SMILE
FOR TOTAL HEALTH

A guide to your dental benefits: Base Level Point-of-Service Plan

Your dental plan emphasizes healthy smiles through the prevention and early detection of dental problems to avoid costly procedures in the future.

With the Base Level Point-of-Service (POS) plan, you have the freedom and flexibility to see any dentist inside or outside of the plan network. You may choose to see an in-plan dentist from among one of the largest dental provider networks[1] in the Mid-Atlantic area.[2] 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 dental offices where you can receive care.

The Base Level POS plan provides coverage for more than 250 dental procedures. The preventive care procedures covered in this plan account for over 65% of the dental services most frequently performed for adults.[1]

In-plan

You pay low copayments for preventive care procedures, such as:

- Oral evaluations
- Routine cleaning
- Certain X-rays
- Topical fluoride

Out-of-plan

You pay the dentist the charged amount and submit a claim form to Kaiser Permanente for reimbursement. You will be reimbursed up to the maximum stated in the out-of-plan copayment schedule. The dentist's charges may be more than the amount Kaiser Permanente reimburses you under the copayment schedule. For more information, 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 and there are no claims to submit.

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 and has passed a thorough on-site office evaluation.

[1]Dominion National, based on annual review of utilization data, network survey and analysis report, 3rd Quarter 2018.
[2]Mid-Atlantic area includes Washington, DC, and parts of Maryland and Virginia.

KAISER PERMANENTE®

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.

Deductibles and annual maximums

The deductible is the amount of charges that you must pay for covered dental services during a plan year before the plan begins paying or reimbursing its share for those services. The deductibles are $25 in-plan per member and $50 out-of-plan per member. The deductible applies to in-plan and out-of-plan benefits combined per member, per plan year.

The maximum annual benefit applies to in-plan and out-of-plan benefits combined per member, per plan year. The annual maximums are $1,000 in-plan and $500 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-plan appointments only. There is no separate dental ID card.

Do I need to submit claims?

Claims only need to be submitted when you receive care from an out-of-plan dentist. You may be expected to pay the dentist the full amount at the time of service and then submit a claim to Kaiser Permanente for reimbursement. You must submit the claim within 365 days of the date of service. Reimbursement is capped at the amount shown on the out-of-plan copayment schedule.

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 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 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**)

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 PERMANENTE®

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. 2101 E. Jefferson St., Rockville, MD 20852 2021MC0970 MAS 8/31/21-12/31/22

KAISER PERMANENTE®
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
2101 E. Jefferson Street, Rockville, MD 20852
301-816-2424

Kaiser Permanente
District of Columbia Large Group Agreement and Evidence of Coverage

Kaiser Foundation Health Plan of the Mid–Atlantic States, Inc.
Description of Benefits and Member Copayments
Base Level Point–of–Service (POS) Plan

Procedures not shown in this list are not covered. Refer to the description of your dental benefit for a complete description of the terms and conditions of your covered benefit.

Deductible

The Deductible is the amount of charges that you must pay during a calendar year for covered dental services before the Health Plan starts paying its cost share for these services. The Deductible applies to In-Plan and Out-of-Plan Benefits combined per Member, per calendar year. Refer to the Point-of-Service Dental Rider for an example of how the combined Deductible works. You must pay the full amount charged by the dentist for the services when you receive them, until you meet your Deductible. After you meet the Deductible, you pay the applicable fee shown below for services provided In-Plan, and you will be reimbursed the amount shown below for services provided Out-of-Plan, up to the Annual Maximum Benefit. You are responsible for the remaining balance for Out-of-Plan Services, and for any amounts that exceed the Annual Maximum Benefit.

Deductible
In-Plan: $25 per Member
Out-of-Plan: $50 per Member

Annual Maximum Benefit

The maximum benefit applies to In-Plan and Out-of-Plan Benefits combined per Member, per calendar year. Refer to the Point-of-Service Dental Rider for an explanation of how the combined Annual Maximum Benefit works. The maximum benefit will not exceed $1,000 per calendar year.

Annual Maximum
In-Plan: $1,000 per calendar year
Out-of-Plan: $500 per calendar year

The dental plan is administered by:

Dominion Dental Services USA, Inc.
251 18th Street South, Suite 900, Arlington, VA 22202
Phone: 855.733.7524

PLEASE NOTE: The heading “In-Plan means the cost that you pay in-plan to dentist. The heading “Out-of-Plan” means the cost that you are reimbursed out-of-plan.

