KP OR DENTAL 80H
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 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
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	**You Pay**
Oral exam, including evaluations and diagnostic exams	20% Coinsurance
Fluoride treatments	20% Coinsurance
Teeth cleaning	20% Coinsurance
Sealants	20% Coinsurance
Space maintainers	20% Coinsurance
X-rays	20% Coinsurance
Minor Restorative Services	**You Pay**
Routine fillings	75% Coinsurance
Simple extractions	75% Coinsurance
Restorations (composite/acrylic and steel)	75% Coinsurance
Oral Surgery Services	**You Pay**
Major oral surgery	75% Coinsurance
Surgical tooth extractions	75% Coinsurance
Periodontic Services	**You Pay**
Scaling and root planing	75% Coinsurance
Periodontal surgery	75% Coinsurance
Treatment of gum disease	75% Coinsurance
Endodontic Services	**You Pay**
Root canal and related therapy	
Anterior tooth	75% Coinsurance
Bicuspid tooth	75% Coinsurance
Molar tooth	75% Coinsurance
Major Restorative Services	**You Pay**
Bridge abutments	75% Coinsurance
Noble metal gold or porcelain crowns	75% Coinsurance
Inlays	75% Coinsurance
Pontics	75% Coinsurance
Removable Prosthetic Services	**You Pay**
Full upper and lower dentures	75% Coinsurance

Partial dentures	75% Coinsurance
Rebases	75% Coinsurance
Relines	75% Coinsurance
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
Emergency Dental Care	**You Pay**
From Participating Providers	$25 plus 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 counted toward the 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