SMILE FOR TOTAL HEALTH

A guide to your dental benefits: Small Group Adult POS 1 and POS 3 (Virginia)

Your dental plan emphasizes healthy smiles through the prevention and early detection of dental problems to avoid costly procedures in the future. With our Dental Point-of-Service (POS) plans, you have the freedom to see any dentist inside or outside of the plan. You may choose to see any in-plan dentist, or if you prefer, you can visit any other licensed dentist not in the plan to receive your care. You have your choice of convenient private dental offices where you can receive care.

In-plan

You receive 100% in-network coverage for preventive care procedures such as:

- Oral evaluation
- Routine cleanings
- Bitewing X-rays

The preventive care procedures covered in this plan account for over 65% of dental services most frequently performed for adults.[1]

Out-of-plan

Depending on the service, you will receive 80% (POS 1) or 100% (POS 3) out-of-network coverage for preventive services if you choose to visit a licensed dentist not included in the network of participating dentists. The dentist may charge above the amount covered by your POS plan, and the balance is your responsibility. For a complete coinsurance schedule, and a list of exclusions and limitations, please refer to your *Evidence of Coverage* or you can find your plan on **dominionnational.com/kaiserdentists**.

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.

Choose a dentist

In-plan dental providers

You may select any general dentist from among our network of participating dentists. When you choose an in-plan dentist, your out-of-pocket expenses are lower.

You can be confident that your in-plan 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.

For a list of participating in-plan dentists, 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.

Out-of-plan dental providers

You can visit any licensed dentist not included in the network of participating dentists.

[1]Dominion National, based on annual review of utilization data, network survey and analysis report, 3rd Quarter 2018.

Deductibles and annual maximums

There is a single combined deductible for services covered in-plan and out-of-plan, per member, per plan year, of $50 ($150 adult maximum). The deductible is the amount of charges that you must pay for covered dental services during a plan year before the plan begins paying its share for those services. There is also a maximum annual benefit that applies to all in-plan and out-of-plan benefits combined per member, per plan year. The annual maximum is $1,000 (POS 1) or $2,000 (POS 3) combined in-plan and out-of-plan.

Make appointments

On or after your effective date of coverage, you can make an appointment with any participating (in-plan) dentist. You can also choose to visit a licensed dentist not in the network of participating dentists (out-of-plan). Make sure you bring your Kaiser Permanente medical ID card for your in-network appointments only. There is no separate dental ID card.

Do I need to submit claims?

In-plan claims are submitted by the dentist. For out-of-plan claims, you may be expected to pay the dentist the full amount at the time of service and then submit a claim to Dominion National. You must submit the claim within 365 days of the date of service.

Claims should be mailed to:
Dominion National
P.O. Box 1126
Elk Grove, IL 60009

Claims can be faxed to: **888-208-8290**

Dedicated customer service

Quality service is an important part of any dental plan. Knowledgeable 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 interactive 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**)

Fax: **855-485-0115**

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.

KAISER PERMANENTE®

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. 2101 E. Jefferson St., Rockville, MD 20852 2019MC1436 MAS 9/1/19-9/1/20

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
2020 POS 1 Dental Fee Coverage Schedule

100/80/50/0

Benefit Coverage	In-Network	Out-of-Network
Class I	100%	80%
Class II	80%	60%
Class III	50%	40%
Class IV	0%	0%
Endo/Perio	*Class II Benefits*	*Class II Benefits*

Annual Deductible	In-Network	Out-of-Network
Amount	$50	$50
Max for Adults	$150	$150
Applies to all Benefits	*No, Waived on Class I Benefits*	*No, Waived on Class I Benefits*

Maximums	In-Network	Out-of-Network
Annual	$1,000	$1,000
Lifetime Ortho	N/A	N/A

* Annual Maximum applies to Class I, Class II and Class III Benefits.

