SMILE FOR TOTAL HEALTH

A GUIDE TO YOUR DENTAL BENEFITS

2018 Adult $30 Preventive and Pediatric Dental HMO

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®

Discover the full-body benefits of dental coverage

We bet you brush like the best of them, but did you know oral health goes beyond a great grin? By visiting a dentist regularly, you're actually doing your entire body a favor, without even stepping into a medical office.

Here are a few small things dental coverage with Kaiser Permanente can do for you, your health, and the smile that expresses it all.

Prevent

Can clean teeth improve your overall health? Studies show that conditions like heart disease and stroke may be connected to your oral hygiene. So take a trip to the dentist—you might prevent more than just cavities!

Catch

Dentists see what a toothbrush can't. On top of preventive care, dentists do double duty by spotting early symptoms of diabetes, cancer, and more.

Support

Dental checkups are also a great way to help with pre-existing conditions like diabetes that might put you at risk for gum disease. Give your brushing some healthy backup!

The Adult $30 Preventive and Pediatric Dental HMO plans emphasize healthy smiles through prevention and the 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 networks[1] 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 every year
- Up to two cleanings every year
- Up to two fluoride treatments every year
- Up to two dental bitewing X-rays every year

For children up to age 19, you pay a $10 copay for each preventive care office visit which may include:

- One oral evaluation every 6 months
- One routine cleaning every 6 months
- One bitewing X-ray every 6 months
- One topical fluoride treatment every 6 months

The preventive care procedures covered in this plan account for over 65 percent of dental services most frequently performed for adults, and almost 90 percent of the most frequently performed services for children.[1] Other listed dental services are available for the fixed fees shown below, 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 below are available for fixed fees, provided the services are performed by plan participating dentists and specialists. For a complete list of covered benefits, 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**.

Choose a dentist

You may select any general dentist from among our participating dental providers for yourself. 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. There is no separate dental ID card. There is virtually no paperwork and no pre-existing condition exclusions to worry about.

[1] Dominion National., based on annual review of utilization data, network survey and analysis report, 3rd Quarter 2016.
[2] Mid-Atlantic area includes Washington, DC, and parts of Maryland and Virginia.

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, from 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 Street, 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 return email.

2018 schedule of covered benefits and dental fees – Adult $30 Preventive Plan

This Adult $30 Preventive Dental program includes (a) coverage for preventive dental benefits for which fixed copayments are charged, and (b) fixed fees for services that are not covered benefits but for which you are entitled to pay a pre-determined fee directly to the provider as payment in full. Procedures not shown in this list are not covered by this program. Detailed dental benefits may be found in the *Evidence of Coverage*.

Amounts quoted in the "Dentist Copay" column apply only when performed by a participating general dentist. If specialty care is required, your general dentist must refer you to a participating specialist except as otherwise described in your *Agreement* or *Evidence of Coverage*. Services received from non-participating dentists are not covered under this program except as otherwise described in your *Agreement* or *Evidence of Coverage*.

Fixed Copayment (FC) $30: You pay a combined fixed copayment (FC) of $30 for any visit during which one or more of the following procedures are performed: (a) an oral exam (D0120, D0140, D0150, D0170 or D0180); (b) X-rays (D0220, D0230, D0240, D0250, D0270, D0272, D0273, D0274, D0277, D0340, D0350 or D0351); (c) a pulp vitality test (D0460); (d) a diagnostic cast (D0470); (e) a routine cleaning (D1110); (f) fluoride application (D1206 or D1208); or (g) you are given oral hygiene or counseling instructions (D1310, D1320, D1330, or D1352). You pay a separate copayment or fee for any other procedure performed at your visit as shown below.

NOTE:
The schedule of covered benefits and dental fees is reviewed annually and is subject to change at contract renewal. If you have any questions concerning this copayment schedule, contact Dominion for details at: **855-733-7524 (TTY 711),** Monday through Friday, 7:30 a.m. to 6 p.m.

Your dental plan administrators and health plan carrier—Dominion National (Dominion), and Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (Kaiser Permanente)—are working together to help you stay healthy.