ADA Code	Description of Services	You Pay In-Plan to Dentist	You Are Reimbursed Out-of-Plan
Diagnostic Services			
D0120	Periodic oral evaluation- established patient	$5	$17
D0140	Limited oral eval - problem focused	$7	$27
D0150	Comprehensive oral eval - new or established patient	$7	$26
D0180	Comp. periodontal eval - new or established patient	$7	$26
D0210	Intraoral – complete series of radiographic images	$19	$48
D0220	Intraoral – periapical first radiographic image	$3	$9
D0230	Intraoral – periapical each add. radiographic image	$2	$7
D0240	Intraoral – occlusal radiographic image	$4	$14
D0270	Bitewing – single radiographic image	$3	$9
D0272	Bitewings – two radiographic images	$4	$15
D0274	Bitewings – four radiographic images	$7	$22
D0277	Vertical bitewings - 7 to 8 radiographic images	$7	$22
D0330	Panoramic radiographic images	$18	$44
D0460	Pulp vitality tests	$5	$18
D0470	Diagnostic casts	$15	$37
D0701	Panoramic radiographic image – image capture only	$0	$0
D0702	2-D cephalometric radiographic image – image capture only	$0	$0
D0703	2-D oral/facial photographic image obtained intra-orally or extra-orally – image capture only	$0	$0
D0704	3-D photographic image – image capture only	$0	$0
D0705	Extra-oral posterior dental radiographic image – image capture only	$0	$0
D0706	Intraoral – occlusal radiographic image – image capture only	$0	$0
D0707	Intraoral – periapical radiographic image – image capture only	$0	$0
D0708	Intraoral – bitewing radiographic image – image capture only	$0	$0
D0709	Intraoral – complete series of radiographic images – image capture only	$0	$0
D0999	Unspecified diagnostic procedure, by report	$5	No Benefit
Preventive Services			
D1110	Prophylaxis (cleaning) – adult	$14	$34
D1120	Prophylaxis (cleaning) – child	$7	$22

ADA Code	Description of Services	You Pay In-Plan to Dentist	You Are Reimbursed Out-of-Plan
D1206	Topical application of fluoride varnish	$0	$18
D1208	Topical application of fluoride – excluding varnish	$0	$18
D1321	Counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use	$0	$0
D1330	Oral hygiene instructions	$0	$0
D1351	Sealant – per tooth	$5	$18
D1352	Prev resin rest. Mod/high caries risk – perm. Tooth	$5	$18
D1354	Interim caries arresting medicament application – per tooth	$0	$15
D1510	Space maintainer – fixed, unilateral – per quadrant	$42	$110
D1516	Space maintainer – fixed – maxillary	$78	$200
D1517	Space maintainer – fixed – mandibular	$78	$200
D1520	Space maintainer – removable, unilateral – per quadrant	$48	$147
D1526	Space maintainer – removable – bilateral, maxillary	$84	$205
D1527	Space maintainer – removable – bilateral, mandibular	$84	$205
D1551	Re-cement or re-bond bilateral space maintainer – maxillary	$7	$22
D1552	Re-cement or re-bond bilateral space maintainer – mandibular	$7	$22
D1553	Re-cement or re-bond unilateral space maintainer – per quadrant	$7	$22
D1575	Distal shoe space maintainers – fixed, unilateral – per quadrant	$42	$110
Restorative Services			
D2140	Amalgam – 1 surface	$39	$25
D2150	Amalgam – 2 surfaces	$49	$33
D2160	Amalgam – 3 surfaces	$61	$39
D2161	Amalgam – >=4 surfaces	$76	$48
D2330	Resin-based composite – 1 surface, anterior	$47	$30
D2331	Resin-based composite – 2 surfaces, anterior	$61	$39
D2332	Resin-based composite – 3 surfaces, anterior	$76	$48
D2335	Resin-based composite – >=4 surfaces, anterior	$82	$55
D2391	Resin-based composite – 1 surface, posterior	$51	$31
D2392	Resin-based composite – 2 surfaces, posterior	$67	$45

ADA Code	Description of Services	You Pay In-Plan to Dentist	You Are Reimbursed Out-of-Plan
D2393	Resin-based composite – 3 surfaces, posterior	$84	$57
D2394	Resin-based composite – - >=4 surfaces, posterior	$97	$66
D2510	Inlay – metallic – 1 surface	$258	$167
D2520	Inlay – metallic – 2 surfaces	$291	$188
D2530	Inlay – metallic – 3 or more surfaces	$348	$220
D2542	Onlay – metallic – 2 surfaces	$234	$150
D2543	Onlay – metallic – 3 surfaces	$234	$150
D2544	Onlay – metallic – 4 or more surfaces	$234	$150
D2610	Inlay – porcelain/ceramic – 1 surface	$215	$210
D2620	Inlay – porcelain/ceramic – 2 surfaces	$321	$220
D2630	Inlay – porcelain/ceramic – >=3 surfaces	$365	$236
D2642	Onlay – porcelain/ceramic – 2 surfaces	$189	$124
D2643	Onlay – porcelain/ceramic – 3 surfaces	$189	$124
D2644	Onlay – porcelain/ceramic – >=4 surfaces	$189	$124
D2650	Inlay – resin-based composite – 1 surface	$215	$210
D2651	Inlay – resin-based composite – 2 surfaces	$321	$220
D2652	Inlay – resin-based composite – >=3 surfaces	$365	$236
D2710	Crown – resin-based composite (indirect)	$159	$102
D2712	Crown – 3/4 resin-based composite (exclusive of veneers)	$159	$102
D2740	Crown – porcelain/ceramic	$437	$279
D2750	Crown – porcelain fused to high noble metal	$428	$274
D2751	Crown – porcelain fused to predominantly base metal	$378	$241
D2752	Crown – porcelain fused to noble metal	$404	$258
D2753	Crown – porcelain fused to titanium and titanium alloys	$428	$274
D2780	Crown – 3/4 cast high noble metal	$418	$263
D2781	Crown – 3/4 cast predominantly base metal	$418	$263
D2782	Crown – 3/4 cast noble metal	$418	$263
D2790	Crown – full cast high noble metal	$418	$269
D2791	Crown – full cast predominantly base metal	$373	$241
D2792	Crown – full cast noble metal	$397	$252
D2794	Crown – titanium and titanium alloys	$418	$269
D2910	Recement inlay	$30	$20
D2915	Recement cast or prefab. post and core	$30	$20
D2920	Recement crown	$30	$20
D2930	Prefab. stainless steel crown – prim. tooth	$96	$60