Waiting Periods	In-Network	Out-of-Network
Class I	NONE	NONE
Class II	NONE	NONE
Class III	NONE	NONE
Class IV	N/A	N/A

- Deductible is combined for all services for each Contract Year per member – maximum $150 for adults.
- Annual maximum amount listed is a combined total that applies to both in and out-of-network services.
- Services may be received from any licensed dentist.
- If course of treatment is to exceed $300, prior review is requested.
  Plan will pay either the participating dentist's negotiated fee or the maximum allowable charge (subject to benefit coverage percentage) for dental procedures and services as shown below, after any required annual deductible**.**

Class I. Diagnostic and Preventive Services:

1. Two evaluations per Contract Year including a maximum of one comprehensive evaluation per 36 months.
2. One emergency or problem focused exam (D0140) per Contract Year.
3. Two prophylaxis (cleaning, scaling and polishing teeth) per Contract Year (one additional cleaning is covered during pregnancy and for diabetic patients).
4. Bitewing x-rays, 2 per Contract Year.
5. Periapical x-rays.
6. Emergency palliative treatment (only if no services other than exam and x-rays were performed on the same date of service).
7. One full mouth or panoramic x-ray per 60 months.
8. One topical fluoride per Contract Year, age 16 and under.
9. One sealant per tooth per lifetime, age 16 and under (limited to permanent first and second molars).
10. One (1) interim caries arresting medicament application per primary tooth is covered per lifetime.
11. Space maintainers to preserve space between teeth for premature loss of primary tooth (does not include use for orthodontic treatment).

Class II. Basic Services:

1. Simple extraction of teeth.
2. Amalgam and composite fillings (restorations of mesiolingual, distolingual, mesiobuccal, and distobuccal surfaces considered single surface restorations), per tooth, per surface every 24 months.
3. Pin retention of fillings (multiple pins on the same tooth are allowable as one pin).
4. Antibiotic injections administered by a dentist.
5. Oral surgery, including postoperative care for:
    a. Removal of teeth, including impacted teeth.
    b. Extraction of tooth root.
    c. Alveolectomy, alveoplasty, and frenectomy.
    d. Excision of periocoronal gingiva, exostosis, or hyper plastic tissue, and excision of oral tissue for biopsy.
    e. Tooth reimplantation and/or stabilization; tooth transplantation.
    f. Excision of a tumor or cyst and incision and drainage of an abscess or cyst.
    g. Coronectomy - intentional partial tooth removal, once per lifetime.
6. Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:
    a. Root canal therapy (not covered if pulp chamber was opened before effective date of coverage).
    b. Pulpotomy.
    c. Apicoectomy.
    d. Retrograde fillings, per root per lifetime.
7. Periodontic services, limited to:
    a. Two periodontal maintenance visits following surgery per Contract Year.
    b. One scaling and root planing per quadrant (D4341 or D4342) per 24 months.
    c. Occlusal adjustment performed with covered surgery.

d. Gingivectomy.
e. Osseous surgery including flap entry and closure.
f. One pedicle or free soft tissue graft per site per lifetime.
g. One appliance (night guards) per 5 years within 6 months of osseous surgery.
h. One full mouth debridement per lifetime.
i. 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.

Class III. Major Services:

1. One study model per 36 months.
2. Crown build-up for non-vital teeth.
3. Recementing bridges, inlays, onlays and crowns after first 12 months and per 12 months per tooth thereafter.
4. One repair of dentures or fixed bridgework per 24 months.
5. General anesthesia and analgesic, including intravenous sedation, in conjunction with covered oral surgery or periodontal surgery.
6. Restoration services, limited to:
    a. Cast metal, porcelain/ceramic, all ceramic and resin-based inlays, onlays and crowns for tooth with extensive caries or fracture that is unable to be restored with an amalgam or composite filling.
    b. Replacement of existing inlay, onlay, or crown, after 7 years of the restoration initially placed or last replaced (will not apply if replacement is necessary due to the extraction of functioning natural teeth after the effective date of coverage).
    c. Post and core in addition to crown when separate from crown for endodontically treated teeth, with a good prognosis endodontically and periodontally.
7. Prosthetic services, limited to:
    a. Initial placement of removable dentures or fixed bridges.
    b. Replacement of removable dentures or fixed bridges that cannot be repaired after 7 years from the date of last placement.
    c. Addition of teeth to existing partial denture.
    d. One relining or rebasing of existing removable dentures per 24 months (only after 24 months from date of last placement, unless an immediate prosthesis replacing at least 3 teeth.
    e. 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 once per two years.
8. Teledentistry, synchronous (D9995) or asynchronous (D9996), limited to two per Contract Year (when available).

