

KP WA PEDIATRIC DENTAL 100

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 applicable Deductible, Copayment, or Coinsurance, unless otherwise noted.

Dental Services described in this “Benefit Summary” are only covered for Members through the end of the Year in which they turn 19 years of age.

Deductible	
For one Member per Year	\$50
For an entire Family per Year	\$150
Out-of-Pocket Maximum	
For one Member per Year	\$350
For an entire Family per Year	\$700
Benefits	You Pay
Preventive and Diagnostic Services (not subject to the Deductible)	
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	50% Coinsurance after Deductible
Surgical tooth extractions	50% 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	50% Coinsurance after Deductible
Bicuspid Tooth	50% Coinsurance after Deductible
Molar Tooth	50% 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

Benefits	You Pay
Pontics	50% Coinsurance after Deductible
Removable Prosthodontic 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)	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	Any Charges that normally apply plus amounts that exceed Usual and Customary Charges for qualifying claims
Other Dental Services (not subject to the Deductible)	You Pay
House/extended care facility calls and hospital calls	\$0
Nightguards	10% Coinsurance
Nitrous oxide	
Members age 13 years and older	\$25
Members age 12 years and younger	\$0
Limiting Age	Limiting Age
Limiting Age	19