

Summary of Dental Benefits

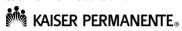
All plans offered and underwritten by Kaiser Foundation Health Plan of the Northwest. 500 NE Multnomah St., Suite 100, Portland, OR 97232

Voluntary PMAX PPO 4

1/1/2024 - 12/31/2024

	In-network benefit	Out-of-network benefit (reimbursement is based on UCC) *	
	(reimbursement is based on MAC) *		
Benefit Maximum per Calendar Year (Covered Servi			
received in the same Year will count toward both the i			
Per Member per Year	\$2,000	\$2,000	
	Υ	ou pay	
Deductible (Per Calendar Year; applies to all services	s unless otherwise indicated)		
For one Member		\$0	
For an entire Family		\$0	
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	20% Coinsurance	
Plastic and steel crowns	20% Coinsurance	20% Coinsurance	
Simple extractions	20% Coinsurance	20% Coinsurance	
Oral Surgery Services	1	1	
Surgical tooth extractions	20% Coinsurance	20% Coinsurance	
Periodontics	'	,	
Treatment of gum disease	20% Coinsurance	20% Coinsurance	
Scaling and root planing	20% Coinsurance	20% Coinsurance	
Endodontics	1	1	
Root canal therapy	20% Coinsurance	20% Coinsurance	
Major Restoration Services		1	
Gold or porcelain crowns	50% Coinsurance	50% Coinsurance	
Bridges	50% Coinsurance	50% Coinsurance	
Removable Prosthetic Services			
Full and partial dentures	50% Coinsurance	50% Coinsurance	
Relines	50% Coinsurance	50% Coinsurance	
Rebases	50% Coinsurance	50% Coinsurance	
Nitrous oxide (Not subject to or counted toward the D		207/ 0011100101100	
Adults and children age 13 years and older	\$25	\$25	
Children age 12 years and younger	\$0	\$0	
Teledentistry		**	
Telephone and video visits	\$0	\$0	
Orthodontics	· ·	Rider Available for Purchase	
Implants		Rider Available for Purchase	
		Tridel Available for Lateriase	

SSOB ORLGPPOdental0124



* "UCC" means Usual and Customary Charge. "MAC" means Maximum Allowable Charge. For the Services that are subject to a Benefit Maximum, it is your responsibility to pay the full amount of any Charges (MAC) or Usual and Customary Charges (UCC) incurred above the applicable Benefit Maximum.

Your dentist must submit a request for prior authorization for any procedure over \$500. 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, or you may go to **kp.org/plandocuments**.

Visit: **kp.org/dental/nw/ppo** for a searchable provider directory.

Questions? Call Customer Service at 1-866-653-0338 (M-F, 8 am-6 pm) or visit **kp.org.** TTY, all areas: 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.