ADA CODE	BENEFIT	DENTIST COPAY	SPECIALIST COPAY
	DIAGNOSTIC/PREVENTIVE		
D0120	Periodic oral eval – established patient	FC $30	No benefit
D0140	Limited oral eval – problem focused	FC $30	No benefit
D0150	Comprehensive oral eval – new or established patient	FC $30	No benefit
D0170	Re-eval – limted, problem focused	FC $30	No benefit
D0180	Comp. periodontal eval – new or established patient	FC $30	No benefit
D0210	Intraoral – complete series (including bitewings)	$54	$69
D0220	Intraoral – periapical first film	FC $30	$14
D0230	Intraoral – periapical each additional film	FC $30	$11
D0240	Intraoral – occlusal film	FC $30	$21
D0250	Extraoral – first film	FC $30	$26
D0270	Bitewing X-rays – single film	FC $30	$14
D0272	Bitewing X-rays – two films	FC $30	$21
D0273	Bitewing X-rays – three films	FC $30	$28

Adult $30 Preventive Plan

ADA CODE	BENEFIT	DENTIST COPAY	SPECIALIST COPAY
D0274	Bitewing X-rays – four films	FC $30	$31
D0277	Vertical bitewings – 7 to 8 films	FC $30	$47
D0330	Panoramic film	$43	$55
D0340	Cephalometric film	FC $30	$55
D0350	Oral/facial photographic images	FC $30	$29
D0351	3-D photographic images	FC $30	$32
D0460	Pulp vitality tests	FC $30	$35
D0470	Diagnostic casts	FC $30	No benefit
D1110	Prophylaxis (cleaning) – adult	FC $30	No benefit
D1110*	Additional cleaning (expecting mothers and diabetics)	$40	$40
D1206	Topical fluoride varnish for mod./high caries risk patients	FC $30	No benefit
D1208	Topical application of fluoride	FC $30	No benefit
D1310	Nutritional counseling for control of dental disease	FC $30	No benefit
D1320	Tobacco counseling for control and prevention of oral disease	FC $30	No benefit
D1330	Oral hygiene instructions	FC $30	No benefit
D1352	Prev resin rest. moderate/high caries risk – perm. tooth	$30	No benefit
	RESTORATIVE DENTISTRY (FILLINGS)		
D2140	Amalgam – one surface	$68	No benefit
D2150	Amalgam – two surfaces	$88	No benefit
D2160	Amalgam – three surfaces	$105	No benefit
D2161	Amalgam – >=4 surfaces	$126	No benefit
D2330	Resin-based composite – one surface, anterior	$83	No benefit
D2331	Resin-based composite – two surfaces, anterior	$105	No benefit
D2332	Resin-based composite – three surfaces, anterior	$129	No benefit
D2335	Resin-based composite – >=4 surfaces, anterior	$163	No benefit
D2390	Resin-based composite crown, anterior	$216	No benefit
D2391	Resin-based composite – one surface, posterior	$108	No benefit
D2392	Resin-based composite – two surfaces, posterior	$143	No benefit
D2393	Resin-based composite – three surfaces, posterior	$179	No benefit
D2394	Resin-based composite – >=4 surfaces, posterior	$204	No benefit

ADA CODE	BENEFIT	DENTIST COPAY	SPECIALIST COPAY
	CROWNS AND BRIDGES♦		
D2510	Inlay – metallic – one surface	$493	No benefit
D2520	Inlay – metallic – two surfaces	$556	No benefit
D2530	Inlay – metallic – three or more surfaces	$604	No benefit
D2542	Onlay – metallic – two surfaces	$641	No benefit
D2543	Onlay – metallic – three surfaces	$653	No benefit
D2544	Onlay – metallic – four or more surfaces	$657	No benefit
D2610	Inlay – porcelain/ceramic – one surface	$541	No benefit
D2620	Inlay – porcelain/ceramic – two surfaces	$576	No benefit
D2630	Inlay – porcelain/ceramic – >=3 surfaces	$665	No benefit
D2642	Onlay – porcelain/ceramic – two surfaces	$616	No benefit
D2643	Onlay – porcelain/ceramic – three surfaces	$666	No benefit
D2644	Onlay – porcelain/ceramic – >=4 surfaces	$710	No benefit
D2650	Inlay – resin-based composite – one surface	$498	No benefit
D2651	Inlay – resin-based composite – two surfaces	$538	No benefit
D2652	Inlay – resin-based composite – >=3 surfaces	$699	No benefit
D2662	Onlay – resin-based composite – two surfaces	$568	No benefit
D2663	Onlay – resin-based composite – three surfaces	$699	No benefit
D2664	Onlay – resin-based composite – >=4 surfaces	$662	No benefit
D2710	Crown – resin based composite (indirect)	$277	No benefit
D2712	Crown – 3/4 resin-based composite (indirect)	$255	No benefit
D2720	Crown – resin with high noble metal	$675	No benefit
D2721	Crown – resin with predominantly base metal	$601	No benefit
D2722	Crown – resin with noble metal	$628	No benefit
D2740	Crown – porcelain/ceramic substrate	$741	No benefit
D2750	Crown – porcelain fused to high noble metal	$755	No benefit
D2751	Crown – porcelain fused to predominantly base metal	$653	No benefit
D2752	Crown – porcelain fused to noble metal	$679	No benefit
D2780	Crown – 3/4 cast high noble metal	$724	No benefit
D2781	Crown – 3/4 cast predominantly base metal	$566	No benefit