ADA Code	Description of Services	You Pay In-Plan to Dentist	You Are Reimbursed Out-of-Plan
D2931	Prefab. stainless steel crown – perm. tooth	$96	$65
D2932	Prefabricated resin crown	$96	$60
D2934	Prefab. esthetic coated primary tooth	$96	$60
D2940	Protective restoration	$33	$21
D2941	Interim therapeutic restoration, prim. dentition	$21	$21
D2950	Core buildup, including any pins	$96	$60
D2951	Pin retention – per tooth, in addition to restoration	$18	$12
D2952	Post and core in addition to crown	$126	$81
D2954	Prefab. Post and core in addition to crown	$107	$70
D2980	Crown repair necessitated by restorative material failure	$72	$48
D2981	Inlay repair necessitated by restorative material failure	$72	$48
D2982	Onlay repair necessitated by restorative material failure	$72	$48
Endodontic Services			
D3110	Pulp cap – direct (excl. final restoration)	$21	$15
D3120	Pulp cap – indirect (excl. final restoration)	$19	$13
D3220	Therapeutic pulpotomy (excl. final restor.)	$60	$38
D3230	Pulpal therapy - resorbable filling, anterior, primary tooth	$70	$45
D3240	Pulpal therapy - resorbable filling, posterior, primary tooth	$121	$76
D3310	Endodontic therapy, anterior tooth (excl final restoration	$258	$162
D3320	Endodontic therapy, premolar tooth (excl final restoration)	$378	$193
D3330	Endodontic therapy, molar tooth (excl final restoration)	$466	$295
D3346	Retreat of prev. root canal therapy, ant.	$320	$187
D3347	Retreat of prev. root canal therapy, premolar	$459	$224
D3348	Retreat of prev. root canal therapy, molar	$537	$343
D3351	Apexification/recalcification - initial visit	$107	$70
D3352	Apexification/recalcification - interim med. repl.	$107	$70
D3353	Apexification/recalcification - final visit	$107	$70
D3355	Pulpal regeneration, initial visit	$107	$70
D3356	Pulpal regeneration, int. med. Replacement	$107	$70
D3357	Pulpal regeneration, completion of treatment	$107	$70

ADA Code	Description of Services	You Pay In-Plan to Dentist	You Are Reimbursed Out-of-Plan
D3410	Apicoectomy - anterior	$329	$210
D3421	Apicoectomy - premolar (first root)	$359	$231
D3425	Apicoectomy - molar (first root)	$404	$258
D3426	Apicoectomy - (each add. Root)	$126	$81
D3427	Periradicular surg. w/o apicoectomy	$307	$189
D3428	Bone graft in conj. w/ periradicular surg., per tooth, single site	$354	$150
D3429	Bone graft in conj. w/ periradicular surg., each add. contiguous tooth in same site	$177	$75
D3430	Retrograde filling – per root	$107	$70
D3431	Biologic materials to aid soft/osseous tissue regen. in conj. w/ periradicular surg.	$70	$76
D3450	Root amputation - per root	$205	$129
D3471	Surgical repair of root resorption - anterior	$329	$210
D3472	Surgical repair of root resorption – premolar	$359	$231
D3473	Surgical repair of root resorption – molar	$404	$258
D3501	Surgical exposure of root surface without apicoectomy or repair of root resorption – anterior	$329	$210
D3502	Surgical exposure of root surface without apicoectomy or repair of root resorption – premolar	$359	$231
D3503	Surgical exposure of root surface without apicoectomy or repair of root resorption – molar	$404	$258
D3920	Hemisection, not inc. root canal therapy	$189	$119
Periodontic Services			
D4210	Gingivectomy or gingivoplasty - >3 cont. teeth, per quad.	$266	$172
D4211	Gingivectomy or gingivoplasty - <=3 teeth, per quad.	$82	$55
D4240	Gingival flap proc., inc. root planing - >3 cont. teeth, per quad	$321	$204
D4241	Gingival flap proc, inc. root planing - <=3 cont. teeth, per quad	$161	$102
D4249	Clinical crown lengthening - hard tissue	$365	$231
D4260	Osseous surgery - >3 cont. teeth, per quad	$530	$338
D4261	Osseous surgery - <=3 cont. teeth, per quad	$266	$170
D4263	Bone replacement graft, first site in quad.	$354	$150
D4264	Bone replacement graft, each add. site in quad.	$177	$75
D4265	Biologic materials	$70	$76

