

Summary of Dental Benefits

All plans offered and underwritten by Kaiser Foundation Health Plan of the Northwest, 500 NE Multnomah St., Suite 100, Portland, OR 97232

Membership Services: 1-800-813-2000

Dental PPO Plan FH PreventaMax

1/1/2021 - 12/31/2021

Group Number: 0000-001

	In-network benefit (reimbursement is based on MAC) *	Out-of-network benefit (reimbursement is based on UCC) *
Benefit Maximum per Calendar Year (covered Services subject to either Benefit Maximum count toward both Benefit Maximums)	\$1,500	
You pay		
Deductible (Per Calendar Year; applies to all services unless otherwise indicated)		
For one Member (select Deductible amount)	\$0 / \$25 / \$50 / \$75 / \$100	
For an entire Family (select Deductible amount)	\$0 / \$75 / \$150 / \$225 / \$300	
Preventive and Diagnostic Services (Not subject to or counted toward the Deductible or Benefit Maximum)		
Oral exam	\$0	\$0
X-rays	\$0	\$0
Teeth cleaning	\$0	\$0
Fluoride	\$0	\$0
Minor Restoration Services		
Routine fillings	20% Coinsurance after Deductible	20% Coinsurance after Deductible
Plastic and steel crowns	20% Coinsurance after Deductible	20% Coinsurance after Deductible
Simple extractions	20% Coinsurance after Deductible	20% Coinsurance after Deductible
Oral Surgery Services		
Surgical tooth extractions	20% Coinsurance after Deductible	20% Coinsurance after Deductible
Periodontics		
Treatment of gum disease	20% Coinsurance after Deductible	20% Coinsurance after Deductible
Scaling and root planing	20% Coinsurance after Deductible	20% Coinsurance after Deductible
Endodontics		
Root canal therapy	20% Coinsurance after Deductible	20% Coinsurance after Deductible
Major Restoration Services		
Gold or porcelain crowns	50% Coinsurance after Deductible	50% Coinsurance after Deductible
Bridges	50% Coinsurance after Deductible	50% Coinsurance after Deductible

Removable Prosthetic Services

Full and partial dentures	50% Coinsurance after Deductible	50% Coinsurance after Deductible
Relines	50% Coinsurance after Deductible	50% Coinsurance after Deductible
Rebases	50% Coinsurance after Deductible	50% Coinsurance after Deductible

Nitrous oxide (Not subject to or counted toward the Deductible or Benefit Maximum)

Adults and children age 13 years and older	\$25	\$25
Children age 12 years and younger	\$0	\$0

Orthodontics	Not a covered benefit	Not a covered benefit
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**UCC” means Usual and Customary Charge. “MAC” means Maximum Allowable Charge. See your Evidence of Coverage (EOC) for more details.

Plan is subject to exclusions and limitations. A complete list of the exclusions and limitations is included in the Evidence of Coverage (EOC). Sample EOCs are available upon request.

Questions? Call Member Services (M-F, 8 am-6 pm) or visit **kp.org** Portland area: 503-813-2000

All other areas: 1-800-813-2000 TTY..711. Language Interpretation Services, all areas 1-800-324-8010

This is not a contract. This benefit summary does not fully describe your benefit coverage with Kaiser Foundation Health Plan of the Northwest. For more details on benefit coverage, claims review, and adjudication procedures, please see your EOC or call Member Services. In the case of a conflict between this summary and the EOC, the EOC will prevail.