ADA CODE	BENEFIT	DENTIST COPAY	SPECIALIST COPAY
D2782	Crown – 3/4 cast noble metal	$611	No benefit
D2783	Crown – 3/4 porcelain/ceramic	$628	No benefit
D2790	Crown – full cast high noble metal	$675	No benefit
D2791	Crown – full cast predominately base metal	$601	No benefit
D2792	Crown – full cast noble metal	$628	No benefit
D2794	Crown – titanium	$679	No benefit
D2910	Recement inlay	$68	No benefit
D2920	Recement crown	$68	No benefit
D2932	Prefabricated resin crown	$254	No benefit
D2940	Sedative filling	$77	No benefit
D2941	Interim therapeutic rest., prim. dentition	$49	No benefit
D2950	Core buildup, including any pins	$172	No benefit
D2951	Pin retention – per tooth, in addition to restoration	$40	No benefit
D2952	Cast post and core in addition to crown	$252	No benefit
D2954	Prefab. post and core in addition to crown	$224	No benefit
D2955	Post removal (not in conj. w/ endo therapy)	$194	No benefit
D2980	Crown repair, by report	$138	No benefit
	ENDODONTICS		
D3110	Pulp cap – direct (excl. final restoration)	$47	No benefit
D3120	Pulp cap – indirect (excl. final restoration)	$47	No benefit
D3220	Therapeutic pulpotomy (excl. final restoration)	$104	$122
D3221	Pulpal debridement	$126	No benefit
D3310	Endodontic therapy, anterior tooth	$482	$554
D3320	Endodontic therapy, bicuspid tooth	$576	$663
D3330	Endodontic therapy, molar	$755	$867
D3333	Internal root repair of perforation defects	No benefit	$225
D3346	Retreat of prev. root canal therapy, anterior	No benefit	$609
D3347	Retreat of prev. root canal therapy, bicuspid	No benefit	$812
D3348	Retreat of prev. root canal therapy, molar	No benefit	$1047
D3410	Apicoectomy/periradicular surgery, anterior	$422	$524

ADA CODE	BENEFIT	DENTIST COPAY	SPECIALIST COPAY
D3421	Apicoectomy/periradicular surgery, bicuspid (first root)	$471	$655
D3425	Apicoectomy/periradicular surgery, molar (first root)	$518	$687
D3426	Apicoectomy/periradicular surgery (each additional root)	$314	$371
D3427	Periradicular surgery w/o apicoectomy	$402	$504
D3430	Retrograde filling – per root	$118	$295
D3450	Root amputation – per root	$205	$330
D3920	Hemisection, not including root canal therapy	$258	$305
D3950	Canal prep/fitting of preformed dowel or post	$154	$216
	PERIODONTICS		
D4210	Gingivectomy or gingivoplasty – >3 cont. teeth, per quad.	$372	$439
D4211	Gingivectomy or gingivoplasty – <=3 teeth, per quad.	$161	$190
D4240	Gingival flap proc., including root planing – >3 cont. teeth, per quad.	$479	$566
D4241	Gingival flap proc., including root planing – <=3 cont. teeth, per quad.	$121	$239
D4260	Osseous surgery – >3 cont. teeth, per quad.	$709	$836
D4261	Osseous surgery – <=3 cont. teeth, per quad.	$452	$534
D4268	Surgical revision proc., per tooth	$389	$562
D4274	Mesial/distal wedge procedure, single tooth	$329	$466
D4341	Perio scaling and root planing – >3 cont. teeth, per quad.	$137	$194
D4342	Perio scaling and root planing – <= 3 teeth, per quad.	$99	$117
D4346	Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	$76	$103
D4355	Full mouth debridement	$121	$175
D4381	Localized delivery of chemotherapeutic agents	$33	$44
D4910	Periodontal maintenance	$83	$110
	PROSTHETICS (DENTURES)		
D5110	Complete denture – maxillary	$845	No benefit
D5120	Complete denture – mandibular	$845	No benefit
D5130	Immediate denture – maxillary	$910	No benefit
D5140	Immediate denture – mandibular	$910	No benefit
D5211	Maxillary partial denture – resin base	$653	No benefit
D5212	Mandibular partial denture – resin base	$653	No benefit

