Summary of Dental Benefits

All plans offered and underwritten by Kaiser Foundation Health Plan of the Northwest. 500 NE Multnomah St., Suite 100, Portland, OR 97232

PPO PLAN LB **1/1/2024 - 12/31/2024**

	In-network benefit (reimbursement is based on MAC) *	Out-of-network benefit (reimbursement is based on UCC) *
Benefit Maximum per Calendar Year (Covered Services that are subject to either Benefit Maximum and that are received in the same Year will count toward both the in-network and out-of-network Benefit Maximums.)		
Per Member per Year	$2,000	$2,000
	You pay	
Deductible (Per Calendar Year; applies to all services unless otherwise indicated)		
For one Member	$25 / $50 / $75 / $100	
For an entire Family	$75 / $150 / $225 / $300	
Preventive and Diagnostic Services (Not subject to or counted toward the Deductible)		
Oral exam	$0	10% Coinsurance
X-rays	$0	10% Coinsurance
Teeth cleaning	$0	10% Coinsurance
Fluoride	$0	10% Coinsurance
Minor Restoration Services		
Routine fillings	20% Coinsurance after Deductible	30% Coinsurance after Deductible
Plastic and steel crowns	20% Coinsurance after Deductible	30% Coinsurance after Deductible
Simple extractions	20% Coinsurance after Deductible	30% Coinsurance after Deductible
Oral Surgery Services		
Surgical tooth extractions	20% Coinsurance after Deductible	30% Coinsurance after Deductible
Periodontics		
Treatment of gum disease	20% Coinsurance after Deductible	30% Coinsurance after Deductible
Scaling and root planing	20% Coinsurance after Deductible	30% Coinsurance after Deductible
Endodontics		
Root canal therapy	20% Coinsurance after Deductible	30% Coinsurance after Deductible
Major Restoration Services		
Gold or porcelain crowns	50% Coinsurance after Deductible	60% Coinsurance after Deductible
Bridges	50% Coinsurance after Deductible	60% Coinsurance after Deductible

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Removable Prosthetic Services		
Full and partial dentures	50% Coinsurance after Deductible	60% Coinsurance after Deductible
Relines	50% Coinsurance after Deductible	60% Coinsurance after Deductible
Rebases	50% Coinsurance after Deductible	60% Coinsurance after Deductible
Nitrous oxide (Not subject to or counted toward the Deductible or Benefit Maximum)		
Adults and children age 13 years and older	$25	$25
Children age 12 years and younger	$0	$0
Teledentistry		
Telephone and video visits	$0	$0
Orthodontics	Rider Available for Purchase	
Implants	Rider Available for Purchase	

* "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 (M-F, 8 am-6 pm) 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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