance after deductible
Major restoration services		
Bridges abutments	50% coinsurance after deductible	50% coinsurance after deductible
Gold or porcelain crowns	50% coinsurance after deductible	50% coinsurance after deductible
Inlays & pontics	50% coinsurance after deductible	50% coinsurance after deductible
Removable prosthetic services		
Full upper and lower dentures	50% coinsurance after deductible	50% coinsurance after deductible
Partial dentures	50% coinsurance after deductible	50% coinsurance after deductible
Rebases	50% coinsurance after deductible	50% coinsurance after deductible
Relines	50% coinsurance after deductible	50% coinsurance after deductible

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Dental care	In-network benefit (reimbursement is based on MAC)* You Pay	Out-of-network benefit (reimbursement is based on 90% UCC)* You Pay
Emergency dental care or urgent dental care	The cost share that normally applies for non-emergency dental care services	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	35% coinsurance	35% coinsurance
Nitrous oxide	$25	$25
Teledentistry services – telephone and video visits	$0	$0
Medically necessary orthodontics (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	50% coinsurance after deductible
Orthodontics (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	All Members: 50% of Charges up to the $1,500 Lifetime Benefit Maximum, and 100% of Charges thereafter
Dental implant services (for members age 19 years and older)	50% coinsurance after deductible up to the Benefit Maximum and 100% of charges thereafter.	50% coinsurance after deductible up to the Benefit Maximum and 100% of charges thereafter.

* “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**.

Visit **kp.org/dental/nw/ppo** for a searchable provider directory.

Questions? Call customer service at **1-866-653-0338** (Monday through Friday, 7 a.m. to 7 p.m.) or visit **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.

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Nondiscrimination notice

Kaiser Foundation Health Plan of the Northwest (Kaiser Health Plan) complies with applicable federal and state civil rights laws and does not discriminate, exclude people or treat them differently on the basis of race, color, national origin (including limited English proficiency), age, disability, or sex (including sex characteristics, intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes).

Kaiser Health Plan:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats, such as large print, audio, braille, and accessible electronic formats
- Provides no cost language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call Member Services at **1-800-813-2000** (TTY: **711**).
If you believe that Kaiser Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation, you can file a grievance with our Civil Rights Coordinator, by mail, phone, or fax. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You may contact our Civil Rights Coordinator at:

Member Relations Department
Attention: Kaiser Civil Rights Coordinator
500 NE Multnomah St., Suite 100
Portland, OR 97232-2099
Fax: **1-855-347-7239**

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, DC 20201
Phone: **1-800-368-1019**
TDD: **1-800-537-7697**

Complaint forms are available at **www.hhs.gov/ocr/office/file/index.html**.

For Washington Members:
You can also file a complaint with the Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint portal, available at **https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status**, or by phone at **1-800-562-6900**, or **360-586-0241** (TDD). Complaint forms are available at **https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx**.

This notice is available at https://healthy.kaiserpermanente.org/oregon-washington/language-assistance/nondiscrimination-notice

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Help in Your Language

ATTENTION: If you speak English, language assistance services including appropriate auxiliary aids and services, free of charge, are available to you. Call **1-800-813-2000** (TTY: **711**).

አማርኛ (Amharic) ትኩረት: አማርኛ የሚናገሩ ከሆነ ተገቢ የሆኑ ረዳት መርጃዎችን እና አገልግሎቶችን ጨምሮ የቋንቋ እርዳታ አገልግሎቶች በነጻ ይገኛሉ። በ **1-800-813-2000** ይደውሉ (TTY: **711**)።

العربية(Arabic) تنبيه: إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية بما في ذلك من وسائل المساعدة والخدمات المناسبة بالمجان. اتصل بالرقم **1-800-813-2000** (TTY: **711**).

中文 (Chinese) 注意事項：如果您說中文，您可獲得免費語言協助服務，包括適當的輔助器材和服務。致電**1-800-813-2000**（TTY：**711**）。

فارسی(Farsi) توجه: اگر به زبان فارسی صحبت می‌کنید، «تسهیلات زبانی»، از جمله کمک‌ها و خدمات پشتیبانی مناسب، به صورت رایگان در دسترس‌تان است با**1-800-813-2000** (TTY (تلفن متنی): **711**) تماس بگیرید.