ADA CODE	BENEFIT	DENTIST COPAY	SPECIALIST COPAY
D5213	Maxillary partial denture – cast metal	$906	No benefit
D5214	Mandibular partial denture – cast metal	$906	No benefit
D5221/22	Immediate Maxillary/mandibular partial denture – resin base	$653	No benefit
D5223/24	Immediate Maxillary/mandibular partial denture – cast metal	$906	No benefit
D5225	Maxillary partial denture – flexible base	$904	No benefit
D5226	Mandibular partial denture – flexible base	$1,004	No benefit
D5281	Rem. unilateral partial denture – one piece cast metal	$510	No benefit
D5410	Adjust complete denture – maxillary	$79	No benefit
D5411	Adjust complete denture – mandibular	$79	No benefit
D5421	Adjust partial denture – maxillary	$79	No benefit
D5422	Adjust partial denture – mandibular	$79	No benefit
D5510	Repair broken complete denture base	$101	No benefit
D5520	Replace missing or broken teeth – complete denture	$77	No benefit
D5610	Repair resin denture base	$102	No benefit
D5620	Repair cast framework	$147	No benefit
D5630	Repair or replace broken clasp	$139	No benefit
D5640	Replace broken teeth – per tooth	$88	No benefit
D5650	Add tooth to existing partial denture	$131	No benefit
D5660	Add clasp to existing partial denture	$160	No benefit
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$559	No benefit
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$559	No benefit
D5710	Rebase complete maxillary denture	$344	No benefit
D5711	Rebase complete mandibular denture	$331	No benefit
D5720	Rebase maxillary partial denture	$265	No benefit
D5721	Rebase mandibular partial denture	$265	No benefit
D5730	Reline complete maxillary denture (chairside)	$214	No benefit
D5731	Reline complete mandibular denture (chairside)	$215	No benefit
D5740	Reline maxillary partial denture (chairside)	$212	No benefit
D5741	Reline mandibular partial denture (chairside)	$212	No benefit
D5750	Reline complete maxillary denture (lab)	$260	No benefit

ADA CODE	BENEFIT	DENTIST COPAY	SPECIALIST COPAY
D5751	Reline complete mandibular denture (lab)	$258	No benefit
D5760	Reline maxillary partial denture (lab)	$250	No benefit
D5761	Reline mandibular partial denture (lab)	$249	No benefit
D5810	Interim compl. denture – maxillary	$549	No benefit
D5811	Interim compl. denture – mandibular	$400	No benefit
D5820	Interim partial denture – maxillary	$424	No benefit
D5821	Interim partial denture – mandibular	$429	No benefit
D5850	Tissue conditioning – maxillary	$120	No benefit
D5851	Tissue conditioning – mandibular	$121	No benefit
	BRIDGES AND PONTICS♦		
	D6000-D6199 ALL IMPLANT SERVICES – 15% DISCOUNT (incl. D0360-D0363 cone beam imaging w/ implants)		
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	$99	$117
D6210	Pontic – cast high noble metal	$610	No benefit
D6211	Pontic – cast predominately base metal	$624	No benefit
D6212	Pontic – cast noble metal	$586	No benefit
D6214	Pontic – titanium	$571	No benefit
D6240	Pontic – porcelain fused to high noble metal	$755	No benefit
D6241	Pontic – porcelain fused to predominately base metal	$653	No benefit
D6242	Pontic – porcelain fused to noble metal	$679	No benefit
D6245	Pontic – porcelain/ceramic	$741	No benefit
D6250	Pontic – resin w/ high noble metal	$745	No benefit
D6251	Pontic – resin w/ predominately base metal	$707	No benefit
D6252	Pontic – resin w/ noble metal	$717	No benefit
D6545	Retainer – cast metal for resin bonded fixed prosthesis	$270	No benefit
D6548	Retainer – porcelain/ceramic for resin bonded fixed prosthesis	$481	No benefit
D6549	Resin retainer for resin bonded fixed prosthesis	$270	No benefit
D6600	Inlay – porcelain/ceramic, two surfaces	$400	No benefit
D6601	Inlay – porcelain/ceramic, >=3 surfaces	$426	No benefit
D6602	Inlay – cast high noble metal, two surfaces	$422	No benefit

