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 Cost Share, 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	$375
For an entire Family per Year	$750

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
Pontics	50% Coinsurance after Deductible

Benefits	You Pay
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 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
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