Class IV. Orthodontia Services: Not Covered

Diagnostic, active and retention treatment to include removable fixed appliance therapy and comprehensive therapy.

Plan Exclusions:

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. Reconstructive, plastic, cosmetic, elective or aesthetic dentistry.
4. Oral surgery requiring the setting of fractures and dislocations.
5. Services with respect to malignancies, cysts or neoplasms, hereditary, congenital, mandibular prognathism or development malformations where such services should not be performed in a dental office.
6. Dispensing of drugs.
7. Hospitalization for any dental procedure.
8. Treatment required for conditions resulting while on active duty as a member of the armed forces of any nation or from war or acts of war, whether declared or undeclared.
9. Implant removal or the replacement of dentures, bridges, inlays, onlays or crowns that can be repaired or restored to normal function.
10. Diagnosis or treatment of Temporomandibular Disorder (TMD) syndromes, problems and/or occlusal disharmony.
11. Elective surgery including, but not limited to, extraction of non- pathologic, symptomatic impacted teeth as determined by the Plan.
12. Services not listed as covered benefits by the Plan.
13. Implants and related services; replacement of lost, stolen or damaged prosthetic or orthodontic appliances; athletic mouthguards; precision or semi-precision attachments; denture duplication; periodontal splinting of teeth.
14. Services for increasing vertical dimension, replacing tooth structure lost by attrition, and correcting developmental malformations and/or congenital conditions.
15. Procedures that in the opinion of the Plan are experimental or investigative in nature because they do not meet professionally recognized standards of dental practice and/or have not been shown to be consistently effective for the diagnosis or treatment of the Member's condition.
16. Treatment of cleft palate, malignancies or neoplasms.
17. Any service or supply rendered to replace a tooth lost prior to the effective date of coverage. This exclusion expires after 36 months of Member's continuous coverage under the plan.

KAISER PERMANENTE®

KAISER FOUNDATION HEALTH PLAN OF THE MID-ATLANTIC STATES, INC.
2101 East Jefferson Street
Rockville, Maryland 20852

POS 1 PLAN

This POS Plan Dental Rider is effective as of the date of your Small Group Agreement and Small Group Evidence of Coverage (EOC) and shall terminate as of the date your Small Group Agreement and Small Group Evidence of Coverage (EOC) terminates.

The following dental Services are hereby added to the Small Group Evidence of Coverage (EOC) to which this POS Plan Dental Rider (hereinafter "Rider") is attached, in consideration of Group's application and payment of premium for such Services.

I. DEFINITIONS

Annual Maximum: The maximum amount Health Plan will pay for Covered Dental Services on your behalf each contract year.

Benefits: The amount payable by the Health Plan, as set forth in the Coverage Schedule, for a Covered Dental Service.

Covered Dental Services: A range of diagnostic, preventive, restorative, endodontic, periodontic, prosthetic and oral surgery services that are covered under this Rider.

Deductible: The amount of charges you must pay during a contract year for Covered Dental Services before those Services are covered under this benefit. The Deductible is shown on the attached Coverage Schedule.

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

In-Plan: The Covered Dental Services that are provided to you by a Participating Dental Provider.

Maximum Allowable Charge: A limitation on the billed charge as determined by the Plan by geographic area where the expenses are incurred and may not be less than the negotiated fee for the same service when provided by a Participating Dental Provider.

Non-Participating Dental Provider: A licensed dentist who has not entered into an agreement with Dental Administrator for the purposes of providing dental Services to Members.

Out-of-Plan: Those Covered Dental Services that are provided to you by Non-Participating Dental Providers.

Participating Dental Provider: A licensed dentist (general or specialist) who has entered into an agreement with Dental Administrator for the purposes of providing dental Services to Members on a preferential basis.

II. GENERAL PROVISIONS

A. Subject to the terms, conditions, limitations, and exclusions specified in the Small Group Evidence of Coverage and this Rider, coverage will be provided to allow you to receive Covered Dental Services from Participating Dental Providers and Non-Participating Dental Providers.