ADA CODE	BENEFIT	DENTIST COPAY	SPECIALIST COPAY
D6603	Inlay – cast high noble metal, >=3 surfaces	$468	No benefit
D6604	Inlay – cast predominantly base metal, two surfaces	$422	No benefit
D6605	Inlay – cast predominantly base metal, >=3 surfaces	$404	No benefit
D6606	Inlay – cast noble metal, two surfaces	$384	No benefit
D6607	Inlay – cast noble metal, >=3 surfaces	$426	No benefit
D6608	Onlay – porcelain/ceramic, two surfaces	$437	No benefit
D6609	Onlay – porcelain/ceramic, >=3 surfaces	$458	No benefit
D6610	Onlay – cast high noble metal, two surfaces	$501	No benefit
D6611	Onlay – cast high noble metal, >=3 surfaces	$548	No benefit
D6612	Onlay – cast predominantly base metal, two surfaces	$431	No benefit
D6613	Onlay – cast predominantly base metal, >=3 surfaces	$478	No benefit
D6614	Onlay – cast noble metal, two surfaces	$454	No benefit
D6615	Onlay – cast noble metal, >=3 surfaces	$501	No benefit
D6624	Inlay – titanium	$468	No benefit
D6634	Onlay – titanium	$548	No benefit
D6720	Crown – resin with high noble metal	$747	No benefit
D6721	Crown – resin with predom. base metal	$666	No benefit
D6722	Crown – resin with noble metal	$696	No benefit
D6740	Crown – porcelain/ceramic	$741	No benefit
D6750	Crown – porcelain fused to high noble metal	$639	No benefit
D6751	Crown – porcelain fused to predominately base metal	$571	No benefit
D6752	Crown – porcelain fused to noble metal	$599	No benefit
D6780	Crown – 3/4 cast high noble metal	$724	No benefit
D6781	Crown – 3/4 cast predominantly base metal	$566	No benefit
D6782	Crown – 3/4 cast noble metal	$578	No benefit
D6783	Crown – 3/4 porcelain/ceramic	$808	No benefit
D6790	Crown – full cast high noble metal	$675	No benefit
D6791	Crown – full cast predominately base metal	$601	No benefit
D6792	Crown – full cast noble metal	$628	No benefit
D6794	Crown – titanium	$679	No benefit

ADA CODE	BENEFIT	DENTIST COPAY	SPECIALIST COPAY
D6930	Recement fixed partial denture	$88	No benefit
D6940	Stress breaker	$205	No benefit
D6980	Fixed partial denture repair, by report	$206	No benefit
	ORAL SURGERY		
D7111	Extraction, coronal remnants – deciduous tooth	$72	$85
D7140	Extraction, erupted tooth or exposed root	$83	$97
D7210	Extraction, erupted tooth req. elev., etc.	$149	$176
D7220	Removal of impacted tooth – soft tissue	$183	$216
D7230	Removal of impacted tooth – partially bony	$250	$295
D7240	Removal of impacted tooth – completely bony	$295	$347
D7241	Removal of impacted tooth – completely bony w/ unusual surg. complications	$363	$429
D7250	Removal of residual tooth roots	$167	$199
D7251	Coronectomy – intentional partial tooth removal	$363	$429
D7270	Tooth reimplant./stabiliz. of acc. evulsed/displaced tooth	$279	$330
D7280	Exposure of an unerupted tooth	$312	$369
D7282	Mobil. of erupted/malpositioned tooth to aid eruption	$96	$210
D7285	Biopsy of oral tissue – hard (bone, tooth)	$196	$231
D7286	Biopsy of oral tissue – soft (all others)	$184	$216
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	$142	$169
D7310	Alveoloplasty in conjunction with extractions – per quadrant	$150	$177
D7311	Alveoloplasty in conj. with extractions	$130	$154
D7320	Alveoloplasty not in conjunction with extractions – per quadrant	$193	$227
D7321	Alveoloplasty not in conjunc w/ extractions	$40	$84
D7471	Removal of lateral exostosis	$314	$370
D7472	Removal of torus palatinus	$263	$311
D7473	Removal of torus mandibularis	$271	$320
D7485	Reduction of osseous tuberosity	$297	$351
D7510	Incision and drainage of abscess – intraoral soft tissue	$108	$127
D7511	Incision/drainage of abscess – intra. soft tissue, comp.	$226	$260
D7910	Suture of recent small wounds up to 5 cm	$246	$290

