Dental Plans

	KP OR Family Dental - $1000/$50 Ded		KP OR Family Dental - $1000		KP OR Family Dental - $100 Ded	
	Child (18 or younger)	Adult (19 or older)	Child (18 or younger)	Adult (19 or older)	Child (18 or younger)	Adult (19 or older)
Features						
Benefit maximum	Does not apply	$1,000	Does not apply	$1,000	Does not apply	No maximum
Deductible (individual/family)	$50/$150	$50/$150	$0	$0	$100/$300	$100/$300
Out-of-pocket maximum (individual/family)	$450/$900	Does not apply	$450/$900	Does not apply	$450/$900	Does not apply
Benefits (subject to deductible unless otherwise noted)						
Preventive and diagnostic services	0% (not subject to deductible)		20% coinsurance (not subject to deductible)		20% coinsurance (not subject to deductible)	
Basic restorative services	20% coinsurance		75% coinsurance		50% coinsurance	
Oral surgery, endodontics, and periodontics	20% coinsurance		75% coinsurance		50% coinsurance	
Major restorative services	50% coinsurance		75% coinsurance		50% coinsurance	

Monthly rates

Age on 2026 effective date	KP OR Family Dental - $1000/$50 Ded	KP OR Family Dental - $1000	KP OR Family Dental - $100 Ded
<19	$42.31	$26.79	$31.87
19–29	39.41	26.86	35.03
30–34	42.77	29.15	38.01
35–39	45.01	30.67	40.00
40–44	49.21	33.54	43.74
45–49	53.98	36.79	47.98
50–54	57.98	39.51	51.53
55–59	63.34	43.16	56.29
60+	67.48	45.99	59.97

To calculate the rate of your dental plan for you and your entire family, add the rate for each family member based on their age. For children who are under 21 and covered under the same dental plan, include a rate for no more than the 3 oldest children.

Note: All family members must enroll in a pediatric dental plan unless you confirm on your application that you and your family members are enrolled in another Oregon Health Insurance Marketplace–certified pediatric dental plan.

This brochure provides summaries of various plans and is not a contract. Dental plan details are provided in your *Evidence of Coverage*. For specific plan information about dental plans, see the following forms: *EOIDFAMILYDNT0126, EOIDDEDFAMILYDNT0126–Evidence of Coverage; BOIDFAMILYDNT0126, BOIDDEDFAMILYDNT0126–Benefit Summaries; FSOIDFAMILYDNT0126–Face Sheet.*