B. Dental Administrator will pay for Covered Dental Services incurred for you or your covered Dependents. Covered Dental Services must be incurred while this Rider is in force or under the extension of benefits provision in Part IV. The description of Covered Dental Services is shown in the Coverage Schedule. Benefits will be paid after you comply with any Waiting Periods, Deductibles and Annual Maximums as specified in the Coverage Schedule. All Benefits are subject to Plan Exclusions as set forth in Part VIII of this Rider. Benefit amounts will vary depending on whether you obtain services from a Participating Dental Provider or a Non -Participating Dental Provider. To be considered a Covered Dental Service, the service must be performed by a dentist, a physician, or a dental hygienist, and be deemed by the treating dentist to be necessary for the patient's dental health. A Covered Dental Service is considered

incurred on the following dates:

Dentures – on the date the final impression is taken.
Fixed bridges, crowns, inlays and onlays – on the date the teeth are initially prepared. Root canal therapy – on the date the pulp chamber is opened.
Periodontal surgery – on the date surgery is performed. All other services – on the date the service is performed.

C. To receive "In-Plan" Covered Dental Services you should select a Participating Dental Provider from the list made available to you by the Health Plan or Dental Administrator. You should confirm continued participation of a Participating Dental Provider prior to receiving treatment. Dental Administrator will pay a percentage of the Participating Dental Provider's charge for each Covered Dental Service up to the Participating Dental Provider's negotiated fee. The percentage of payment by Dental Administrator is determined by procedure classification as set forth in the Coverage Schedule. For example, if a procedure is covered at 80%, Dental Administrator will pay 80% and you will pay the remaining balance of 20%, up to the Participating Dental Provider's negotiated fee. You may be required to remit payment for the remaining balance at the time of service. Billing arrangements are between you and the Participating Dental Provider.

To receive Out-of-Plan Covered Dental Services, you may go to any Non-Participating Dental Provider. Benefit percentages for Out-of-Plan Covered Dental Services are listed in the Coverage Schedule according to procedure classification. Benefits are calculated using a Maximum Allowable Charge. You are responsible for any amount charged which exceeds the Maximum Allowable Charge per procedure. Billing arrangements are between you and the Non-Participating Dental Provider. If you receive treatment from a Non-Participating Dental Provider, you may be required to make payment in full at the time of service. You may then submit a claim to the Dental Administrator for Benefit payment. For information on how to submit a claim, please see Part VII of this Rider.

D. **Dental Administrator:** Health Plan has entered into an agreement with Dominion Dental Services USA, Inc. d/b/a Dominion National ("Dominion National") to provide or arrange for Covered Dental Services as described in this Rider. For assistance concerning dental coverage questions or for help finding a Participating Dental Provider, 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

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

E. **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. NON-PARTICIPATING SPECIALIST REFERRALS

Benefits may be provided for referrals to Non-Participating Dental Provider specialists when you have been diagnosed by a Participating Dental Provider with a condition or disease that requires care from a dental specialist, and:

1. Neither Health Plan nor Dental Administrator have a Participating Dental Provider who possesses the professional training and expertise to treat the condition or disease; or
2. Neither Health Plan nor Dental Administrator is able to provide reasonable access to a Participating Dental Provider 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 Non-Participating Dental Provider specialist rendering the Covered Dental Services were a Participating Dental Provider.

IV. EXTENSION OF BENEFITS

In those instances when your coverage with us has terminated, we will extend Covered Dental Services, without payment of premium 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 Evidence of Coverage and Dental Rider in effect at the time your coverage ended, for a period of 90 days following the date your coverage ended.

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

Extension of Benefits Limitations:

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

1. Coverage ends because of your failure to pay premium
2. Coverage ends as the result of you committing fraud or material misrepresentation;
3. When coverage is provided by another 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 Rider; and
    b. will not result in an interruption of Covered Dental Services to you.

V. PRE-DETERMINATION OF BENEFITS

If the charge for treatment is expected to exceed $300, it is strongly advised that the treating dentist submit a treatment plan prior to initiating services. Dental Administrator may request x-rays, periodontal charting or other dental records, prior to issuing the pre-determination. The proposed services will be reviewed and a pre-determination will be issued to you or the treating dentist, specifying coverage. The pre-determination is not a guarantee of coverage and is considered valid for 180 days.