Adult $30 Preventive Plan

ADA CODE	BENEFIT	DENTIST COPAY	SPECIALIST COPAY
D7960	Frenulectomy (frenectomy/frenotomy) – separate procedure	$266	$314
D7963	Frenuloplasty	$99	$245
D7970	Excision of hyperplastic tissue – per arch	$456	$539
D7971	Excision of pericoronal gingiva	$225	$265
D7972	Surgical reduction of fibrous tuberosity	$78	$185
	ORTHODONTICS – PREAUTHORIZATION REQUIRED		
D8090	Comp. ortho treatment – adult dentition	No benefit	$3,658
D8660	Pre-orthodontic treatment visit	No benefit	$413
D8670	Periodic ortho. treatment visit (as part of contract)	No benefit	$118
D8680	Ortho. retention (rem of appl./placement of retainers)	No benefit	$516
	ADJUNCTIVE GENERAL SERVICES		
D9110	Palliative (emergency) treatment of dental pain	$30	$75
D9210	Local anesthesia not in conj. w/ operative/surg. procedures	$0	No benefit
D9211	Regional block anesthesia	$0	No benefit
D9212	Trigeminal division block anesthesia	$0	No benefit
D9215	Local anesthesia in conj. w/ operative/surg. procedures	$0	No benefit
D9223	Deep sedation/general anesthesia each 15-minute increment	$40	$139
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	$36	$41
D9243	IV moderate conscious sedation/analgesia – each 15-minute increment	$61	$136
D9310	Consultation (diagnostic service by nontreating dentist)	$59	$96
D9439	Office visit not including an FC visit	$10	$10
D9440	Office visit after regularly scheduled hours	$27	$111
D9910	Application of desensitizing medicament	$30	$60
D9930	Treatment of complications, post-surgical	$48	$48
D9940	Occlusal guard, by report	$338	$519
D9950	Occlusion analysis, mounted case	$169	$169
D9951	Occlusal adjustment – limited	$88	$115
D9952	Occlusal adjustment – complete	$372	$597
D9986	Missed appointment	$50	$50

* All fees exclude the cost of noble and precious metals. An additional fee will be charged if these materials are used.
Only current ADA CDT codes are considered valid by Dominion Dental Services, Inc.

ADULT $30 PREVENTIVE EXCLUSIONS AND LIMITATIONS

MARYLAND AND DC

Exclusions

The following services are not covered:

