KP OR DENTAL 100
DENTAL PLAN BENEFIT SUMMARY

This "Benefit Summary," which is part of this *Evidence of Coverage* (*EOC*), is a summary of answers to the most frequently asked questions about benefits. This summary does not fully describe benefits, limitations, or exclusions. To see complete explanations of what is covered for each benefit (including exclusions and limitations), and for additional benefits that are not included in this summary, please refer to the "Benefits," "Exclusions and Limitations," and "Reductions" sections of this *EOC*. All Services are subject to the Deductible, Copayment, or Coinsurance, unless otherwise noted.

Benefit Maximum (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	$1,000
Deductible	
For one Member per Year	$50
For an entire Family per Year	$150
Out-of-Pocket Maximum (Applies to covered Services you receive until the end of the month in which you turn 19 years of age)	
For one Member per Year	$350
For two or more Members per Year	$700
Preventive and Diagnostic Services (Not subject to the Deductible)	**You Pay**
Oral exam, including evaluations and diagnostic exams	$0
Fluoride treatments	$0
Teeth cleaning	$0
Sealants	$0
Space maintainers	$0
X-rays	$0
Minor Restorative Services	**You Pay**
Routine fillings	20% Coinsurance after Deductible
Simple extractions	20% Coinsurance after Deductible
Restorations (composite/acrylic and steel)	20% Coinsurance after Deductible
Oral Surgery Services	**You Pay**
Major oral surgery	20% Coinsurance after Deductible
Surgical tooth extractions	20% Coinsurance after Deductible
Periodontic Services	**You Pay**
Scaling and root planing	20% Coinsurance after Deductible
Periodontal surgery	20% Coinsurance after Deductible
Treatment of gum disease	20% Coinsurance after Deductible
Endodontic Services	**You Pay**
Root canal and related therapy	
Anterior tooth	20% Coinsurance after Deductible
Bicuspid tooth	20% Coinsurance after Deductible
Molar tooth	20% Coinsurance after Deductible
Major Restorative Services	**You Pay**
Bridge abutments	50% Coinsurance after Deductible
Noble metal gold or porcelain crowns	50% Coinsurance after Deductible
Inlays	50% Coinsurance after Deductible

Pontics	50% Coinsurance after Deductible
Removable Prosthetic Services	**You Pay**
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
Orthodontic Services	**You Pay**
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
Emergency Dental Care	**You Pay**
From Participating Providers	$25 plus Deductible, Copayment, or Coinsurance that normally apply for non-emergency dental care Services
From Non-Participating Providers outside the Service Area (coverage is limited to $100 per incident)	All Charges over $100
Other Dental Services (Not subject to or counted toward the Deductible or Benefit Maximum)	**You Pay**
Nightguards	10% Coinsurance
Nitrous oxide	
Members age 13 years and older	$25
Members age 12 years and younger	$0
Dependent Limiting Age	**Limiting Age**
Dependent Limiting Age	26