VI. SUBMISSION OF CLAIMS

When you receive Covered Dental Services from a Non-Participating Dental Provider, 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.

The Dental Administrator will accept a recognized ADA claim form from the dental provider's office. Claims can be submitted to Dominion National, P.O. Box 1126; Elk Grove Village, IL 60009. If you would like to request a claim form you may go online at DominionNational.com or please call Dental Administrator at the phone number listed above (See Section II.E) to request a claim form. Once you have completed the claim form, you must attach copies of all itemized bills and proof of payment, if any.

If Dental Administrator does not provide the claim form within 15 days, after notice is given, you may submit proof of loss by submitting, within the one year time frame for filing proof of loss stated below, written proof of the occurrence, character, and extent of the loss for which the claim is made.

All itemized bills and/or proof of payment must be submitted within one (1) year of the date of service. Failure to submit the itemized bill and/or proof of payment within the one-year period does not invalidate or reduce Benefits payable if it was not reasonably possible for you to submit the itemized bills and/or proof of payment within the – one-year period. If you submit the itemized bill and/or proof of payment as soon as reasonably possible and, except in the absence of legal capacity, no later than one (1) year from the time proof is otherwise required, Benefits will be payable.

Benefits payable under the Small Group Evidence of Coverage for any loss will be paid within the time required by state regulations after receipt of written proof of loss. If Dental Administrator fails to pay claim within the time required by state regulations, it will pay interest from the date on which payment is required to the date the claim is paid. If a claim is denied in whole or in part, the written notice of the denial will contain the reasons for denial and reference to the pertinent provisions of the Small Group Evidence of Coverage and this Rider.

If a claim is denied, you or your Authorized Representative may file an appeal in accordance with the "Getting Assistance, Health Care Service Review and Grievance and Appeal Process" section of the Small Group Evidence of Coverage.

VII. EXCLUSIONSAND LIMITATIONS

A. Exclusions

The following services are excluded under this Rider:

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. Reconstructive, plastic, cosmetic, elective or aesthetic dentistry.
4. Oral surgery requiring the setting of fractures and dislocations.
5. Services with respect to malignancies, cysts or neoplasms, hereditary, congenital, mandibular prognathism or development malformations where such services should not be performed in a dental office.
6. Dispensing of drugs.
7. Hospitalization for any dental procedure.
8. Treatment required for conditions resulting while on active duty as a member of the armed forces of any nation or from war or acts of war, whether declared or undeclared.
9. Implant removal or the replacement of dentures, bridges, inlays, onlays or crowns that can be repaired or restored to normal function.
10. Diagnosis or treatment of Temporomandibular Disorder (TMD) syndromes, problems and/or occlusal disharmony.
11. Elective surgery including, but not limited to, extraction of non- pathologic, symptomatic impacted teeth as determined by the Plan.
12. Services not listed as covered benefits by the Plan.
13. Implants and related services; replacement of lost, stolen or damaged prosthetic or orthodontic appliances; athletic mouthguards; precision or semi-precision attachments; denture duplication; sealants; periodontal splinting of teeth.
14. Services for increasing vertical dimension, replacing tooth structure lost by attrition, and correcting developmental malformations and/or congenital conditions.
15. Procedures that in the opinion of the Plan are experimental or investigative in nature because they do not meet professionally recognized standards of dental practice and/or have not been shown to be consistently effective for the diagnosis or treatment of the Member's condition.
16. Treatment of cleft palate, malignancies or neoplasms.
17. Any service or supply rendered to replace a tooth lost prior to the effective date of coverage. This exclusion expires after 36 months of Member's continuous coverage under the plan.

