

SMILE FOR TOTAL HEALTH

A guide to your dental benefits:
Small Group Adult \$30 Preventive
and Pediatric Dental HMO with
Cosmetic Dental



The Adult \$30 Preventive and Pediatric Dental HMO with Cosmetic Dental plans emphasize healthy smiles through the prevention and early detection of dental problems to avoid costly procedures in the future. The combination of predictable costs, no deductibles, and no annual maximums helps you reach a state of good oral health without facing the high cost of treatment typical of many dental plans.

Your plan provides coverage—or access to a fixed fee schedule for certain non-covered dental services—for more than 250 dental procedures through one of the largest dental provider networks¹ in the Mid-Atlantic area.² You have your choice of convenient dental offices where you can receive care.

Adults pay a \$30 copay for each covered preventive care office visit, which may include:

- Up to two oral exams per contract year
- Up to two cleanings per contract year
- One fluoride treatment per contract year
- Up to two dental bitewing X-rays per contract year

For children—through the end of the month in which they turn 19—you pay a \$10 office visit fee for each dental office visit. Preventive care services are provided at no charge, and may include:

- One oral evaluation every six months
- One routine cleaning every six months
- One bitewing X-ray every six months
- One topical fluoride treatment every six months

New member? Get started by choosing a dentist.

Visit dominionnational.com/kaiserdentists or call Dominion Member Services at 855-733-7524 (TTY 711), Monday through Friday, 7:30 a.m. to 6 p.m.

The preventive care procedures covered in this plan account for over 65% of dental services most frequently performed for adults, and almost 90% of the most frequently performed services for children. Other listed dental services are available for the fixed fees shown on the fee schedule, which you pay directly to your provider as payment in full.

Save on restorative care

More extensive care (fillings, crowns, dentures, root canals, periodontal treatment, oral surgery, etc.) is offered at fixed fees lower than the usual and customary charges for these services. Only the services listed on the fee schedule are available for fixed fees, provided the services are performed by plan-participating dentists and specialists. For a complete list of covered benefits, services, exclusions, and limitations, and terms for the fixed fees, please refer to your *Evidence of Coverage*, or you can find your plan on dominionnational.com/kaiserdentists.

¹Over 2,000 dentists in the Maryland, Virginia, and Washington, DC, area who participate in the Dominion National network.

²When services are received from our contracted dental provider network.

³Discounted rates for dental services are negotiated by the Program Administrator with participating providers. These negotiated rates are reflected in the fee schedule as fixed fees.

Cosmetic dental services

The brilliant, healthy smile you've always wanted can now be yours through Kaiser Permanente's Cosmetic Dental Services. Our program offers discounted fees for cosmetic and other dental services including:

- Teeth whitening
- Crowns
- Veneers
- Bonding
- Invisalign®
- Orthodontics
- And more

You'll enjoy great benefits, including:

- **Network dentists**¹ who meet highly selective credentialing standards
- **Discounts** of up to 75% on dental procedures.³
- **No deductibles** or annual maximums
- **No surprises.** For the majority of services, the program fee schedule reflects negotiated discounts and shows exactly what you'll pay

Choose a dentist

You may select any general dentist from among our participating dental providers for yourself and/or eligible family members. Each eligible family member may use a different participating dentist. For a list of participating dentists or information about a dentist, including office hours, directions, languages spoken, etc., visit dominionnational.com/kaiserdentists or call Dominion Member Services at 855-733-7524 (TTY 711), Monday through Friday, 7:30 a.m. to 6 p.m.

Specialty care is also available in many locations. To receive treatment from a participating specialist, ask your participating general dentist to arrange a referral. Services received from non-participating dentists are not covered.

Make appointments

After your effective date of coverage, you can make an appointment with a participating general dentist. Make sure you bring your Kaiser Permanente medical ID card to your appointment. To receive cosmetic dental services, you will also need to print and bring your cosmetic services ID card to your appointment. And you'll have virtually no paperwork and no pre-existing condition exclusions to worry about.

Quality dental care

You can be confident that your dentist was carefully selected to offer quality care. All participating dentists go through a strict quality assurance program developed in accordance with the National Association of Dental Plans' recommendations. This process confirms that each dentist has the required credentials and has passed a thorough on-site office evaluation.

Dedicated customer service

Quality customer service is an important part of any dental plan. Dominion Member Services specialists are available Monday through Friday, 7:30 a.m. to 6 p.m., to answer questions about coverage or to help you find a participating dentist. Dominion's voice response system is available 24 hours a day for information about participating dental providers in your area or to help you select a dental provider. The most up-to-date list of participating dental providers can be found online.

Toll-free phone: 855-733-7524 (TTY 711)

Mailing address:

Dominion National
251 18th St. S., Suite 900
Arlington, VA 22202

Web: dominionnational.com/kaiserdentists

Online self-service options

Dominion provides members with secure online access to:

- Plan information
- Dentist search and dental office transfers
- Contact information
- Member Services requests and general correspondence

All changes are confirmed by email.

In the event of ambiguity, or a conflict between this summary and the *Evidence of Coverage*, the *Evidence of Coverage* shall control.

Dental benefits are underwritten by Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., and administered by Dominion National. This program also includes fixed fees for certain dental services that are not covered benefits.



**Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
Pediatric and Cosmetic Dental Plan
2020 Schedule of Dental Fees**

Description of Services & Fees for Pediatric and Cosmetic Services (up to age 19). Annual Out-of-Pocket Maximum: You pay the Copayment set forth below for covered dental services until you reach the Out-of-Pocket Maximum shown in the Summary of Services and Cost Shares in the EOC. You will not be charged more than the amount of your Out-of-Pocket Maximum for any dental services. Please refer to your medical plan for specific details.

Procedures not shown in this list are not covered. Refer to the Pediatric and Cosmetic Dental Plan for a complete description of the terms and conditions of your covered dental benefit. Cosmetic Dental Services are also included in this Schedule of Dental Fees and are not covered benefits[†]. Please refer to Pediatric and Cosmetic Dental Services Appendix for further details on the program along with exclusions and limitations.

Fees quoted in the “You pay to Dentist” column apply only when performed by a participating General Dentist or Dental Specialist. If specialty care is required, your general dentist must refer you to a participating specialist except for Cosmetic Services and as otherwise described in the Pediatric and Cosmetic Dental Plan Appendix.

NOTE: If you have any questions concerning this fee schedule, Contact Dominion for details at: toll-free at 855-733-7524, Monday through Friday, 7:30 a.m. to 6 p.m., (TTY 711).

ADA CODE	DESCRIPTION OF SERVICES	YOU PAY TO DENTIST
D9439	Office visit	\$10
	DIAGNOSTIC/PREVENTIVE	
D0120	Periodic oral eval - established patient	\$0
D0140	Limited oral eval - problem focused	\$0
D0145	Oral eval for a patient under 3 years of age	\$0
D0150	Comprehensive oral eval - new or established patient	\$0
D0160	Detailed and extensive oral eval - problem focused	\$0
D0170	Re-evaluation - limited, problem focused	\$0
D0210	Intraoral - complete series of radiographic images	\$26
D0220/30	Intraoral - periapical first radiographic image	\$0
D0240	Intraoral - occlusal radiographic image	\$0
D0250	Extraoral – 2D projection radiographic image	\$0
D0270-74	Bitewing x-rays - 1 to 4 radiographic images	\$0
D0277	Vertical bitewings - 7 to 8 radiographic images	\$0
D0290	Posterior/anterior or lateral skull bone film	\$83
D0310	Sialography	\$370

ADA CODE	DESCRIPTION OF SERVICES	YOU PAY TO DENTIST
D0320	Temporomandibular joint arthrogram, incl. injection	\$562
D0321	Other temporomandibular joint films, by report	\$120
D0330	Panoramic radiographic image	\$30
D0340	2D cephalometric radiographic image	\$0
D0350	2D oral/facial photographic images	\$0
D0351	3D photographic image	\$0
D0460	Pulp vitality tests	\$0
D0470	Diagnostic casts	\$0
D0486	Accession of brush biopsy sample	\$0
D0600	Non-ionizing diagnostic procedure capable of quantifying, monitoring and recording changes in structure of enamel, dentin, and cementum	\$0
D0601	Caries risk assessment & documentation, with a finding of low risk	\$0
D0602	Caries risk assessment & documentation, with a finding of moderate risk	\$0
D0603	Caries risk assessment & documentation, with a finding of high risk	\$0
D1110	Prophylaxis (cleaning) - adult	\$0
D1120	Prophylaxis (cleaning) - child	\$0
D1206	Topical application of fluoride varnish	\$0
D1208	Topical application of fluoride – excluding varnish	\$0
D1310	Nutritional counseling for control of dental disease	\$0
D1320/30	Oral hygiene instructions	\$0
D1351	Sealant - per tooth	\$21
D1352	Prev resin rest. mod/high caries risk – perm. tooth	\$21
D1354	Interim caries arresting medicament application – per tooth	0
SPACE MAINTAINERS		
D1510/20	Space maintainer - fixed/removable - unilateral	\$143
D1516	Space maintainer - fixed - bilateral, maxillary	\$198
D1517	Space maintainer - fixed - bilateral, mandibular	\$198
D1526	Space maintainer - removable - bilateral, maxillary	\$198
D1527	Space maintainer - removable - bilateral, mandibular	\$198
D1550	Re-cementation of space maintainer	\$23
D1555	Removal of fixed space maintainer, by non-originating dentist	\$44
D1575	Distal shoe space maintainer - fixed - unilateral	\$143

