

# Summary of Dental Benefits

**KP OR Family Traditional 100 - \$100 Ded/\$2000 Max**

**2021 Contract**

<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	\$2,000
<b>Dental Office Visit – Per visit</b>	\$10
<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	\$350
For two or more members per Year	\$700
<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
X-rays	\$0
Teeth cleaning	\$0
Fluoride treatments	\$0
<b>Minor Restoration Services</b>	
Routine fillings	20% Coinsurance after Deductible
Restorations (composite / acrylic and steel)	20% Coinsurance after Deductible
Simple extractions	20% Coinsurance after Deductible
<b>Oral Surgery Services</b>	
Surgical tooth extractions	20% Coinsurance after Deductible
<b>Periodontics</b>	
Treatment of gum disease	20% Coinsurance after Deductible
Scaling and root planing	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
<b>Major Restoration Services</b>	
Nobel metal gold or porcelain crowns	50% Coinsurance after Deductible
Bridges abutments	50% Coinsurance after Deductible
<b>Removable Prosthetic Services</b>	
Full upper and lower dentures	50% Coinsurance after Deductible
Partial dentures	50% Coinsurance after Deductible
Relines	50% Coinsurance after Deductible
Rebases	50% Coinsurance after Deductible

<b>Nitrous oxide</b> (Not subject to or counted toward the Deductible or Benefit Maximum)	
Members age 13 years and older	\$25
Members age 12 years and younger	\$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

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.

**Questions? Call Member Services** (M-F, 8 am-6 pm) or visit **kp.org** Portland area: 503-813-2000  
 All other areas: 1-800-813-2000 TTY: 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.