ADA Code	Description of Services	You Pay In-Plan to Dentist	You Are Reimbursed Out-of-Plan
.D4268	Surgical revision proc., per tooth	$335	$215
D4270	Pedicle soft tissue graft procedure	$354	$226
D4275	Soft tissue allograft	$411	$263
D4276	Comb. connec. tissue/double pedicle graft, per tooth	$354	$226
D4277	Free soft tissue graft, per tooth	$389	$161
D4278	Free soft tissue graft, each add. Tooth	$129	$51
D4320	Provisional splinting – intracoronal	$113	$76
D4321	Provisional splinting – extracoronal	$113	$76
D4341	Perio scaling and root planing - >3 cont teeth, per quad.	$113	$76
D4342	Perio scaling and root planing - <= 3 teeth, per quad	$57	$38
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation	$7	$17
D4355	Full mouth debridement	$0	$0
D4910	Periodontal maintenance	$60	$38
Prosthetics – Removable			
D5110	Complete denture - maxillary	$456	$290
D5120	Complete denture - mandibular	$456	$290
D5130	Immediate denture - maxillary	$492	$317
D5140	Immediate denture - mandibular	$492	$317
D5211	Maxillary partial denture - resin base	$404	$258
D5212	Mandibular partial denture - resin base	$404	$258
D5213	Maxillary partial dent. - cast metal	$499	$317
D5214	Mandibular partial dent. - cast metal	$499	$317
D5221	Immediate maxillary partial denture	$404	$258
D5222	Immediate mandibular partial denture	$404	$258
D5223	Immediate maxillary partial denture	$499	$317
D5224	Immediate mandibular partial denture	$499	$317
D5225	Maxillary partial denture	$499	$317
D5226	Mandibular partial denture	$499	$317
D5282	Removable unilateral partial denture - one piece cast metal, maxillary	$272	$172
D5283	Removable unilateral partial denture - one piece cast metal, mandibular	$272	$172

ADA Code	Description of Services	You Pay In-Plan to Dentist	You Are Reimbursed Out-of-Plan
D5284	Removable unilateral partial denture – one piece flexible base (including clasps and teeth) – per quadrant	$272	$172
D5286	Removable unilateral partial denture – one piece resin (including clasps and teeth) – per quadrant	$272	$172
D5410	Adjust complete denture – maxillary	$22	$16
D5411	Adjust complete denture - mandibular	$22	$16
D5421	Adjust partial denture - maxillary	$22	$16
D5422	Adjust partial denture - mandibular	$22	$16
D5511	Repair broken complete denture base, mandibular	$51	$34
D5512	Repair broken complete denture base, maxillary	$51	$34
D5520	Replace missing or broken teeth - complete denture	$41	$27
D5611	Repair resin partial denture base, mandibular	$49	$31
D5612	Repair resin partial denture base, maxillary	$49	$31
D5621	Repair cast partial framework, mandibular	$60	$38
D5622	Repair cast partial framework, maxillary	$60	$38
D5630	Repair or replace broken retentive/clasping material – per tooth	$57	$37
D5640	Replace broken teeth - per tooth	$43	$28
D5650	Add tooth to existing partial denture	$55	$35
D5660	Add clasp to existing partial denture – per tooth	$63	$43
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$242	$155
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$242	$155
D5710	Rebase complete maxillary denture	$170	$108
D5711	Rebase complete mandibular denture	$170	$108
D5720	Rebase maxillary partial denture	$170	$108
D5721	Rebase mandibular partial denture	$170	$108
D5730	Reline complete maxillary denture (direct)	$101	$65
D5731	Reline complete. mandibular denture (direct)	$101	$65
D5740	Reline maxillary partial denture (direct)	$101	$65
D5741	Reline mandibular partial denture (direct)	$101	$65
D5750	Reline complete maxillary denture (indirect)	$140	$86
D5751	Reline complete mandibular denture (indirect)	$140	$86
D5760	Reline maxillary partial denture (indirect)	$140	$86
D5761	Reline mandibular partial denture (indirect)	$140	$86