ADA CODE	DESCRIPTION OF SERVICES	YOU PAY TO DENTIST
RESTORATIVE DENTISTRY (FILLINGS)		
D2140	Amalgam - one surface, prim. or perm.	\$41
D2150	Amalgam - two surfaces, prim. or perm.	\$51
D2160	Amalgam - three surfaces, prim. or perm.	\$64
D2161	Amalgam - >=4 surfaces, prim. or perm.	\$78
RESIN/COMPOSITE RESTORATIONS (TOOTH COLORED)		
D2330	Resin-based composite - one surface, anterior	\$69
D2331	Resin-based composite - two surfaces, anterior	\$83
D2332	Resin-based composite - three surfaces, anterior	\$99
D2335	Resin-based composite - >=4 surfaces, anterior	\$119
D2390	Resin-based composite crown, anterior	\$192
D2391	Resin-based composite - one surface, posterior	\$73
D2392	Resin-based composite - two surfaces, posterior	\$87
D2393	Resin-based composite - three surfaces, posterior	\$102
D2394	Resin-based composite - >=4 surfaces, posterior	\$123
CROWNS & BRIDGES*		
D2510	Inlay - metallic - one surface	\$407
D2520	Inlay - metallic - two surfaces	\$407
D2530	Inlay - metallic - three or more surfaces	\$425
D2542	Onlay - metallic-two surfaces	\$458
D2543	Onlay - metallic-three surfaces	\$524
D2544	Onlay - metallic-four or more surfaces	\$524
D2610	Inlay - porcelain/ceramic - one surface	\$427
D2620	Inlay - porcelain/ceramic - two surfaces	\$427
D2630	Inlay - porcelain/ceramic - >=3 surfaces	\$445
D2642	Onlay - porcelain/ceramic - two surfaces	\$479
D2643	Onlay - porcelain/ceramic - three surfaces	\$499
D2644	Onlay - porcelain/ceramic - >=4 surfaces	\$499
D2650	Inlay - resin-based composite - one surface	\$440
D2651	Inlay - resin-based composite - two surfaces	\$440
D2652	Inlay - resin-based composite - >=3 surfaces	\$440

ADA CODE	DESCRIPTION OF SERVICES	YOU PAY TO DENTIST
D2662	Onlay - resin-based composite - two surfaces	\$444
D2663	Onlay - resin-based composite - three surfaces	\$444
D2664	Onlay - resin-based composite - >=4 surfaces	\$444
D2710	Crown - resin based composite (indirect)	\$272
D2712	Crown - 3/4 resin-based composite (indirect)	\$255
D2720/21/22	Crown - resin with metal	\$495
D2740	Crown - porcelain/ceramic	\$560
D2750/51/52	Crown - porcelain fused metal	\$523
D2780/81/82	Crown - 3/4 cast with metal	\$478
D2783	Crown - 3/4 porcelain/ceramic	\$511
D2790-94	Crown - full cast metal	\$495
D2910/20	Recement inlay, onlay/crown or partial coverage rest.	\$43
D2930	Prefab. stainless steel crown - prim. tooth	\$110
D2931	Prefab. stainless steel crown - perm. tooth	\$121
D2932	Prefabricated resin crown	\$140
D2933	Prefab. stainless steel crown w/ resin window	\$271
D2934	Prefab. esthetic coated primary tooth	\$296
D2940	Protective restoration	\$39
D2941	Interim therapeutic restoration, primary dentition	\$31
D2950	Core buildup, including any pins	\$125
D2951	Pin retention - per tooth, in addition to restoration	\$22
D2952	Post and core in addition to crown	\$186
D2954	Prefab. post and core in addition to crown	\$154
D2955	Post removal (not in conj. with endo. therapy)	\$105
D2960	Labial veneer (resin laminate) - chairside	\$434
D2961	Labial veneer (resin laminate) - laboratory	\$601
D2962	Labial veneer (porcelain laminate) - laboratory	\$449
D2980	Crown repair necessitated by restorative material failure	\$102
D2981	Inlay repair necessitated by restorative material failure	\$102
D2982	Onlay repair necessitated by restorative material failure	\$102
D2983	Veneer repair necessitated by restorative material failure	\$102
PROSTHETICS (DENTURES)		
D5110/20	Complete denture - maxillary/mandibular	\$697
D5130/40	Immediate denture - maxillary/mandibular	\$722

ADA CODE	DESCRIPTION OF SERVICES	YOU PAY TO DENTIST
D5211/12	Maxillary/mandibular partial denture - resin base	\$649
D5213/14	Maxillary/mandibular partial denture - cast metal	\$750
D5221/22	Immediate Maxillary/mandibular partial denture –resin base	\$649
D5223/24	Immediate Maxillary/mandibular partial denture – cast metal	\$750
D5225/26	Maxillary/mandibular partial denture - flexible base	\$750
D5282	Rem. unilateral partial denture - one piece cast metal, maxillary	\$419
D5283	Rem. unilateral partial denture - one piece cast metal, mandibular	\$419
D5410/11	Adjust complete denture - maxillary/mandibular	\$38
D5421/22	Adjust partial denture - maxillary/mandibular	\$38
D5511	Repair broken complete denture base, mandibular	\$87
D5512	Repair broken complete denture base, maxillary	\$87
D5520	Replace missing or broken teeth - complete denture	\$77
D5611	Repair resin partial denture base, mandibular	\$87
D5612	Repair resin partial denture base, maxillary	\$87
D5621	Repair cast partial framework, mandibular	\$87
D5622	Repair cast partial framework, maxillary	\$87
D5630	Repair or replace broken retentive/clasping material – per tooth	\$115
D5640	Replace broken teeth - per tooth	\$87
D5650	Add tooth to existing partial denture – per tooth	\$87
D5660	Add clasp to existing partial denture - per tooth	\$115
D5670/71	Replace all teeth and acrylic on cast metal framework	\$287
D5710/11	Rebase complete maxillary/mandibular denture	\$260
D5720/21	Rebase maxillary/mandibular partial denture	\$260
D5730/31	Reline complete maxillary/mandibular denture (chairside)	\$159
D5740/41	Reline maxillary/mandibular partial denture (chairside)	\$155
D5750/51	Reline complete maxillary/mandibular denture (lab)	\$224
D5760/61	Reline maxillary/mandibular partial denture (lab)	\$224
D5810/11	Interim complete denture - maxillary/mandibular	\$362
D5820/21	Interim partial denture - maxillary/mandibular	\$362
D5850/51	Tissue conditioning - maxillary/mandibular	\$79
D5863	Overdenture - complete maxillary	\$1,694
D5864	Overdenture - partial maxillary	\$1,668
D5865	Overdenture - complete mandibular	\$1,694
D5866	Overdenture - partial mandibular	\$1,668

D5992 Adjustment of prosthetic appliance, by report \$24

ADA CODE	DESCRIPTION OF SERVICES	YOU PAY TO DENTIST
D5993	Cleaning and maintenance prosthetic appliance	\$18
BRIDGES & PONTICS*		
D6058	Abutment supported porcelain/ceramic crown	\$560
D6059/60/61	Abutment porc/metal crown- metal	\$523
D6066	Implant porc/metal crown	\$523
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure	\$63
D6210/11/12	Pontic - metal	\$495
D6240/41/42	Pontic - porcelain fused metal	\$523
D6245	Pontic - porcelain/ceramic	\$560
D6250/51/52	Pontic - resin with metal	\$495
D6545	Retainer - cast metal for resin bonded fixed prosthesis	\$251
D6548	Ret. - porc./ceramic for resin bonded fixed prosthesis	\$393
D6549	Resin retainer for resin bonded fixed prosthesis	\$251
D6600	Retainer inlay - porc./ceramic, two surfaces	\$400
D6601	Retainer inlay - porc./ceramic, >=3 surfaces	\$426
D6602	Retainer inlay - cast high noble metal, two surfaces	\$407
D6603	Retainer inlay - cast high noble metal, >=3 surfaces	\$425
D6604	Retainer inlay - cast predominantly base metal, two surfaces	\$407
D6605	Retainer inlay - cast predominantly base metal, >=3 surfaces	\$404
D6606	Retainer inlay - cast noble metal, two surfaces	\$384
D6607	Retainer inlay - cast noble metal, >=3 surfaces	\$425
D6608	Retainer onlay -porc./ceramic, two surfaces	\$437
D6609	Retainer onlay - porc./ceramic, three or more surfaces	\$458
D6610	Retainer onlay - cast high noble metal, two surfaces	\$458
D6611	Retainer onlay - cast high noble metal, >=3 surfaces	\$524
D6612	Retainer onlay - cast predominantly base metal, two surfaces	\$431
D6613	Retainer onlay - cast predominantly base metal, >=3 surfaces	\$478
D6614	Retainer onlay - cast noble metal, two surfaces	\$454
D6615	Retainer onlay - cast noble metal, >=3 surfaces	\$501
D6720/21/22	Retainer crown - resin with metal	\$495
D6740	Retainer crown - porcelain/ceramic	\$560

