cis benefits
www.cisbenefits.org

KAISER PERMANENTE®

Effective January 1, 2025- December 31, 2025

Dental II	
Deductible (Per Calendar Year; applies to all services unless otherwise indicated)	None
Benefit Maximum per Calendar Year	$2,000
Dental Office Visit Charge – Per visit	$10
Preventive and Diagnostic Services (not subject to or counted toward the deductible or benefit maximum) – includes oral examinations and x-rays, teeth cleaning (prophylaxis), fluoride treatments, instruction in the care of your teeth and gums, and prescribed space maintainers	No additional charge
Minor Restoration Services – includes routine fillings, plastic and stainless steel crowns	No additional charge
Simple Extractions	No additional charge
Oral Surgery Services	No additional charge
Periodontics – includes diagnosis, evaluation, and treatment of disease of the gums, including scaling and root planing	No additional charge
Endodontics – includes root canal and related therapy, including diagnosis and evaluation	No additional charge
Major Restoration Services – includes gold or porcelain crowns, inlays, bridge abutments and pontics	$45 for each
Removable Prosthetic Services – Full and partial dentures Relines Rebasis	 $95 for each partial denture, $65 for each full denture $25 $25
Teledentistry - Telephone and video visits	$0
Orthodontics	Not covered
Implants	50% up to benefit maximum

PLEASE NOTE:

- You will be charged a $25 fee when you miss a dental appointment without calling in advance to cancel.
- You pay $25 for nitrous oxide for adults and children 13 and older.
- You pay 10% of charges for night-guards.

EXCLUSIONS

The following are not covered:

- Service not approved by a Kaiser Permanente dentist. Kaiser Permanente does not pay for unauthorized services from dentists or facilities not affiliated with Kaiser Permanente, except as indicated under “Emergency Treatment.”
- Conditions covered by workers’ compensation or that are the employer’s responsibility.
- Procedures not generally and customarily available in the service area.
- Surgery to correct malocclusion or temporomandibular joint disorders; treatment for problems of the jaw joint, including temporomandibular joint syndrome and craniomadibular disorders; and treatment of conditions of the joint linking the jaw bone and skull and of the complex of muscles, nerves, and other tissues related to that joint.
- Restorative or reconstructive treatment for specific congenital or developmental malformations.
- Full-mouth reconstruction and occlusal rehabilitation including appliances, restorations, and procedures needed to alter vertical dimension or occlusion or to splint or correct attrition or abrasion.
- Cosmetic services.
- Prescription Drugs.
- Experimental or investigational services.
- Orthodontic services.
- More than two visits for routine teeth cleaning (oral prophylaxis) in any twelve consecutive month period.
- Conditions covered by government agencies or programs other than Medicaid.
- Genetic testing.
- Dental implants, including bone augmentation and fixed or removable prosthetic devices attached to or covering the implants; all related services, including diagnostic consultations, impressions, oral surgery, placement, removal, and cleaning; and services associated with postoperative conditions and complications arising from implants.
- Removal and replacement, with alternative materials, of clinically acceptable material or restorations for any reason except the pathological condition of the tooth or teeth.
- General anesthesia and intravenous sedation.
- Medical, hospital, and certain dental services.
- Work in progress before your coverage is effective.
- Replacement of prefabricated, non-cast crowns, including stainless steel crowns, that were not placed by a Kaiser Permanente dentist.
- Repair or replacement of fixed prosthetics or removable prosthetic appliances that are less than five years old.

This summary provides a brief description of your dental plan benefits. Any errors or omissions are unintentional. Plan is subject to exclusions and limitations. A complete list of the exclusions and limitations is included in the Evidence of Coverage (EOC). EOCs are available upon request or you may go to **kp.org/plandocuments**.

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.