ADA Code	Description of Services	You Pay In-Plan to Dentist	You Are Reimbursed Out-of-Plan
D5820	Interim partial denture (including retentive/clasping materials, rests, and teeth), maxillary	$175	$113
D5821	Interim partial denture (including retentive/clasping materials, rests, and teeth), mandibular	$175	$113
D5850	Tissue conditioning, maxillary	$49	$33
D5851	Tissue conditioning, mandibular	$45	$31
Prosthetics – Fixed			
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	$57	$38
D6205	Pontic - indirect resin based composite	$159	$102
D6210	Pontic - cast high noble metal	$411	$263
D6211	Pontic - cast predom. base metal	$378	$226
D6212	Pontic - cast noble metal	$365	$231
D6214	Pontic – titanium and titanium alloy	$411	$263
D6240	Pontic - porcelain fused to high noble metal	$418	$269
D6241	Pontic - porcelain fused to predom. base metal	$365	$231
D6242	Pontic - porcelain fused to noble metal	$397	$252
D6243	Pontic – porcelain fused to titanium and titanium alloys	$411	$263
D6545	Retainer - cast metal for resin bonded fixed prosthesis	$159	$102
D6602	Retainer inlay - cast high noble metal, 2 surfaces	$319	$208
D6603	Retainer inlay - cast high noble metal, >=3 surfaces	$382	$242
D6604	Retainer inlay - cast predom. base metal, 2 surfaces	$319	$208
D6605	Retainer inlay - cast predom. base metal, >=3 surfaces	$330	$210
D6606	Retainer inlay - cast noble metal, two surfaces	$291	$188
D6607	Retainer inlay - cast noble metal, >=3 surfaces	$348	$220
D6610	Retainer onlay - cast high noble metal, 2 surfaces	$372	$162
D6611	Retainer onlay - cast high noble metal, >=3 surfaces	$407	$176
D6612	Retainer onlay - cast predom. base metal, 2 surfaces	$320	$138
D6613	Retainer onlay - cast predom. base metal, >=3 surfaces	$355	$153
D6614	Retainer onlay - cast noble metal, two surfaces	$337	$146

ADA Code	Description of Services	You Pay In-Plan to Dentist	You Are Reimbursed Out-of-Plan
D6615	Retainer onlay - cast noble metal, >=3 surfaces	$372	$162
D6624	Retainer inlay – titanium	$382	$242
D6634	Retainer onlay – titanium	$407	$176
D6710	Retainer crown – indirect resin-based composite	$159	$102
D6750	Retainer crown - porc. fused to high noble metal	$428	$274
D6751	Retainer crown - porc. fused to predom. base metal	$378	$241
D6752	Retainer crown - porc. fused to noble metal	$404	$258
D6753	Retainer crown – porcelain fused to titanium and titanium alloys	$410	$269
D6780	Retainer crown - 3/4 cast high noble metal	$397	$247
D6781	Retainer crown - 3/4 cast predom. base metal	$397	$247
D6782	Retainer crown - 3/4 cast noble metal	$397	$247
D6783	Retainer crown – 3/4 titanium and titanium alloys	$410	$269
D6790	Retainer crown - full cast high noble metal	$418	$269
D6791	Retainer crown - full cast predom. base metal	$373	$241
D6792	Retainer crown - full cast noble metal	$397	$252
D6794	Retainer crown – titanium and titanium alloys	$410	$269
D6930	Recement fixed partial denture	$41	$27
Oral Surgery			
D7111	Extraction, coronal remnants - primary tooth	$23	$16
D7140	Extraction, erupted tooth or exposed root	$47	$30
D7210	Extraction, erupted tooth req. elev, etc.	$107	$70
D7220	Removal of impacted tooth - soft tissue	$132	$86
D7230	Removal of impacted tooth - partially bony	$165	$102
D7240	Removal of impacted tooth - completely bony	$195	$124
D7250	Removal of residual tooth roots	$120	$76
D7260	Oroantral fistula closure	$302	$193
D7261	Primary closure of a sinus perforation	$302	$193
D7270	Tooth reimplant./stabiliz. of acc. evulsed/displaced tooth	$159	$108
D7280	Exposure of an unerupted tooth	$253	$162
D7282	Mobiliz. of erupted or malpos. tooth to aid eruption	$215	$134
D7283	Place. of device to facilitate erupt. of impacted tooth	$126	$81
D7285	Incisional biopsy of oral tissue - hard (bone, tooth)	$120	$81
D7286	Incisional biopsy of oral tissue - soft	$140	$91
D7287	Exfoliative cytological sample collection	$70	$46
D7288	Brush biopsy – transepithelial sample collect	$70	$46

ADA Code	Description of Services	You Pay In-Plan to Dentist	You Are Reimbursed Out-of-Plan
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	$33	$23
D7310	Alveoloplasty in conj. with extractions - per quadrant	$126	$81
D7311	Alveoloplasty in conj. w/ extractions	$63	$41
D7320	Alveoloplasty not in conj. with extractions - per quadrant	$170	$108
D7321	Alveoloplasty not in conj. w/ extractions	$86	$55
D7410	Excision of benign lesion up to 1.25 cm	$170	$108
D7411	Excision of benign lesion > 1.25 cm	$272	$172
D7412	Excision of benign lesion, complicated	$299	$189
D7450	Removal of benign odon cyst/tumor - diam <=1.25cm	$159	$102
D7451	Removal of benign odon cyst/tumor - diam >1.25cm	$291	$183
D7460	Removal of benign nonodon cyst/tumor-diam <=1.25cm	$175	$113
D7461	Removal of benign nonodon cyst/tumor-diam >1.25cm	$329	$210
D7471	Removal of lateral exostosis	$258	$167
D7472	Removal or torus palatinus	$258	$167
D7473	Removal or torus mandibularis	$258	$167
D7485	Reduction of osseous tuberosity	$258	$167
D7510	Incision and drainage of abscess - intraoral soft tissue	$82	$55
D7511	Incision and drainage of abscess – intraoral soft tissue comp.	$103	$68
D7520	Incision/drainage of abscess - extra. soft tissue	$120	$76
D7521	Incision/drainage of abscess - extra. soft tissue, comp.	$150	$94
D7530	Removal of foreign body from mucosa/skin/subcutaneous alveolar tissue	$96	$60
D7550	Partial ostect/sequestrect non-vital bone rem.	$132	$156
D7910	Suture of recent small wounds up to 5 cm	$43	$28
D7911	Complicated suture, <= 5 cm	$69	$43
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	$25	$25
D7961	Buccal/labial frenectomy (frenulectomy)	$215	$134

