

# KP WA DENTAL 100 ADULT TRADITIONAL 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 applicable Cost Share, unless otherwise noted.

Dental Services described in this “Benefit Summary” are only covered for Members age 19 years and older.

<b>Benefit Maximum</b>	
Per Member per Year	\$1,000
<b>Deductible</b>	
For one Member per Year	\$50
For an entire Family per Year	\$150
<b>Benefits</b>	<b>You Pay</b>
<b>Preventive and Diagnostic Services</b> (not subject to the Deductible)	
Oral exam, including evaluations and diagnostic exams	\$0
Fluoride treatments	\$0
Teeth cleaning	\$0
Space maintainers	\$0
X-rays	\$0
<b>Minor Restorative Services</b>	<b>You Pay</b>
Routine fillings	20% Coinsurance after Deductible
Simple extractions	20% Coinsurance after Deductible
Restorations (composite/acrylic and steel)	20% Coinsurance after Deductible
<b>Oral Surgery Services</b>	<b>You Pay</b>
Major oral surgery	50% Coinsurance after Deductible
Surgical tooth extractions	50% Coinsurance after Deductible
<b>Periodontic Services</b>	<b>You Pay</b>
Scaling and root planing	50% Coinsurance after Deductible
Periodontal surgery	50% Coinsurance after Deductible
Treatment of gum disease	50% Coinsurance after Deductible
<b>Endodontic Services</b>	<b>You Pay</b>
Root canal and related therapy	
Anterior Tooth	50% Coinsurance after Deductible
Bicuspid Tooth	50% Coinsurance after Deductible
Molar Tooth	50% Coinsurance after Deductible
<b>Major Restorative Services</b>	<b>You Pay</b>
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
<b>Removable Prosthetic Services</b>	<b>You Pay</b>
Full upper and lower dentures	50% Coinsurance after Deductible

<b>Benefits</b>	<b>You Pay</b>
Partial dentures	50% Coinsurance after Deductible
Rebases	50% Coinsurance after Deductible
Relines	50% Coinsurance after Deductible
<b>Emergency Dental Care</b>	<b>You Pay</b>
From Participating Providers	\$25 plus the Cost Share that normally applies for non-emergency dental care Services
From Non-Participating Providers outside the Service Area	The Cost Share that normally applies for non-emergency dental care Services, plus amounts that exceed Usual and Customary Charges for qualifying claims
<b>Other Dental Services</b> (not subject to or counted toward the Deductible or Benefit Maximum)	<b>You Pay</b>
Nightguards	10% Coinsurance
Nitrous oxide	\$25
<b>Dependent Limiting Age</b>	<b>Limiting Age</b>
Dependent Limiting Age	26