D6750/51/52	Retainer crown - porcelain fused metal	\$523
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ADA CODE	DESCRIPTION OF SERVICES	YOU PAY TO DENTIST
D6780	Retainer crown - 3/4 cast high noble metal	\$470
D6781	Retainer crown - 3/4 cast predominantly base metal	\$470
D6782	Retainer crown - 3/4 cast noble metal	\$470
D6783	Retainer crown - 3/4 porc./ceramic	\$511
D6790/91/92	Retainer crown - full cast metal	\$495
D6930	Recement or rebond fixed partial denture	\$69
D6980	Fixed partial denture repair, by report	\$172
ADJUNCTIVE GENERAL SERVICES		
D9110	Palliative (emergency) treatment of dental pain	\$30
D9210/15	Local anesthesia	\$0
D9211/12	Regional block anesthesia	\$0
D9219	Evaluation for deep sedation or general anesthesia	\$0
D9222	Deep sedation/general anesthesia - first 15 minutes	\$103
D9223	Deep sedation/general anesthesia each subsequent 15 minute increment	\$103
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis,	\$36
D9239	IV moderate conscious sedation/analgesia – first 15 minutes	\$103
D9243	IV moderate conscious sedation/analgesia – each subsequent 15 minute increment	\$103
D9248	Non-intravenous conscious sedation	\$145
D9310	Consultation (diagnostic service by nontreating dentist)	\$43
D9410	House/extended care facility call	\$200
D9420	Hospital call	\$350
D9439	Office visit	\$10
D9613	Infiltration of sustained release therapeutic drug – single or multiple sites	\$190
D9910	Application of desensitizing medicament	\$30
D9930	Treatment of complications (post-surgical)	\$43
D9940	Occlusal guard, by report	\$272
D9944	Occlusal guard – hard appliance, full arch	\$272
D9945	Occlusal guard – soft appliance, full arch	\$272
D9946	Occlusal guard – hard appliance, partial arch	\$272
D9941	Fabrication of athletic mouthguard	\$102
D9950	Occlusion analysis - mounted case	\$104

D9951	Occlusal adjustment - limited	\$66
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ADA CODE	DESCRIPTION OF SERVICES	YOU PAY TO DENTIST
D9952	Occlusal adjustment - complete	\$266
D9986	Missed appointment	\$50
D9995	Teledentistry – synchronous; real-time encounter	\$20
D9996	Teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review	\$20
ENDODONTICS		
D3110/20	Pulp cap - direct/indirect (excl. final restoration)	\$32
D3220	Therapeutic pulpotomy (excl. final restor.)	\$81
D3221	Pulpal debridement, prim. and perm. teeth	\$94
D3230	Pulpal therapy - resorbable filling, anterior, primary tooth	\$160
D3240	Pulpal therapy - resorbable filling, posterior, primary tooth	\$164
D3310	Endodontic therapy, anterior tooth	\$341
D3320	Endodontic therapy, premolar tooth (excl. final restor.)	\$418
D3330	Endodontic therapy, molar (excl. final restor.)	\$512
D3332	Incomp endo. Therapy-inop. or fractured tooth	\$183
D3333	Internal root repair of perforation defects	\$105
D3346	Retreat of prev. root canal therapy, anterior	\$387
D3347	Retreat of prev. root canal therapy, premolar	\$465
D3348	Retreat of prev. root canal therapy, molar	\$558
D3351	Apexification/recalcification - initial visit	\$202
D3352	Apexification/recalcification - interim med. repl.	\$589
D3353	Apexification/recalcification - final visit	\$449
D3355	Pulpal regeneration - initial visit	\$202
D3356	Pulpal regeneration - interim medication replacement	\$589
D3357	Pulpal regeneration - completion of treatment	\$449
D3410	Apicoectomy- anterior	\$323
D3421	Apicoectomy - premolar (first root)	\$364
D3425	Apicoectomy - molar (first root)	\$418
D3426	Apicoectomy- (each add. root)	\$152
D3427	Periradicular surgery w/o apicoectomy	\$266
D3430	Retrograde filling - per root	\$118
D3450	Root amputation - per root	\$205
D3470	Intentional reimplantation	\$718

D3920	Hemisection, not inc. root canal therapy	\$234
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ADA CODE	DESCRIPTION OF SERVICES	YOU PAY TO DENTIST
D3950	Canal prep/fitting of preformed dowel or post	\$136
PERIODONTICS		
D0180	Comp. periodontal eval - new or established patient	\$0
D4210	Gingivectomy or gingivoplasty - >3 cont. teeth, per quad.	\$279
D4211	Gingivectomy or gingivoplasty - <=3 teeth, per quad.	\$100
D4230	Anatomical crown exposure, >=4 teeth per quad.	\$454
D4231	Anatomical crown exposure, 1-3 teeth per quad.	\$424
D4240	Gingival flap proc., inc. root planing - >3 cont. teeth, per quad	\$345
D4241	Gingival flap proc, inc. root planing - <=3 cont. teeth, per quad	\$106
D4249	Clinical crown lengthening - hard tissue	\$576
D4260	Osseous surgery - >3 cont. teeth, per quad	\$499
D4261	Osseous surgery - <=3 cont. teeth, per quad	\$392
D4268	Surgical revision proc., per tooth	\$358
D4274	Mesial/distal wedge procedure, single tooth	\$308
D4320	Provisional splinting - intracoronal	\$427
D4321	Provisional splinting - extracoronal	\$377
D4341	Perio scaling and root planing - >3 cont teeth, per quad.	\$109
D4342	Perio scaling and root planing - <= 3 teeth, per quad	\$63
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation	\$45
D4355	Full mouth debridement	\$89
D4381	Localized delivery of antimicrobial agents	\$98
D4910	Periodontal maintenance	\$74
D4920	Unscheduled dressing change by non-treating dentist	\$84
ORAL SURGERY		
D7111	Extraction, coronal remnants - primary tooth	\$56
D7140	Extraction, erupted tooth or exposed root	\$69
D7210	Extraction, erupted tooth req. elev., etc.	\$133
D7220	Removal of impacted tooth - soft tissue	\$151
D7230	Removal of impacted tooth - partially bony	\$196
D7240	Removal of impacted tooth - completely bony	\$241
D7241	Removal of imp. tooth - completely bony, with unusual surg. complications	\$217

D7250 Removal of residual tooth roots \$141

ADA CODE	DESCRIPTION OF SERVICES	YOU PAY TO DENTIST
D7251	Coronectomy-intentional partial tooth removal	\$217
D7260	Oroantral fistula closure	\$578
D7270	Tooth reimplant./stabiliz. of acc. evulsed/displaced tooth	\$226
D7272	Tooth transplantation	\$615
D7280	Exposure of an unerupted tooth	\$153
D7282	Mobiliz. of erupted or malpos. tooth-aid erup.	\$96
D7285	Incisional biopsy of oral tissue - hard (bone, tooth)	\$196
D7286	Incisional biopsy of oral tissue - soft (all others)	\$184
D7290	Surgical repositioning of teeth	\$407
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	\$60
D7310/20	Alveoloplasty, per quad	\$141
D7311	Alveoloplasty in conj. with extractions	\$130
D7321	Alveoloplasty in conj. without extractions	\$40
D7340	Vestibuloplasty - ridge ext. sec. epithel.	\$923
D7350	Vestibuloplasty - ridge ext. inc. grafts, etc	\$1,776
D7410	Excision of benign lesion up to 1.25 cm	\$278
D7440	Exc. of malignant tumor- lesion diam. <=1.25cm	\$608
D7450	Removal of benign odon cyst/tumor - diam <=1.25cm	\$354
D7451	Removal of benign odon cyst/tumor - diam >1.25cm	\$543
D7460	Removal of benign nonodon cyst/tumor-diam <=1.25cm	\$516
D7461	Removal of benign nonodon cyst/tumor-diam >1.25cm	\$718
D7471	Removal of lateral exostosis	\$314
D7472	Removal of torus palatinus	\$263
D7473	Removal of torus mandibularis	\$271
D7485	Surgical reduction of osseous tuberosity	\$297
D7510	Incision and drainage of abscess - intraoral soft tissue	\$96
D7511	Incision and drainage of abscess – intraoral	\$108
D7520	Incision/drainage of abscess -extra. soft tiss	\$116
D7550	Partial ostect/sequestrect non-vital bone rem.	\$336
D7910	Suture of recent small wounds up to 5cm	\$246
D7960	Frenulectomy (frenectomy/frenotomy) - separate proc.	\$263
D7963	Frenuloplasty	\$99
D7970	Excision of hyperplastic tissue - per arch	\$233

D7971	Excision of pericoronal gingiva	\$131
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ADA CODE	DESCRIPTION OF SERVICES	YOU PAY TO DENTIST
D7972	Surgical reduction of fibrous tuberosity	\$78
D7979	Non-surgical sialolithotomy	\$43
ORTHODONTICS - PRE-AUTHORIZATION REQUIRED		
D8070	Comp. ortho. treatment - transitional dentition	\$3,304
D8080	Comp. ortho. treatment - adolescent dentition	\$3,422
D8090	Comp. ortho. treatment - adult dentition	\$3,658
D8660	Pre-orthodontic treatment visit	\$413
D8670	Periodic ortho. treatment visit (as part of contract)	\$118
D8680	Orthodontic retention (rem. of appl. and placement of retainer(s))	\$413
D8692	Replacement of lost or broken retainer	\$179
D8693	Rebonding or recementing fixed retainer	\$174
D8694	Repair of fixed retainers, includes reattachment	\$174

* All fees exclude the cost of noble and precious metals. An additional fee will be charged if these materials are used.