ADA Code	Description of Services	You Pay In-Plan to Dentist	You Are Reimbursed Out-of-Plan
D7962	Lingual frenectomy (frenulectomy)	$215	$134
D7963	Frenuloplasty	$0	$0
D7970	Excision of hyperplastic tissue - per arch	$146	$91
D7971	Excision of pericoronal gingiva	$88	$54
D7972	Surgical reduction of fibrous tuberosity	$146	$87
D7979	Non-surgical sialolithotomy	$29	$18
Orthodontics			
D8070	Comp ortho treatment of the trans dentition	No Benefit	No Benefit
D8080	Comp. ortho treatment of the adol. Dentition	No Benefit	No Benefit
D8670	Periodic orthodontic treatment visit	No Benefit	No Benefit
Additional Procedures			
D9110	Palliative (emergency) treatment of dental pain	$29	$18
D9210	Local anesthesia not in conj. Operative/surg. procedures	$0	$0
D9219	Evaluation for deep sedation or general anesthesia	$0	$0
D9222	Deep sedation/general anesthesia - first 15 minute increment	$27	$44
D9223	Deep sedation/general anesthesia each subsequent 15 minute increment	$27	$44
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis,	$21	$15
D9239	IV moderate conscious sedation/analgesia – first 15 minute increment	$27	$44
D9243	IV moderate conscious sedation/analgesia – each subsequent 15 minute increment	$27	$44
D9310	Consultation (diagnostic service by nontreating dentist)	$36	$30
D9440	Office Visit - After Regularly Scheduled Hours	$30	No Benefit
D9613	Infiltration of sustained release therapeutic drug – single or multiple sites	$190	$190
D9910	Application of desensitizing medicament	$16	$10
D9942	Repair and/or reline of occlusal guard	$61	$55
D9944	Occlusal guard – hard appliance, full arch	$198	$170
D9945	Occlusal guard – soft appliance, full arch	$198	$170
D9946	Occlusal guard – hard appliance, partial arch	$198	$170
D9951	Occlusal adjustment - limited	$37	$38
D9952	Occlusal adjustment - complete	$159	$162
D9986	Missed appointment	$50	$50
D9995	Teledentistry – synchronous; real-time encounter	$20	$20

ADA Code	Description of Services	You Pay In-Plan to Dentist	You Are Reimbursed Out-of-Plan
D9996	Teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review	$20	$20
D9997	Dental case management – patients with special health care needs	$50	$50

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

By: _____

Gracelynn McDermott
Vice President Marketing, Sales & Business Development

KAISER PERMANENTE®
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
2101 E. Jefferson Street, Rockville, MD 20852
301-816-2424

Kaiser Permanente
Virginia Large Group Agreement and Evidence of Coverage

Point-of-Service Adult Dental Rider

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

The following dental Services, for adults age 19 or older, are hereby added to the Group Evidence of Coverage (EOC) to which this Point-of-Service (POS) Adult Dental Rider (hereinafter "Rider") is attached, in consideration of Group's application and payment of Premium for such Services.

Definitions

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

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 calendar year for Covered Dental Services before the Health Plan starts paying its cost share for these Services. The Deductible is shown on the attached ***Description of Benefits and Member Copayments***.

Dental Administrator: The entity that has entered into a contract with the 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 below.

Dental Fee: The fee for a Covered Dental Service charged by a Participating Dental Provider as listed in the ***Description of Benefits and Member Copayments***.

Dental Specialist: A Participating Dental Provider that is a dental specialist.

General Dentist: A Participating Dental Provider that is a general dentist.

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

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

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

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

Kaiser Permanente
Virginia Large Group Agreement and Evidence of Coverage

General Provisions

Subject to the terms, conditions, limitations, and exclusions specified in the 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.

The Health Plan has entered into an agreement with the Dental Administrator under which the Dental Administrator will provide or arrange for the administration of In-Plan covered dental Services to Members.

You will receive a list of Participating Dental Providers from the Health Plan or from the Dental Administrator. To receive "In-Plan" Covered Dental Services, you should select a Participating Dental Provider who is a "General Dentist" for you and your covered family members. Specialty care is also available should further covered Services be necessary; however, referrals to a Dental Specialist for specialty care services are strongly advised so as to assist with communications from the general dentist to the treating specialist. Please refer to the ***Description of Benefits and Member Copayments*** for those fees you will pay for In-Plan Services.