Français (French) ATTENTION : si vous parlez français, des services d'assistance linguistique comprenant des aides et services auxiliaires appropriés, gratuits, sont à votre disposition. Appelez le **1-800-813-2000** (TTY: **711**).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen die Sprachassistenz mit entsprechenden Hilfsmitteln und Dienstleistungen kostenfrei zur Verfügung. Rufen Sie **1-800-813-2000** an (TTY: **711**).

日本語 (Japanese) 注意：日本語を話す場合、適切な補助機器やサービスを含む言語支援サービスが無料で提供されます。**1-800-813-2000**までお電話ください（TTY: **711**）。

ខ្មែរ (Khmer) យកចិត្តទុកដាក់៖ បើអ្នកនិយាយខ្មែរ សេវាជំនួយភាសា រួមទាំងជំនួយនិងសេវាសម្រួលដោយឥតគិតថ្លៃ មានចំពោះអ្នក។ ហៅ **1-800-813-2000** (TTY: **711**).

한국어 (Korean) 주의: 한국어를 구사하실 경우, 필요한 보조 기기 및 서비스가 포함된 언어 지원 서비스가 무료로 제공됩니다. **1-800-813-2000**로 전화해 주세요(TTY: **711**).

ລາວ (Laotian) ເອົາໃຈໃສ່: ຖ້າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ລວມທັ້ງອຸປະກອນ ແລະ ການບໍລິການຊ່ວຍເຫຼືອທີ່ເໝາະສົມ ຈະມີໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ. ໂທ **1-800-813-2000** (TTY: **711**).

Afaan Oromoo (Oromo) XIYYEEFFANNOO: Yoo Afaan Oromo dubbattu ta'e, Tajaajila gargaarsa afaanii, gargaarsota dabalataa fi tajaajiloota barbaachisoo kaffaltii irraa bilisa ta'an, isiniif ni jira. **1-800-813-2000** irratti bilbilaa (TTY:- **711**)

ਪੰਜਾਬੀ (Punjabi) ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫ਼ਤ ਉਪਲਬਧ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ, ਜਿਨ੍ਹਾਂ ਵਿੱਚ ਯੋਗ ਸਹਾਇਕ ਸਹਾਇਤਾਵਾਂ ਅਤੇ ਸੇਵਾਵਾਂ ਸ਼ਾਮਲ ਹਨ। ਕਾਲ ਕਰੋ **1-800-813-2000** (TTY:- **711**).

Română (Romanian) ATENȚIE: Dacă vorbiți română, vă sunt disponibile gratuit servicii de asistență lingvistică, inclusiv ajutoare și servicii auxiliare adecvate. Sunați la **1-800-813-2000** (TTY: **711**).

Русский (Russian) ВНИМАНИЕ! Если вы говорите по-русски, вам доступны бесплатные услуги языковой поддержки, включая соответствующие вспомогательные средства и услуги. Позвоните по номеру **1-800-813-2000** (TTY: **711**).

Español (Spanish) ATENCIÓN: Si habla español, tiene a su disposición servicios de asistencia lingüística que incluyen ayudas y servicios auxiliares adecuados y gratuitos. Llame al **1-800-813-2000** (TTY: **711**).

Tagalog (Tagalog) PAALALA: Kung nagsasalita ka ng Tagalog, available sa iyo ang serbisyo ng tulong sa wika kabilang ang mga naaangkop na karagdagang tulong at serbisyo, nang walang bayad. Tumawag sa **1-800-813-2000** (TTY: **711**).

ไทย (Thai) โปรดทราบ: หากท่านพูดภาษาไทย ท่านสามารถขอรับบริการช่วยเหลือด้านภาษา รวมทั้งเครื่องช่วยเหลือและบริการเสริมที่เหมาะสมได้ฟรี โทร **1-800-813-2000** (TTY: **711**).

Українська (Ukrainian) УВАГА! Якщо ви володієте українською мовою, вам доступні безкоштовні послуги з мовної допомоги, включно із відповідною додатковою допомогою та послугами. Зателефонуйте за номером **1-800-813-2000** (TTY: **711**).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói tiếng Việt, bạn có thể sử dụng các dịch vụ hỗ trợ ngôn ngữ miễn phí, bao gồm các dịch vụ và phương tiện hỗ trợ phù hợp. Xin gọi **1-800-813-2000** (TTY: **711**).