ADA CODE	DESCRIPTION OF COSMETIC SERVICES	YOU PAY TO DENTIST
BRIDGES & PONTICS*		
D6214	Pontic – titanium (Cosmetic Service)	\$571+
D6624	Retainer inlay – titanium (Cosmetic Service)	\$468+
D6634	Retainer onlay – titanium (Cosmetic Service)	\$548+
D6794	Retainer crown – titanium (Cosmetic Service)	\$659+
D6940	Stress breaker (Cosmetic Service)	\$205+
ADJUNCTIVE GENERAL SERVICES		
D9440	Office visit after hours (Cosmetic Service)	\$27+
D9972	External Bleaching – Per Arch (Cosmetic Service)	\$265+
D9979	Laser Whitening – Per Arch (Cosmetic Service)	\$200+
ORTHODONTICS - PRE-AUTHORIZATION REQUIRED		
	Invisalign (Cosmetic Service)	15% Discount

* All fees exclude the cost of noble and precious metals. An additional fee will be charged if these materials are used.

+ Cost of these services are pre-negotiated discounted rates and payments are not applied toward covered benefits.

Only current ADA CDT codes are considered valid by Dominion Dental Services, Inc.

Current Dental Terminology © American Dental Association.

**Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
Pediatric and Cosmetic Dental Plan
2020 Schedule of Dental Fees**

Description of Services & Fees for Pediatric and Cosmetic Services (up to age 19). Annual Out-of-Pocket Maximum: You pay the Copayment set forth below for covered dental services until you reach the Out-of-Pocket Maximum shown in the Summary of Services and Cost Shares in the EOC. You will not be charged more than the amount of your Out-of-Pocket Maximum for any dental services. Please refer to your medical plan for specific details.

Procedures not shown in this list are not covered. Refer to the Pediatric and Cosmetic Dental Plan for a complete description of the terms and conditions of your covered dental benefit. Cosmetic Dental Services are also included in this Schedule of Dental Fees and are not covered benefits[†]. Please refer to Pediatric and Cosmetic Dental Services Appendix for further details on the program along with exclusions and limitations.

Fees quoted in the “You pay to Dentist” column apply only when performed by a participating General Dentist or Dental Specialist. If specialty care is required, your general dentist must refer you to a participating specialist except for Cosmetic Services and as otherwise described in the Pediatric and Cosmetic Dental Plan Appendix.

NOTE: If you have any questions concerning this fee schedule, Contact Dominion for details at: toll-free at 855-733-7524, Monday through Friday, 7:30 a.m. to 6 p.m., (TTY 711).

ADA CODE	DESCRIPTION OF SERVICES	YOU PAY TO DENTIST
D9439	Office visit	\$10
	DIAGNOSTIC/PREVENTIVE	
D0120	Periodic oral eval - established patient	\$0
D0140	Limited oral eval - problem focused	\$0
D0145	Oral eval for a patient under 3 years of age	\$0
D0150	Comprehensive oral eval - new or established patient	\$0
D0160	Detailed and extensive oral eval - problem focused	\$0
D0170	Re-evaluation - limited, problem focused	\$0
D0210	Intraoral - complete series of radiographic images	\$26
D0220/30	Intraoral - periapical first radiographic image	\$0
D0240	Intraoral - occlusal radiographic image	\$0
D0250	Extraoral – 2D projection radiographic image	\$0
D0270-74	Bitewing x-rays - 1 to 4 radiographic images	\$0
D0277	Vertical bitewings - 7 to 8 radiographic images	\$0
D0290	Posterior/anterior or lateral skull bone film	\$83
D0310	Sialography	\$370

ADA CODE	DESCRIPTION OF SERVICES	YOU PAY TO DENTIST
D0320	Temporomandibular joint arthrogram, incl. injection	\$562
D0321	Other temporomandibular joint films, by report	\$120
D0330	Panoramic radiographic image	\$30
D0340	2D cephalometric radiographic image	\$0
D0350	2D oral/facial photographic images	\$0
D0351	3D photographic image	\$0
D0460	Pulp vitality tests	\$0
D0470	Diagnostic casts	\$0
D0486	Accession of brush biopsy sample	\$0
D0600	Non-ionizing diagnostic procedure capable of quantifying, monitoring and recording changes in structure of enamel, dentin, and cementum	\$0
D0601	Caries risk assessment & documentation, with a finding of low risk	\$0
D0602	Caries risk assessment & documentation, with a finding of moderate risk	\$0
D0603	Caries risk assessment & documentation, with a finding of high risk	\$0
D1110	Prophylaxis (cleaning) - adult	\$0
D1120	Prophylaxis (cleaning) - child	\$0
D1206	Topical application of fluoride varnish	\$0
D1208	Topical application of fluoride – excluding varnish	\$0
D1310	Nutritional counseling for control of dental disease	\$0
D1320/30	Oral hygiene instructions	\$0
D1351	Sealant - per tooth	\$21
D1352	Prev resin rest. mod/high caries risk – perm. tooth	\$21
D1354	Interim caries arresting medicament application – per tooth	0
SPACE MAINTAINERS		
D1510/20	Space maintainer - fixed/removable - unilateral	\$143
D1516	Space maintainer - fixed - bilateral, maxillary	\$198
D1517	Space maintainer - fixed - bilateral, mandibular	\$198
D1526	Space maintainer - removable - bilateral, maxillary	\$198
D1527	Space maintainer - removable - bilateral, mandibular	\$198
D1550	Re-cementation of space maintainer	\$23
D1555	Removal of fixed space maintainer, by non-originating dentist	\$44
D1575	Distal shoe space maintainer - fixed - unilateral	\$143

ADA CODE	DESCRIPTION OF SERVICES	YOU PAY TO DENTIST
RESTORATIVE DENTISTRY (FILLINGS)		
D2140	Amalgam - one surface, prim. or perm.	\$41
D2150	Amalgam - two surfaces, prim. or perm.	\$51
D2160	Amalgam - three surfaces, prim. or perm.	\$64
D2161	Amalgam - >=4 surfaces, prim. or perm.	\$78
RESIN/COMPOSITE RESTORATIONS (TOOTH COLORED)		
D2330	Resin-based composite - one surface, anterior	\$69
D2331	Resin-based composite - two surfaces, anterior	\$83
D2332	Resin-based composite - three surfaces, anterior	\$99
D2335	Resin-based composite - >=4 surfaces, anterior	\$119
D2390	Resin-based composite crown, anterior	\$192
D2391	Resin-based composite - one surface, posterior	\$73
D2392	Resin-based composite - two surfaces, posterior	\$87
D2393	Resin-based composite - three surfaces, posterior	\$102
D2394	Resin-based composite - >=4 surfaces, posterior	\$123
CROWNS & BRIDGES*		
D2510	Inlay - metallic - one surface	\$407
D2520	Inlay - metallic - two surfaces	\$407
D2530	Inlay - metallic - three or more surfaces	\$425
D2542	Onlay - metallic-two surfaces	\$458
D2543	Onlay - metallic-three surfaces	\$524
D2544	Onlay - metallic-four or more surfaces	\$524
D2610	Inlay - porcelain/ceramic - one surface	\$427
D2620	Inlay - porcelain/ceramic - two surfaces	\$427
D2630	Inlay - porcelain/ceramic - >=3 surfaces	\$445
D2642	Onlay - porcelain/ceramic - two surfaces	\$479
D2643	Onlay - porcelain/ceramic - three surfaces	\$499
D2644	Onlay - porcelain/ceramic - >=4 surfaces	\$499
D2650	Inlay - resin-based composite - one surface	\$440
D2651	Inlay - resin-based composite - two surfaces	\$440
D2652	Inlay - resin-based composite - >=3 surfaces	\$440