B. Limitations

Covered Dental Services are subject to the following limitations:

Class I. Diagnostic and Preventive Services:

1. Two evaluations per Contract Year including a maximum of one comprehensive evaluation per 36 months.
2. One emergency or problem focused exam (D0140) per Contract Year.
3. Two prophylaxis (cleaning, scaling and polishing teeth) per Contract Year (one additional cleaning is covered during pregnancy and for diabetic patients).
4. Bitewing x-rays, 2 per Contract Year.
5. Periapical x-rays.
6. Emergency palliative treatment (only if no services other than exam and x-rays were performed on the same date of service).
7. One full mouth or panoramic x-ray per 60 months.
8. One topical fluoride per Contract Year, age 16 and under.
9. One sealant per tooth per lifetime, age 16 and under (limited to permanent first and second molars).
10. One (1) interim caries arresting medicament application per primary tooth is covered per lifetime.
11. Space maintainers to preserve space between teeth for premature loss of primary tooth (does not include use for orthodontic treatment).

Class II. Basic Services:

1. Simple extraction of teeth.
2. Amalgam and composite fillings (restorations of mesiolingual, distolingual, mesiobuccal, and distobuccal surfaces considered single surface restorations), per tooth, per surface every 24 months.
3. Pin retention of fillings (multiple pins on the same tooth are allowable as one pin).
4. Antibiotic injections administered by a dentist.
5. Oral surgery, including postoperative care for:
    a. Removal of teeth, including impacted teeth.
    b. Extraction of tooth root.
    c. Alveolectomy, alveoplasty, and frenectomy.
    d. Excision of periocoronal gingiva, exostosis, or hyper plastic tissue, and excision of oral tissue for biopsy.
    e. Tooth reimplantation and/or stabilization; tooth transplantation.
    f. Excision of a tumor or cyst and incision and drainage of an abscess or cyst.
    g. Coronectomy - intentional partial tooth removal, once per lifetime.
6. Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:
    a. Root canal therapy (not covered if pulp chamber was opened before effective date of coverage).
    b. Pulpotomy.
    c. Apicoectomy.
    d. Retrograde fillings, per root per lifetime.
7. Periodontic services, limited to:
    a. Two periodontal maintenance visits following surgery per Contract Year.
    b. One scaling and root planing per quadrant (D4341 or D4342) per 24 months.
    c. Occlusal adjustment performed with covered surgery.
    d. Gingivectomy.
    e. Osseous surgery including flap entry and closure.

f. One pedicle or free soft tissue graft per site per lifetime.
g. One appliance (night guards) per 5 years within 6 months of osseous surgery.
h. One full mouth debridement per lifetime.
i. 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.

Class III. Major Services:

1. One study model per 36 months.
2. Crown build-up for non-vital teeth.
3. Recementing bridges, inlays, onlays and crowns after first 12 months and per 12 months per tooth thereafter.
4. One repair of dentures or fixed bridgework per 24 months.
5. General anesthesia and analgesic, including intravenous sedation, in conjunction with covered oral surgery, periodontal surgery.
6. Restoration services, limited to:
   a. Cast metal, porcelain/ceramic, all ceramic and resin-based inlays, onlays, and crowns for tooth with extensive caries or fracture that is unable to be restored with an amalgam or composite filling.
   b. Replacement of existing inlay, onlay, or crown, after 7 years of the restoration initially placed or last replaced (will not apply if replacement is necessary due to the extraction of functioning natural teeth after the effective date of coverage).
   c. Post and core in addition to crown when separate from crown for endodontically treated teeth, with a good prognosis endodontically and periodontally.
7. Prosthetic services, limited to:
   a. Initial placement of removable dentures or fixed bridges.
   b. Replacement of removable dentures or fixed bridges that cannot be repaired after 7 years from the date of last placement.
   c. Addition of teeth to existing partial denture.
   d. One relining or rebasing of existing removable dentures per 24 months (only after 24 months from date of last placement, unless an immediate prosthesis replacing at least 3 teeth.
   e. 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 once per two years.
8. Teledentistry, synchronous (D9995) or asynchronous (D9996), limited to two per calendar year (when available)

Class IV. Orthodontia Services: Not Covered

Diagnostic, active and retention treatment to include removable fixed appliance therapy and comprehensive therapy

This Rider is subject to all the terms and conditions of the Small Group Agreement and Evidence of Coverage (EOC) to which this Rider is attached. This Rider does not change any of those terms and conditions, unless specifically stated in this Rider.

KAISER FOUNDATION HEALTH PLAN OF THE MID-ATLANTIC STATES, INC.

By: _____

Mark Ruszczyk
Vice President, Marketing, Sales & Business Development