To receive Out-of-Plan Covered Dental Services, you may go to any Non-Participating Dental Provider. Please refer to the ***Description of Benefits and Member Copayments*** for the Health Plan's reimbursement for those Services. You will be responsible for all balances.

A Non-Participating Dental Provider, at his or her discretion may:

1. Require payment at the time Services are received;
2. Bill you directly for the Services received; or
3. Bill the Dental Administrator directly for the Services you received.

Regardless of how the Non-Participating Provider elects to collect payment for his or her Services, it is your responsibility to pay all applicable balances (after the Dental Administrator has made its payment) and/or fee-for-service charges for non-covered Services directly to the Non-Participating Dental Provider.

It is also your responsibility to file a claim with the Dental Administrator for payment and/or reimbursement. For information on how to submit a claim, please see the "Submission of Claims" section in this Rider.

Dental Administrator

The 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 Service Team Associates are available Monday through Friday from 7:30 a.m. to 6 p.m. (Eastern Time) at 1-855-733-7524 or 711 TTY.

Dominion National's Integrated Voice Response System is available twenty-four (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:

www.DominionNational.com/Kaiserdentists

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

Missed Appointment Fee

Participating Dental Providers may charge you an administrative fee if you miss a scheduled dental appointment without giving twenty-four (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.

Specialist Referrals

Participating Specialist Referrals

If, in the judgment of a General Dentist, you require the Services of a specialist, you may be referred to a Dental Specialist who has agreed to provide Covered Dental Services to you. Referrals to a Dental Specialist for specialty care services are strongly advised so as to assist with communications from the general dentist to the treating specialist. The fees shown on the ***Description of Benefits and Member Copayments*** for Covered Dental Services will apply to the Services provided by the Dental Specialist.

Non-Participating Specialist Referrals

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

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

Extension of Benefits

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

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

Extension of Benefits Limitations

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

1. When coverage ends because of your failure to pay premium
2. When 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.

Dental Emergencies Outside the Service Area

When a dental emergency occurs outside the Service Area, the Dental Administrator will reimburse you for the reasonable charges, less any discounted fee, upon proof of payment, not to exceed $100 per incident. Coverage is provided for emergency dental treatment as may be required to alleviate pain, bleeding, or swelling. In all cases, if post-emergency care is required, you may receive all post-emergency care from your Participating Dental Provider or a Non-Participating Dental Provider.

Annual Deductible

You are responsible for payment of a combined Deductible In-Plan and Out-of-Plan each calendar year before the Dental Administrator will provide Covered Dental Services. The In-Plan Deductible and Out-of-Plan Deductible for this Rider are listed in the ***Description of Benefits and Member Copayments***. The Annual Deductible for Services received Out-of-Plan is higher than the Annual Deductible for Services received In-Plan. Following are examples of how the combined Annual Deductible works:

In-Plan Deductible Met

Once the Deductible for In-Plan Services has been met, all Covered Dental Services provided In-Plan will be provided without an additional Deductible for the rest of the calendar year. If a Member goes Out-of-Plan after having met the In-Plan Deductible, the In-Plan Deductible will apply toward the Out-of-Plan Deductible, and the Member will have to meet the balance of the Out-of-Plan Deductible before the Service will be covered.

Out-of-Plan Deductible Met

Once a Member has met the Out-of-Plan Deductible, all Covered Dental Services provided In-Plan or Out-of-Plan will be provided without an additional Deductible for rest of the calendar year.

Annual Maximum Benefit

In no event will the Dental Administrator pay more than the Annual Maximum Benefit for In-Plan and Out-of-Plan Covered Dental Services combined each calendar year. The Annual Maximum Benefit amount that the Health Plan is obligated to pay, for each Member, each calendar year is listed in the ***Description of Benefits and Member Copayments***. The amount that applies toward the Annual Maximum Benefit for In-Plan dental Services is based on the fee that the Dental Administrator has negotiated with the Participating Dental Provider, reduced by the fee you pay for the Covered Dental Service, if any, as shown on the ***Description of Benefits and Member Copayments***. The amount that applies toward the Annual Maximum Benefit for Out-of-Plan dental Services is the amount listed under "You Are Reimbursed Out-of-Plan" on the ***Description of Benefits and Member Copayments***. You may call the Dental Administrator at the phone number listed above to find out how much has been applied toward your Annual Maximum Benefit for each Covered Dental Service.

The Annual Maximum Benefit is combined for In-Plan and Out-of-Plan benefits. This means that after a Member has met his or her Deductible, all amounts paid by the Dental Administrator for Covered Dental Services provided In-Plan or Out-of-Plan will apply toward the Annual Maximum Benefit as shown on the ***Description of Benefits and Member Copayments***. Because the Annual Maximum Benefit is lower for Out-of-Plan Services, a Member will reach the Out-of-Plan maximum first, regardless of whether the Services were provided In-Plan or Out-of-Plan. Once you have reached the Out-of-Plan Annual Maximum Benefit, no additional dental Services will be covered Out-of-Plan for the rest of the calendar year. Dental

Services provided In-Plan will continue to be covered until the Member has reached the In-Plan Annual Maximum Benefit. Once the In-Plan Annual Maximum Benefit has been reached, no additional dental Services will be covered for that Member for the rest of the calendar year.