ADA CODE	DESCRIPTION OF SERVICES	YOU PAY TO DENTIST
D2662	Onlay - resin-based composite - two surfaces	\$444
D2663	Onlay - resin-based composite - three surfaces	\$444
D2664	Onlay - resin-based composite - >=4 surfaces	\$444
D2710	Crown - resin based composite (indirect)	\$272
D2712	Crown - 3/4 resin-based composite (indirect)	\$255
D2720/21/22	Crown - resin with metal	\$495
D2740	Crown - porcelain/ceramic	\$560
D2750/51/52	Crown - porcelain fused metal	\$523
D2780/81/82	Crown - 3/4 cast with metal	\$478
D2783	Crown - 3/4 porcelain/ceramic	\$511
D2790-94	Crown - full cast metal	\$495
D2910/20	Recement inlay, onlay/crown or partial coverage rest.	\$43
D2930	Prefab. stainless steel crown - prim. tooth	\$110
D2931	Prefab. stainless steel crown - perm. tooth	\$121
D2932	Prefabricated resin crown	\$140
D2933	Prefab. stainless steel crown w/ resin window	\$271
D2934	Prefab. esthetic coated primary tooth	\$296
D2940	Protective restoration	\$39
D2941	Interim therapeutic restoration, primary dentition	\$31
D2950	Core buildup, including any pins	\$125
D2951	Pin retention - per tooth, in addition to restoration	\$22
D2952	Post and core in addition to crown	\$186
D2954	Prefab. post and core in addition to crown	\$154
D2955	Post removal (not in conj. with endo. therapy)	\$105
D2960	Labial veneer (resin laminate) - chairside	\$434
D2961	Labial veneer (resin laminate) - laboratory	\$601
D2962	Labial veneer (porcelain laminate) - laboratory	\$449
D2980	Crown repair necessitated by restorative material failure	\$102
D2981	Inlay repair necessitated by restorative material failure	\$102
D2982	Onlay repair necessitated by restorative material failure	\$102
D2983	Veneer repair necessitated by restorative material failure	\$102
PROSTHETICS (DENTURES)		
D5110/20	Complete denture - maxillary/mandibular	\$697
D5130/40	Immediate denture - maxillary/mandibular	\$722

ADA CODE	DESCRIPTION OF SERVICES	YOU PAY TO DENTIST
D5211/12	Maxillary/mandibular partial denture - resin base	\$649
D5213/14	Maxillary/mandibular partial denture - cast metal	\$750
D5221/22	Immediate Maxillary/mandibular partial denture –resin base	\$649
D5223/24	Immediate Maxillary/mandibular partial denture – cast metal	\$750
D5225/26	Maxillary/mandibular partial denture - flexible base	\$750
D5282	Rem. unilateral partial denture - one piece cast metal, maxillary	\$419
D5283	Rem. unilateral partial denture - one piece cast metal, mandibular	\$419
D5410/11	Adjust complete denture - maxillary/mandibular	\$38
D5421/22	Adjust partial denture - maxillary/mandibular	\$38
D5511	Repair broken complete denture base, mandibular	\$87
D5512	Repair broken complete denture base, maxillary	\$87
D5520	Replace missing or broken teeth - complete denture	\$77
D5611	Repair resin partial denture base, mandibular	\$87
D5612	Repair resin partial denture base, maxillary	\$87
D5621	Repair cast partial framework, mandibular	\$87
D5622	Repair cast partial framework, maxillary	\$87
D5630	Repair or replace broken retentive/clasping material – per tooth	\$115
D5640	Replace broken teeth - per tooth	\$87
D5650	Add tooth to existing partial denture – per tooth	\$87
D5660	Add clasp to existing partial denture - per tooth	\$115
D5670/71	Replace all teeth and acrylic on cast metal framework	\$287
D5710/11	Rebase complete maxillary/mandibular denture	\$260
D5720/21	Rebase maxillary/mandibular partial denture	\$260
D5730/31	Reline complete maxillary/mandibular denture (chairside)	\$159
D5740/41	Reline maxillary/mandibular partial denture (chairside)	\$155
D5750/51	Reline complete maxillary/mandibular denture (lab)	\$224
D5760/61	Reline maxillary/mandibular partial denture (lab)	\$224
D5810/11	Interim complete denture - maxillary/mandibular	\$362
D5820/21	Interim partial denture - maxillary/mandibular	\$362
D5850/51	Tissue conditioning - maxillary/mandibular	\$79
D5863	Overdenture - complete maxillary	\$1,694
D5864	Overdenture - partial maxillary	\$1,668
D5865	Overdenture - complete mandibular	\$1,694
D5866	Overdenture - partial mandibular	\$1,668

D5992 Adjustment of prosthetic appliance, by report \$24

ADA CODE	DESCRIPTION OF SERVICES	YOU PAY TO DENTIST
D5993	Cleaning and maintenance prosthetic appliance	\$18
BRIDGES & PONTICS*		
D6058	Abutment supported porcelain/ceramic crown	\$560
D6059/60/61	Abutment porc/metal crown- metal	\$523
D6066	Implant porc/metal crown	\$523
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure	\$63
D6210/11/12	Pontic - metal	\$495
D6240/41/42	Pontic - porcelain fused metal	\$523
D6245	Pontic - porcelain/ceramic	\$560
D6250/51/52	Pontic - resin with metal	\$495
D6545	Retainer - cast metal for resin bonded fixed prosthesis	\$251
D6548	Ret. - porc./ceramic for resin bonded fixed prosthesis	\$393
D6549	Resin retainer for resin bonded fixed prosthesis	\$251
D6600	Retainer inlay - porc./ceramic, two surfaces	\$400
D6601	Retainer inlay - porc./ceramic, >=3 surfaces	\$426
D6602	Retainer inlay - cast high noble metal, two surfaces	\$407
D6603	Retainer inlay - cast high noble metal, >=3 surfaces	\$425
D6604	Retainer inlay - cast predominantly base metal, two surfaces	\$407
D6605	Retainer inlay - cast predominantly base metal, >=3 surfaces	\$404
D6606	Retainer inlay - cast noble metal, two surfaces	\$384
D6607	Retainer inlay - cast noble metal, >=3 surfaces	\$425
D6608	Retainer onlay -porc./ceramic, two surfaces	\$437
D6609	Retainer onlay - porc./ceramic, three or more surfaces	\$458
D6610	Retainer onlay - cast high noble metal, two surfaces	\$458
D6611	Retainer onlay - cast high noble metal, >=3 surfaces	\$524
D6612	Retainer onlay - cast predominantly base metal, two surfaces	\$431
D6613	Retainer onlay - cast predominantly base metal, >=3 surfaces	\$478
D6614	Retainer onlay - cast noble metal, two surfaces	\$454
D6615	Retainer onlay - cast noble metal, >=3 surfaces	\$501
D6720/21/22	Retainer crown - resin with metal	\$495
D6740	Retainer crown - porcelain/ceramic	\$560

D6750/51/52	Retainer crown - porcelain fused metal	\$523
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ADA CODE	DESCRIPTION OF SERVICES	YOU PAY TO DENTIST
D6780	Retainer crown - 3/4 cast high noble metal	\$470
D6781	Retainer crown - 3/4 cast predominantly base metal	\$470
D6782	Retainer crown - 3/4 cast noble metal	\$470
D6783	Retainer crown - 3/4 porc./ceramic	\$511
D6790/91/92	Retainer crown - full cast metal	\$495
D6930	Recement or rebond fixed partial denture	\$69
D6980	Fixed partial denture repair, by report	\$172
ADJUNCTIVE GENERAL SERVICES		
D9110	Palliative (emergency) treatment of dental pain	\$30
D9210/15	Local anesthesia	\$0
D9211/12	Regional block anesthesia	\$0
D9219	Evaluation for deep sedation or general anesthesia	\$0
D9222	Deep sedation/general anesthesia - first 15 minutes	\$103
D9223	Deep sedation/general anesthesia each subsequent 15 minute increment	\$103
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis,	\$36
D9239	IV moderate conscious sedation/analgesia – first 15 minutes	\$103
D9243	IV moderate conscious sedation/analgesia – each subsequent 15 minute increment	\$103
D9248	Non-intravenous conscious sedation	\$145
D9310	Consultation (diagnostic service by nontreating dentist)	\$43
D9410	House/extended care facility call	\$200
D9420	Hospital call	\$350
D9439	Office visit	\$10
D9613	Infiltration of sustained release therapeutic drug – single or multiple sites	\$190
D9910	Application of desensitizing medicament	\$30
D9930	Treatment of complications (post-surgical)	\$43
D9940	Occlusal guard, by report	\$272
D9944	Occlusal guard – hard appliance, full arch	\$272
D9945	Occlusal guard – soft appliance, full arch	\$272
D9946	Occlusal guard – hard appliance, partial arch	\$272
D9941	Fabrication of athletic mouthguard	\$102
D9950	Occlusion analysis - mounted case	\$104

D9951	Occlusal adjustment - limited	\$66
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ADA CODE	DESCRIPTION OF SERVICES	YOU PAY TO DENTIST
D9952	Occlusal adjustment - complete	\$266
D9986	Missed appointment	\$50
D9995	Teledentistry – synchronous; real-time encounter	\$20
D9996	Teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review	\$20
ENDODONTICS		
D3110/20	Pulp cap - direct/indirect (excl. final restoration)	\$32
D3220	Therapeutic pulpotomy (excl. final restor.)	\$81
D3221	Pulpal debridement, prim. and perm. teeth	\$94
D3230	Pulpal therapy - resorbable filling, anterior, primary tooth	\$160
D3240	Pulpal therapy - resorbable filling, posterior, primary tooth	\$164
D3310	Endodontic therapy, anterior tooth	\$341
D3320	Endodontic therapy, premolar tooth (excl. final restor.)	\$418
D3330	Endodontic therapy, molar (excl. final restor.)	\$512
D3332	Incomp endo. Therapy-inop. or fractured tooth	\$183
D3333	Internal root repair of perforation defects	\$105
D3346	Retreat of prev. root canal therapy, anterior	\$387
D3347	Retreat of prev. root canal therapy, premolar	\$465
D3348	Retreat of prev. root canal therapy, molar	\$558
D3351	Apexification/recalcification - initial visit	\$202
D3352	Apexification/recalcification - interim med. repl.	\$589
D3353	Apexification/recalcification - final visit	\$449
D3355	Pulpal regeneration - initial visit	\$202
D3356	Pulpal regeneration - interim medication replacement	\$589
D3357	Pulpal regeneration - completion of treatment	\$449
D3410	Apicoectomy- anterior	\$323
D3421	Apicoectomy - premolar (first root)	\$364
D3425	Apicoectomy - molar (first root)	\$418
D3426	Apicoectomy- (each add. root)	\$152
D3427	Periradicular surgery w/o apicoectomy	\$266
D3430	Retrograde filling - per root	\$118
D3450	Root amputation - per root	\$205
D3470	Intentional reimplantation	\$718

