Summary of Dental Benefits and Coverage Disclosure Matrix (SDBC)

Part I: GENERAL INFORMATION

Insurer Name: Kaiser Permanente Insurance Company (KPIC)

Plan Name: Kaiser Permanente Insurance Company (KPIC) Plan D

Policy Type: PPO

Insurer Phone #: 800-835-2244

Effective Date: 01/01/2024 – 12/31/2024

Insurer Website: kp.org/kpic-dental

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND WHAT YOU WILL PAY FOR COVERED SERVICES. THIS IS A SUMMARY ONLY AND DOES NOT INCLUDE THE PREMIUM COSTS OF THIS DENTAL BENEFITS PACKAGE. PLEASE CONSULT YOUR EVIDENCE OF COVERAGE AND DENTAL CONTRACT FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS. FOR MORE INFORMATION ABOUT YOUR COVERAGE, VISIT THE INSURER WEBSITE AT kp.org/kpic-dental **OR CALL** 800-835-2244.

THIS MATRIX IS NOT A GUARANTEE OF EXPENSES OR PAYMENT.

Part II: DEDUCTIBLES

Deductible	All Providers
Dental	$25 per individual/ $75 per family
Orthodontia	None

- **The deductible applies to all services except diagnostic and preventive.**
- A **deductible** is the amount you are required to pay for covered dental services each policy year before the insurer begins to pay for the cost of covered dental treatment.
- **In-network services** are dental care services provided by dentists or other licensed dental care providers that contract with your insurer for alternative rates of payment for dental services.
- **Out-of-network services** are dental care services provided by dentists or other licensed dental care providers that have not contracted with your insurer for alternative rates of payment.

Part III: MAXIMUMS POLICY WILL PAY

Maximums	All Providers
Annual Maximum	$1,000.00
Lifetime Maximum for Orthodontia	Not Covered

- **Annual maximum** is the maximum dollar amount your policy will pay toward the cost of dental care within a specific period of time, usually a consecutive 12-month or calendar year period. Not all services accrue to the annual maximum.
- **Lifetime maximum** means the maximum dollar amount your policy providing dental benefits will pay for the life of the enrollee. Lifetime maximums usually apply to specific services, such as orthodontic treatment.

Part IV: WAITING PERIODS

Waiting Periods: A waiting period is the amount of time that must pass before you are eligible to receive benefits for all or certain dental treatments. **There are no waiting periods.**

Part V: WHAT YOU WILL PAY

All copayments and coinsurance costs shown in this chart apply after your deductible has been met, if a deductible applies. The Common Dental Procedures fit into one of the following applicable categories: Preventive & Diagnostic, Basic or Major. The Benefit Limitations and Exclusions column includes common limitations and exclusions only. For a full list, see the full disclosure document referenced in the Benefit Limitations and Exclusions column.

Common Dental Procedures	Category	All Providers	Benefit Limitations and Exclusions
Oral Exam	Diagnostic & Preventive	$0 Deductible does not apply	Benefit is limited to two of any oral evaluation procedures within a calendar year.
Bitewing X-ray	Diagnostic & Preventive	$0 Deductible does not apply	Benefit is limited to one of any bitewing x-ray procedure within a calendar year child up to and not including age 19. 19 years and older, Benefit is limited to one of any bitewing x-ray procedure within a calendar year.

Common Dental Procedures	Category	All Providers	Benefit Limitations and Exclusions
Cleaning	Diagnostic & Preventive	$0 Deductible does not apply	Cleaning: Benefit is limited to two within a calendar. A cleaning is a benefit following active periodontal therapy once a 30-day post-operative period has completed.
Filling	Basic	20%	Benefit is limited to once per surface, per tooth within a 24-month period.
Extraction, Erupted Tooth or Exposed Root	Basic	20%	Once per tooth per lifetime.
Root Canal	Basic	20%	One per tooth per lifetime.
Scaling and Root Planing	Basic	20%	Benefit is limited to once per quadrant within a 24-month period. Radiographic images and a copy of the treatment record are required if more than two quadrants of scaling and root planing are performed on the same date of service. Frequency may be affected by other periodontic services.
Ceramic Crown	Major	Not Covered	Not Covered
Removable Partial Denture	Major	20%	Benefit is limited to once per arch within a 5-year period.
Extraction, Erupted Tooth with Bone Removal	Basic	20%	Once per tooth per lifetime.
Orthodontia	Orthodontia	Not Covered	Not Covered

Part VI: COVERAGE EXAMPLES

THESE EXAMPLES DO NOT REPRESENT A COST ESTIMATOR OR GUARANTEE OF PAYMENT. The examples provided represent commonly used services in the categories of Diagnostic and Preventive, Basic and Major Services for illustrative purposes and to compare this product to other dental products you may be considering. Your actual costs will likely be different from those shown in the chart below depending on the actual care you receive, the prices your providers charge and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and the summary of excluded services under the plan.

Dana Has a Dental Appointment with a New Dentist	**Sam Needs a Tooth Filled**	**Maria Needs a Crown**
New patient exam, x-rays (FMX) and cleaning	Resin-based composite – one surface, posterior	Crown – porcelain/ceramic substrate

Dana's Visit	**Dana's Cost**	**Sam's Visit**	**Sam's Cost**	**Maria's Visit**	**Maria's Cost**
Total Cost of Care	In-network: $400 Out-of-network: $550	Total Cost of Care	In-network: $150 Out-of-network: $200	Total Cost of Care	In-network: $1,300 Out-of-network: $1,750
Deductible	In-network: Exempt Out-of-network: Exempt	Deductible	In-network: $25 Out-of-network: $25	Deductible	In-network: Not Applicable Out-of-network: Not Applicable
Annual Maximum (Plan Will Pay)	In-network: $1,000 Out-of-network: $1,000	Annual Maximum (Plan Will Pay)	In-network: $1,000 Out-of-network: $1,000	Annual Maximum (Plan Will Pay)	In-network: Not Applicable Out-of-network: Not Applicable
Patient Cost (copayment or coinsurance)	In-network: $0.00 Out-of-network: $0.00	Patient Cost (copayment or coinsurance)	In-network: 20% Out-of-network: 20%	Patient Cost (copayment or coinsurance)	In-network: $1,300 Out-of-network: $1,750
In this example, Dana would pay (includes	**In-network:** $0.00	**In this example, Sam would pay (includes**	**In-network:** $55	**In this example, Maria would pay (includes**	**In-network:** $1,300

Dana's Visit	Dana's Cost	Sam's Visit	Sam's Cost	Maria's Visit	Maria's Cost
copays/coinsurance and deductible, if applicable):	**Out-of-network:** $0.00	**copays/coinsurance and deductible, if applicable):**	**Out-of-network:** $65	**copays/coinsurance and deductible, if applicable):**	**Out-of-network:** $1,750
Summary of what is not covered or subject to a limitation:	Oral Exam: Benefit is limited to two of any oral evaluation procedures within a calendar year. X-rays (FMX): Benefit is limited to one full mouth series of intra-oral films with a 5-year period from the last date performed. Cleaning: Benefit is limited to two within a calendar. A cleaning is a benefit following active periodontal therapy once a 30-day post-operative period has completed.	Summary of what is not covered or subject to a limitation:	Benefit is limited to once per tooth within a 24-month period.	Summary of what is not covered or subject to a limitation:	Crown – porcelain/ceramic substrate – not a covered benefit