Submission of Claims

When you receive Covered Dental Services from a Non-Participating Dental Provider, you are responsible for submitting a claim to us for payment and/or reimbursement.

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 www.dominionnational.com or call the Dental Administrator at the phone number listed above. 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 fifteen (15) days, you may submit proof of loss by submitting, within the six-month 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 six (6) months of the date of service. Failure to submit the itemized bill and/or proof of payment within the six-month 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 six-month 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 Group Evidence of Coverage for any loss will be paid not more than thirty (30) days after receipt of written proof of loss. 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 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 Group Evidence of Coverage.

Exclusions and Limitations

Exclusions

The following services are excluded under this Rider:

1. Services which are covered under worker's compensation and/or Employer's Liability laws.
2. Services which are provided without cost to Member by any federal, state, municipal, county, or other subdivision's program (with the exception of Medicaid).
3. Services which are not necessary for the patient's dental health as determined by the Plan.
4. Cosmetic, elective or aesthetic dentistry except as required due to accidental bodily injury to sound teeth as determined by the Plan.
5. Oral surgery requiring the setting of fractures or dislocations, except as may be otherwise covered in your medical plan as described in the Evidence of Coverage.

6. Drugs obtainable with or without a prescription, except as may be otherwise covered in your medical plan that is described in the Evidence of Coverage.
7. Hospitalization for any dental procedure.
8. Treatment required for conditions resulting from major disaster, epidemic, war or acts of war, whether declared or undeclared, or while on active duty as a member of the armed forces of any nation.
9. Replacement due to loss or theft of prosthetic appliance.
10. Services that cannot be performed because of the general health of the patient.
11. Implantation and related restorative procedures.
12. Procedures not listed as a Covered benefit under this Plan.
13. Services related to the treatment of TMD (Temporomandibular disorder).
14. Elective surgery including, but not limited to extraction of non-pathologic, asymptomatic impacted teeth as determined by the Plan.
15. Procedures relating to the change and maintenance of vertical dimension or major restoration of occlusion, or to alter the occlusion (bite) through full mouth adjustment/grinding of the teeth. This does not exclude minor occlusal adjustments on individual teeth to remove high spots or smooth out rough or sharp areas.
16. Dental expenses incurred in connection with any dental procedure that was started prior to your effective date of coverage. Examples include orthodontic work in progress, teeth prepared for crowns, and root canal therapy in progress.
17. Treatment of malignancies, neoplasm or congenital malformations, except as may be otherwise covered in your medical plan as described in the Evidence of Coverage.
18. Lab fees for excisions and biopsies, except as may be otherwise covered in your medical plan which is described in the Evidence of Coverage.
19. Experimental procedures, implantations, or pharmacological regimens.
20. Initial placement or replacement of fixed bridgework solely for the purpose of achieving periodontal stability.
21. Charges for second opinions, unless pre-authorized.
22. Procedures requiring fixed prosthodontic restoration, which are necessary for complete oral rehabilitation or reconstruction.
23. Occlusal guards, except for the purpose of controlling habitual grinding.

Limitations

Covered Dental Services are subject to the following limitations:

1. Replacement of a bridge, crown or denture within five (5) years after the date it was originally installed.
2. Replacement of filling within two (2) years after original date of placement.
3. Two (2) teeth cleanings and fluoride applications are covered per calendar year.
4. One (1) interim caries arresting medicament application per primary tooth per lifetime.
5. Crown and bridge fees apply to treatment involving five or fewer units when presented in a single treatment plan. Additional crown or bridge units, beginning with the sixth unit, are available at the provider's Usual, Customary, and Reasonable (UCR) fee, minus 25%.
6. One (1) set of full mouth x-rays or panoramic film is limited to one (1) set every three (3) years.

7. Retreatment of root canal within two (2) years of the original treatment.
8. Coverage for periodontal surgery of any type, including any associated material is covered once every thirty-six (36) months per quadrant or surgical site.
9. Coverage for root planing or scaling is limited to once every twenty-four (24) months per quadrant.
10. Full mouth debridement (D4355) is covered once per lifetime.
11. Periodontal maintenance after active therapy (D4910) is limited to twice per twelve (12) months within twenty-four (24) months after definitive periodontal therapy.
12. Coverage for relining of dentures is limited to once every twelve (12) months.
13. Scaling in presence of generalized or severe gingival inflammation – full mouth, after oral evaluation and in lieu of a covered D1110, limited to once per two (2) years.
14. 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.
15. Teledentistry, synchronous (D9995) or asynchronous (D9996), limited to two (2) per calendar year.

This Rider is subject to all the terms and conditions of the 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: _____

Gracelynn McDermott
Vice President Marketing, Sales & Business Development