D3920	Hemisection, not inc. root canal therapy	\$234
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ADA CODE	DESCRIPTION OF SERVICES	YOU PAY TO DENTIST
D3950	Canal prep/fitting of preformed dowel or post	\$136
PERIODONTICS		
D0180	Comp. periodontal eval - new or established patient	\$0
D4210	Gingivectomy or gingivoplasty - >3 cont. teeth, per quad.	\$279
D4211	Gingivectomy or gingivoplasty - <=3 teeth, per quad.	\$100
D4230	Anatomical crown exposure, >=4 teeth per quad.	\$454
D4231	Anatomical crown exposure, 1-3 teeth per quad.	\$424
D4240	Gingival flap proc., inc. root planing - >3 cont. teeth, per quad	\$345
D4241	Gingival flap proc, inc. root planing - <=3 cont. teeth, per quad	\$106
D4249	Clinical crown lengthening - hard tissue	\$576
D4260	Osseous surgery - >3 cont. teeth, per quad	\$499
D4261	Osseous surgery - <=3 cont. teeth, per quad	\$392
D4268	Surgical revision proc., per tooth	\$358
D4274	Mesial/distal wedge procedure, single tooth	\$308
D4320	Provisional splinting - intracoronal	\$427
D4321	Provisional splinting - extracoronal	\$377
D4341	Perio scaling and root planing - >3 cont teeth, per quad.	\$109
D4342	Perio scaling and root planing - <= 3 teeth, per quad	\$63
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation	\$45
D4355	Full mouth debridement	\$89
D4381	Localized delivery of antimicrobial agents	\$98
D4910	Periodontal maintenance	\$74
D4920	Unscheduled dressing change by non-treating dentist	\$84
ORAL SURGERY		
D7111	Extraction, coronal remnants - primary tooth	\$56
D7140	Extraction, erupted tooth or exposed root	\$69
D7210	Extraction, erupted tooth req. elev., etc.	\$133
D7220	Removal of impacted tooth - soft tissue	\$151
D7230	Removal of impacted tooth - partially bony	\$196
D7240	Removal of impacted tooth - completely bony	\$241
D7241	Removal of imp. tooth - completely bony, with unusual surg. complications	\$217

D7250 Removal of residual tooth roots \$141

ADA CODE	DESCRIPTION OF SERVICES	YOU PAY TO DENTIST
D7251	Coronectomy-intentional partial tooth removal	\$217
D7260	Oroantral fistula closure	\$578
D7270	Tooth reimplant./stabiliz. of acc. evulsed/displaced tooth	\$226
D7272	Tooth transplantation	\$615
D7280	Exposure of an unerupted tooth	\$153
D7282	Mobiliz. of erupted or malpos. tooth-aid erup.	\$96
D7285	Incisional biopsy of oral tissue - hard (bone, tooth)	\$196
D7286	Incisional biopsy of oral tissue - soft (all others)	\$184
D7290	Surgical repositioning of teeth	\$407
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	\$60
D7310/20	Alveoloplasty, per quad	\$141
D7311	Alveoloplasty in conj. with extractions	\$130
D7321	Alveoloplasty in conj. without extractions	\$40
D7340	Vestibuloplasty - ridge ext. sec. epithel.	\$923
D7350	Vestibuloplasty - ridge ext. inc. grafts, etc	\$1,776
D7410	Excision of benign lesion up to 1.25 cm	\$278
D7440	Exc. of malignant tumor- lesion diam. <=1.25cm	\$608
D7450	Removal of benign odon cyst/tumor - diam <=1.25cm	\$354
D7451	Removal of benign odon cyst/tumor - diam >1.25cm	\$543
D7460	Removal of benign nonodon cyst/tumor-diam <=1.25cm	\$516
D7461	Removal of benign nonodon cyst/tumor-diam >1.25cm	\$718
D7471	Removal of lateral exostosis	\$314
D7472	Removal of torus palatinus	\$263
D7473	Removal of torus mandibularis	\$271
D7485	Surgical reduction of osseous tuberosity	\$297
D7510	Incision and drainage of abscess - intraoral soft tissue	\$96
D7511	Incision and drainage of abscess – intraoral	\$108
D7520	Incision/drainage of abscess -extra. soft tiss	\$116
D7550	Partial ostect/sequestrect non-vital bone rem.	\$336
D7910	Suture of recent small wounds up to 5cm	\$246
D7960	Frenulectomy (frenectomy/frenotomy) - separate proc.	\$263
D7963	Frenuloplasty	\$99
D7970	Excision of hyperplastic tissue - per arch	\$233

D7971	Excision of pericoronal gingiva	\$131
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ADA CODE	DESCRIPTION OF SERVICES	YOU PAY TO DENTIST
D7972	Surgical reduction of fibrous tuberosity	\$78
D7979	Non-surgical sialolithotomy	\$43
ORTHODONTICS - PRE-AUTHORIZATION REQUIRED		
D8070	Comp. ortho. treatment - transitional dentition	\$3,304
D8080	Comp. ortho. treatment - adolescent dentition	\$3,422
D8090	Comp. ortho. treatment - adult dentition	\$3,658
D8660	Pre-orthodontic treatment visit	\$413
D8670	Periodic ortho. treatment visit (as part of contract)	\$118
D8680	Orthodontic retention (rem. of appl. and placement of retainer(s))	\$413
D8692	Replacement of lost or broken retainer	\$179
D8693	Rebonding or recementing fixed retainer	\$174
D8694	Repair of fixed retainers, includes reattachment	\$174

* All fees exclude the cost of noble and precious metals. An additional fee will be charged if these materials are used.

ADA CODE	DESCRIPTION OF COSMETIC SERVICES	YOU PAY TO DENTIST
BRIDGES & PONTICS*		
D6214	Pontic – titanium (Cosmetic Service)	\$571+
D6624	Retainer inlay – titanium (Cosmetic Service)	\$468+
D6634	Retainer onlay – titanium (Cosmetic Service)	\$548+
D6794	Retainer crown – titanium (Cosmetic Service)	\$659+
D6940	Stress breaker (Cosmetic Service)	\$205+
ADJUNCTIVE GENERAL SERVICES		
D9440	Office visit after hours (Cosmetic Service)	\$27+
D9972	External Bleaching – Per Arch (Cosmetic Service)	\$265+
D9979	Laser Whitening – Per Arch (Cosmetic Service)	\$200+
ORTHODONTICS - PRE-AUTHORIZATION REQUIRED		
	Invisalign (Cosmetic Service)	15% Discount

* All fees exclude the cost of noble and precious metals. An additional fee will be charged if these materials are used.

+ Cost of these services are pre-negotiated discounted rates and payments are not applied toward covered benefits.

Only current ADA CDT codes are considered valid by Dominion Dental Services, Inc.

Current Dental Terminology © American Dental Association.

PEDIATRIC AND COSMETIC DENTAL PLAN

This Pediatric and Cosmetic Dental Plan for Members under age 19, is effective as of the date of your Kaiser Permanente Membership Agreement (Agreement) and shall terminate as of the date your Agreement terminates, or the date that is the end of the month in which the Member attains age 19, whichever is earlier. If coverage terminates due to the Member's attainment of age 19, the Member shall be covered under the Adult Dental Plan on the first day of the month following attainment of age 19.

The following dental Services shall be included in the Kaiser Permanente Membership Agreement.

I. DEFINITIONS

The following terms, when capitalized and used in any part of this Pediatric and Cosmetic Dental Services Plan, mean:

Covered Dental Services: A range of diagnostic, preventive, restorative, endodontic, periodontic, prosthetics, orthodontic and oral surgery Services that are covered under this Pediatric and Cosmetic Dental Plan and listed in the Pediatric and Cosmetic Dental Plan Schedule of Dental Fees attached to this Agreement.

Covered Preventive Care Dental Services includes, but is not limited to oral evaluation, cleaning and certain diagnostic X-rays.

Dental Administrator means the entity that has entered into a contract with Health Plan to provide or arrange for the provision of Covered Dental Services. The name and information about the Dental Administrator can be found under General Provisions, see Section II, Paragraph F below.

Dental Fee means the discounted fees that a Participating Dental Provider charges you for a Covered Dental Service. Dental Fees are reviewed annually and subject to change upon renewal and only with 60 days advance notice.

Dental Specialist means a Participating Dental Provider that is a dental specialist.

General Dentist means a Participating Dental Provider that is a general dentist.

Participating Dental Provider means a licensed dentist who has entered into an agreement with Dental Administrator to provide Covered Preventive Care Dental Services, Covered Dental Services and/or other dental Services at negotiated contracted rates.

II. GENERAL PROVISIONS

- A.** Subject to the terms, conditions, limitations, and exclusions specified in this Pediatric and Cosmetic Dental Plan, you may receive Covered Preventive Care Dental and Covered Dental Services from Participating Dental Providers. You may receive Covered Dental Services from a non-Participating Dental Provider for emergencies, urgent care received outside Health Plan's Service Area, and Services obtained pursuant to a referral to a non-participating specialist.
- B.** Health Plan has entered into an agreement with Dental Administrator to provide Covered Preventive Care Dental Services and certain other Covered Dental Services through its Participating Dental Providers.
- C.** Attached is a list of Covered Preventive Care Dental Services and other Covered Dental Services and the associated Dental Fees that you will be charged for each Service. You will pay a \$10 fixed copayment for each office visit. You will pay additional Dental Fees for other Covered Dental Services you receive from Participating Dental Providers. You will pay the applicable Dental Fee directly to the Participating Dental Provider at the time Services are rendered. The Participating Dental Provider has agreed to accept that Dental Fee as payment in full of the Member's responsibility for that procedure. Neither Health Plan nor Dental Administrator are responsible for payment of these fees or for any fees incurred as the result of receipt of

non-Covered Dental Services or any other non-covered dental service. Covered Dental Services are not subject to a Deductible. Copayments and Dental Fees set forth in the attached Pediatric and Cosmetic Dental Plan Schedule of Dental Fees apply toward the Out-of-Pocket Maximum in Summary of Copayments and Coinsurance of this Agreement.

D. You will receive a list of Participating Dental Providers from the Health Plan or from Dental Administrator. You should select a Participating Dental Provider, who is a “General Dentist”, from whom you and your covered family members will receive Covered Preventive Care Dental Services and other Covered Dental Services. Specialty care is also available should such care be required, however, you must be referred to a Dental Specialist by your General Dentist.

E. For assistance concerning the dental coverage benefit of your health insurance plan, you may contact the Health Plan’s Members Services Department at the following telephone numbers:

Toll-Free: 800-777-7902

TTY number is: 771

F. Dental Administrator: Health Plan has entered into an agreement with Dominion Dental Services USA, Inc. d/b/a Dominion National (“Dominion National”) to provide Covered Dental Services as described in this Pediatric and Cosmetic Dental Plan. For assistance concerning dental coverage questions or for help finding a Participating Dental Provider or obtaining a list of Participating Dental Providers, Dominion National Member Services specialists are available Monday through Friday from 7:30 a.m. to 6:00 p.m. (Eastern Time), or you may call the following numbers:

Toll-Free: 855-733-7524

TTY number is: 771

Dominion National’s Integrated Voice Response System is available 24 hours a day for information about Participating Dental Providers in your area, or to help you select a Participating Dental Provider. The most up-to-date list of Participating Dental Providers can be found at the following website:

DominionNational.com/kaiserdentists

Dominion National also provides many other secure features online at DominionNational.com

G. Missed Appointment Fee: Participating Dental Providers may charge you an administrative fee if you miss a scheduled dental appointment without giving 24 hours advance notice. The fee may vary depending on the Participating Dental Provider, however in no event shall the missed appointment fee exceed \$50 for a single visit.

III. SPECIALIST REFERRALS

A. Participating Specialist Referrals

If, in the judgment of your General Dentist, you require the Services of a specialist, you may be referred to a Dental Specialist who will provide Covered Dental Services to you at the Dental Fee for each procedure rendered. Please note that a referral is not required to receive Covered Dental Services from a participating pediatric dentist.

B. Non-Participating Specialist Referrals

Benefits may be provided for referrals to non-Participating Dental Provider specialists when:

1. You have been diagnosed by your General Dentist with a condition or disease that requires care from a dental specialist; AND

2. Health Plan and Dental Administrator do not have a Participating Dental Provider specialist who possesses the professional training and expertise required to treat the condition or disease; or
3. Health Plan and Dental Administrator cannot provide reasonable access to a Dental Specialist with the professional training and expertise to treat the condition or disease without unreasonable delay or travel.

The Member's cost share will be calculated as if the provider rendering the Covered Dental Services was a Participating Dental Provider.

C. Standing Referrals to Dental Specialists

1. If you suffer from a life-threatening, degenerative, chronic or disabling disease or condition that requires specialized care, your General Dentist may determine, in consultation with you and the Dental Specialist that you would be best served through the continued care of a Dental Specialist. In such instances, the General Dentist will issue a standing referral to the Dental Specialist.
2. The standing referral will be made in accordance with a written treatment plan developed by the General Dentist, Dental Specialist, and you. The treatment plan may limit the number of visits to the Dental Specialist or the period of time in which visits to the Dental Specialist are authorized. Health Plan retains the right to require the Dental Specialist to provide the General Dentist with ongoing communication regarding your treatment and dental health status.

IV. EXTENSION OF BENEFITS

A. In those instances when your coverage with Health Plan has terminated, we will extend Covered Dental Services, without payment of Premiums, in the following instances:

1. If you are in the midst of a course of covered dental treatment at the time your coverage ends, we will continue to provide benefits, in accordance with the Agreement and Pediatric and Cosmetic Dental Plan in effect at the time your coverage ended, for a period of 90 days following the date your coverage ended.
2. If you are in the midst of a course of covered orthodontic treatment at the time your coverage ends, we will continue to provide benefits, in accordance with the Agreement and Dental in effect at the time your coverage ended, for a period of:
 - a. 60 days following the date your coverage ended, if the orthodontist has agreed to or is receiving monthly payments; or
 - b. until the later of 60 days following the date your coverage ended, or the end of the quarter in progress, if the orthodontist has agreed to accept or is receiving payments on a quarterly basis.

To assist us, if you believe you qualify under this "Extension of Benefits" provision, please notify us in writing.

B. Extension of Benefit Limitations:

The "Extension of Benefits" section listed above does not apply to the following:

1. Coverage ends because of your failure to pay Premiums;
2. Coverage ends as the result of you committing fraud or material misrepresentation;
3. When coverage is provided by a succeeding health plan and that health plan's coverage:
 - a. is provided at a cost to you that is less than or equal to the cost to you of the extended benefit available under this Pediatric and Cosmetic Dental Plan; and

- b. will not result in an interruption of the Covered Dental Services you are receiving.

V. DENTAL EMERGENCIES OUTSIDE THE SERVICE AREA

When a dental emergency occurs outside the Service Area, Dental Administrator will reimburse the non-participating provider directly. If the member has already paid the charges, the Dental Administrator will reimburse the member (upon proof of payment) instead of paying the provider directly for Covered Dental Services that may have been provided. Reimbursement to the member is not to exceed \$50.00 per incident. Services are limited to those procedures not excluded under Plan Limitations and Exclusions. Proof of payment must be submitted to Dental Administrator by provider within one hundred eighty (180) days of treatment. The Dental Administrator will allow Members to submit claims up to one (1) year after the date of service. However, a Member's legal incapacity shall suspend the time to submit a claim; and the suspension period ends when legal capacity is regained. Failure to submit a claim within one (1) year after the date of services does not invalidate or reduce the amount of the claim if it was not reasonably possible to submit the claim within one (1) year after the date of services; and the claim is submitted within two (2) years after the date of service. Proof of payment should be mailed to: Dominion National, 251 18th Street South, Suite 900, Arlington, VA 22202, ATTN: Accounting Dept. Coverage is provided for emergency dental treatment as may be required to alleviate pain, bleeding, or swelling. You must receive all post-emergency care from your Participating Dental Provider.

VI. PRE-AUTHORIZATION BENEFITS

The Dental Administrator may require the treating dentist to submit a treatment plan prior to initiating Services. The Dental Administrator may request x-rays or other dental records prior to issuing the pre-authorization. The proposed Services will be reviewed and a pre-authorization will be issued to you or the dentist, specifying coverage. The pre-authorization is not a guarantee of coverage and is considered valid for 180 days.

VII. EXCLUSIONS AND LIMITATIONS

A. Plan Exclusions

The following Services are not covered under this Pediatric and Cosmetic Dental Plan:

1. Services which are covered under worker's compensation or employer's liability laws.
2. Services which are not necessary for the patient's dental health as determined by the Plan.
3. Surgery or related services for cosmetic purposes to improve appearance, but not to restore bodily function or correct deformity resulting from disease, trauma, or congenital or development anomalies.
4. Oral surgery requiring the setting of fractures or dislocations.
5. Dispensing of drugs.
6. Hospitalization for the following: the operation or treatment for the fitting or wearing of dentures; orthodontic care or malocclusion; operations on or for treatment of or to the teeth or supporting tissues of the teeth, except for the removal of tumors or cysts or treatment of injury to natural teeth due to an accident if the treatment is received within 6 months of the accident; and dental implants.
7. Procedures not listed as covered benefits under this Plan.
8. Services obtained outside of the dental office in which enrolled and that are not preauthorized or otherwise approved by such office or the Plan (with the exception of out-of-area emergencies).
9. Services performed by a Participating Specialist without a referral from a Participating General Dentist (with the exception of Orthodontics). A referral form is required. Participating dentists should refer to Specialty Care Referral Guidelines.
10. Any bill, or demand for payment, for a dental service that the appropriate regulatory board determines was provided as a result of a prohibited referral. "Prohibited referral" means a referral prohibited by Section 1-302 of the Maryland Health Occupations Article.
11. Non-medically necessary orthodontia is not a covered benefit under this policy. The provider agreements create no liability for payment by the Plan, and payments by the member for these services do not contribute to the Out-of-Pocket Maximum. The Invisalign system and similar specialized braces are not a covered benefit. See limitation #25 concerning medically necessary orthodontia.

B. Plan Limitations

1. One (1) evaluation (D0120, D0145, D0150, D0160) is covered two (2) times per calendar year, per patient, per provider/location.
2. One (1) teeth cleaning (D1110 or D1120) is covered two (2) times per calendar year, per patient.
3. One (1) topical fluoride application (D1206 or D1208) is covered two (2) times per calendar year, per patient; four (4) fluoride varnish treatments are covered per calendar year, per patient for children age three (3) and above; eight (8) topical fluoride varnishes are covered per calendar year, per patient up to age two (2).
4. Two (2) bitewing x-rays are covered per calendar year, per patient, per provider/location (D0270 does not have a frequency limitation).
5. One (1) set of full mouth x-rays or panoramic film is covered every three (3) years. Panoramic x-rays are limited to ages six (6) and above. No more than one (1) set of x-rays are covered per provider/location.
6. One (1) sealant per tooth is covered per lifetime, per patient (limited to occlusal surfaces of posterior permanent teeth without restorations or decay).
7. One (1) interim caries arresting medicament application per primary tooth is covered per lifetime.
8. One (1) space maintainer per 24 months, per quadrant (D1510, D1520 or D1575) or per arch (D1516, D1517, D1526 or D1527), per patient to preserve space between teeth for premature loss of a primary tooth (does not include use for orthodontic treatment).
9. Replacement of a filling is covered if it is more than three (3) years from the date of original placement.
10. Replacement of a crown or denture is covered if it is more than five (5) years from the date of original placement.
11. Replacement of a prefabricated resin and stainless steel crown (D2930, D2932, D2933, D2934) is covered if it is more than three (3) years from the date of original placement, per tooth, per patient.
12. Crown and bridge fees apply to treatment involving five (5) or fewer units when presented in a single treatment plan.
13. Relining and rebasing of dentures is covered once per 24 months, per patient, only after six (6) months of initial placement.
14. Root canal treatment and retreatment of previous root canal are covered once per tooth per lifetime.
15. Periodontal scaling and root planing (D4341 or D4342), osseous surgery (D4260 or D4261) and gingivectomy or gingivoplasty (D4210 or D4211) are each limited to one per 24 months, per patient, per quadrant.
16. Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation and in lieu of a covered D1110, limited to once per two years.
17. Full mouth debridement is covered once per 24 months, per patient.
18. One (1) scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure, per two (2) years.
19. Procedure Code D4381 is limited to one (1) benefit per tooth for three teeth per quadrant; or a total of 12 teeth for all four (4) quadrants per 12 months. Must have pocket depths of five (5) millimeters or greater.
20. Periodontal surgery of any type, including any associated material, is covered once every 24 months, per quadrant or surgical site.
21. Periodontal maintenance after active therapy is covered two (2) times per calendar year.
22. Coronectomy, intentional partial tooth removal, one (1) per lifetime.
23. All dental services that are to be rendered in a hospital setting require coordination and approval from both the dental insurer and the medical insurer before services can be rendered. Services delivered to the patient on the date of service are documented separately using applicable procedure codes.
24. Anesthesia requires a narrative of medical necessity be maintained in patient records. A maximum of 60 minutes of services are allowed for general anesthesia and intravenous or non-intravenous conscious sedation. Non-intravenous conscious sedation is not covered in conjunction with analgesia.
25. Orthodontics is only covered if Medically Necessary as determined by the Dental Administrator. Patient copayments will apply to the routine orthodontic appliance portion of services only. Additional costs incurred will become the patient's responsibility.
26. Teledentistry, synchronous (D9995) or asynchronous (D9996), limited to two per calendar year (when available).

Only current ADA CDT codes are considered valid by the Dental Administrator
Current Dental Terminology © American Dental Association.

PEDIATRIC AND COSMETIC DENTAL APPENDIX

I. DEFINITIONS

The following terms, when capitalized and used in any part of this Pediatric and Cosmetic Dental Services Appendix, mean:

- A. **Program** means the Total Cosmetic Dental Services program described in this Appendix.
- B. **Program Administrator** is Dominion National, 251 18th Street South, Arlington VA 22202, phone 855-733-7524.
- C. **Fee Schedule** amounts mean the amounts a member is responsible for paying directly to Participating Dentists for Cosmetic Dental Services at the time service is rendered as shown in the most current List of Services and Fee Schedule. The List of Services and Fee Schedule may be modified by Health Plan/Program Administrator consistent with terms of the Evidence of Coverage. Neither the Health Plan nor Program Administrator has any responsibility for any payment to a Participating Dentist for the provision of Pediatric Cosmetic Dental Services or any other services to a Member.
- D. **Participating Dentist(s)** means those independent licensed dentists who have contracted with the Program Administrator to provide Cosmetic Dental Services to Members. Participating Dentists are not employees of, nor supervised by, the Health Plan. The list of Participating Dentists is subject to change. The current list of Participating Dentists can be found at Kp.org/totalcosmeticdentalservices or a copy can be obtained from the Program Administrator or Health Plan.
- E. **Dental Specialist** means a Participating Dental Provider that is a dental specialist.
- F. **General Dentist** means a Participating Dental Provider that is a general dentist.
- G. **Pediatric Cosmetic Dental Services** means those services shown on the List of Services and Fee Schedule that are included in the terms of this Program as identified in the Description of Cosmetic Services.

II. GENERAL PROVISIONS

Choice of Participating Dentists. You are responsible for arranging appointments for Pediatric Cosmetic Dental Services directly with the Participating Dentist. You may receive Pediatric Cosmetic Dental Services from Participating Dentist. You are responsible for confirming that your dentist of choice is currently a Participating Dentist before you schedule Dental Services with the dentist through this Program.

Missed Appointment Fee. Participating Dentists may charge you an administrative fee if you miss a scheduled dental appointment without giving 24 hours advance notice to the dentist office. The missed appointment fee may vary depending on the Participating Dentist, however in no event shall the missed appointment fee exceed \$50 for a single visit.

Services. Only the Pediatric Cosmetic Dental Services shown on the most current List of Services and Fee Schedule are offered by this Program. The discounted fixed fees shown on the Fee Schedule apply and cannot be combined with other discounts, programs and/or services. The Pediatric Cosmetic Dental Services are included as discounted services beyond the required pediatric dental services and are not covered services and are not intended to duplicate services covered by your health plan coverage. The discounted fixed fees paid for Pediatric Cosmetic Dental Services do not accumulate towards out-of-pocket maximums. Dental records of Members concerning Pediatric Cosmetic Dental Services performed hereunder are the property of the Participating Dentist(s).

Payment of Fees. At the time of service, Member must show Health Plan ID Card, Total Cosmetic Dental Services ID Card or some other legal proof of identity. Also at time of service, Member is required to pay the required Service Fee directly to the Participating Dentist. All disputes about payment of such fees are between the Member and the

Participating Dentist, and neither Health Plan nor Program Administrator have any responsibility or liability for those fees or payments. The discounted fixed fees listed on the Fee Schedule are guaranteed and the Member will not pay more than the discounted fee listed in the Fee Schedule for a Pediatric Cosmetic Dental Service.

III. NO REPRESENTATION OR WARRANTY; DISCLAIMER OF LIABILITY

Member acknowledges that Services are provided by Participating Dentists and arranged by the Program Administrator and that no Services are provided hereunder by Health Plan. HEALTH PLAN MAKES NO REPRESENTATIONS OR WARRANTIES, AND ACCEPTS NO LEGAL LIABILITY OR RESPONSIBILITY, FOR THE SERVICES MEMBER ELECTS TO RECEIVE FROM PARTICIPATING DENTISTS. IN NO EVENT WILL HEALTH PLAN BE LIABLE FOR ANY LOSS OR DAMAGE RESULTING FROM MEMBER'S RECEIPT OF SERVICES FROM PARTICIPATING DENTISTS.

IV. COMPLAINTS

Complaints about services or quality of services or Payment of Fees should be brought to the attention of the Participating Dentist. If the issue is not resolved to the Member's satisfaction, Member may call the Program Administrator at the number shown below or send the complaint in writing to the Program Administrator at:

Manager of Complaints and Appeals
Dominion National
251 18th Street South
Suite 900
Arlington, VA 22202
1-888-271-7310

If complaints are not resolved with the Program Administrator send the complaint in writing to:

Manager of Complaints
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
2101 East Jefferson Street
Rockville, MD 20852