1. Services which are covered under worker's compensation or employer's liability laws.
2. Services whichare not necessary for the patient's dental health as determined by the Plan.
3. Cosmetic, elective or aesthetic dentistry except as required due to accidental bodily injury to sound natural teeth as determined by the Plan.
4. Oral surgery requiring the setting of fractures or dislocations, except as may be otherwise covered in your medical plan which is described in Section 3 of the Agreement.
5. Services with respect to malignancies, cysts or neoplasms, hereditary, congenital, anodontic, mandibular prognathism or development malformations where, in the opinion of the Plan, such services should not be performed in a dental office except as may be otherwise covered in your medical plan as described in the Evidence of Coverage.
6. Dispensing of drugs, except as may be otherwise covered in your medical plan this is described in the 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. Procedures not listed as a covered benefit under this Plan.
11. Services provided by a non-Participating Dental Provider that was pre-authorized by the Dental Administrator (with the exception of out-of-area emergency dental services).
12. Services related to the treatment of TMD (temporomandibular disorder).
13. Services related to procedures that have such a degree of complexity as not to be performed by a general dentist, unless your participating general dentist refers you to a dental specialist who will provide covered dental services at the dental fee established by the Plan for each procedure rendered.
14. Elective surgery including, but not limited to, extraction of non-pathologic, asymptomatic impacted teeth as determined by the PLan.
15. The Invisalign system and similar specialized braces are not a covered benefit. Patient copayments will apply to the routine orthodontic appliance portion of services only. Additional costs incurred will become the patient's responsibility.
16. Services which are provided without cost to Member by any federal, state, municipal, county, or other political subdivision (with the exception of Medicaid).
17. Services that cannot be performed because of the general health of the patient.
18. Implantation and related restorative procedures.
19. Procedures relating to the change and maintenance of vertical dimension or major restoration of ooclusion, 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.
20. 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.
21. Lab Fees for excisions and biopsies, except as may be otherwise covered in your medical plan that is described in the Agreement.
22. Experimental procedures, implantations, or pharmacological regimens.
23. Initial placement or replacement of fixed bridgework solely for the purpose of achieving periodontal stability.
24. Charges for second opinions, unless pre-authorized.
25. Procedures requiring fixed prosthodontic restoration, which are necessary for complete oral rehabilitation or reconstruction.
26. Occlusal guards, except for the purpose of controlling habitual grinding.
27. Dental services for children under age 19.

Limitations

Covered dental services are subject to the following limitations:

1. Two (2) evaluations are covered per calendar year, per patient, including a maximum of one (1) comprehensive evaluation which is limited to once in 12 months.
2. One (1) problem focused evaluation is covered per plan year.
3. Two (2) teeth cleanings and fluoride applications are covered per plan year. One additional cleaning is covered during pregnancy and for diabetic patients.
4. One (1) topical fluoride or fluoride varnish is covered per calendar year.
5. Two (2) set of bitewing X-rays are covered per calendar year, per patient.
6. One (1) set of full mouth X-rays or panoramic film is covered every three (3) years.
7. Replacement of a filling is covered if it is more than two (2) years from the original date of placement.
8. Replacement of a bridge, crown, or denture is covered if it is more than seven (7) years from the date of original placement.
9. Crown and bridge fees apply to treatment involving five (5) 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%.

10. Relining and rebasing of dentures is limited to once every 24 months.
11. Retreatment of root canal is covered if it is more than two (2) years from the original treatment.
12. Root planing or scaling is covered once every 24 months per quadrant.
13. 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.
14. Full mouth debridement is limited to once per lifetime.
15. Procedure code D4381 is limited to one (1) benefit per tooth for three (3) 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.
16. Periodontal surgery of any type, including any associated material, is covered once every 36 months per quadrant or surgical site.
17. Periodontal maintenance after active therapy is covered twice per calendar year, within 24 months after definitive periodontal therapy.
18. Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation and in lieu or a covered D1110, limited to once per two years.
19. Coronectomy – intentional partial tooth removal, once per lifetime.

VIRGINIA

Exclusions

The following services are not covered:

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. Cosmetic, elective or aesthetic dentistry except as required due to accidental bodily injury to sound natural teeth as determined by the Plan.
4. Oral surgery requiring the setting of fractures or dislocations, except as may be otherwise covered in your medical plan which is described in Section 3 of the Agreement.
5. Services with respect to malignancies, cysts or neoplasms, hereditary, congenital, anodontic, mandibular prognathism or development malformations where, in the opinion of the Plan, such services should not be performed in a dental office except as may be otherwise covered in your medical plan as described in Section 3 of the Agreement.
6. Dispensing of drugs, except as may be otherwise covered in your medical plan this is described in the Agreement.
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. Procedures not listed as a covered benefit under this Plan.
11. Services provided by a non-Participating Dental Provider or not pre-authorized by the Dental Administrator (with the exception of out-of-area emergency dental services).
12. Services related to the treatment of TMD (temporomandibular disorder).
13. Services related to procedures that have such a degree of complexity as not to be performed by a general dentist, unless your participating general dentist refers you to a dental specialist who will provide covered dental services at the dental fee established by the Plan for each procedure rendered.
14. Elective surgery including, but not limited to, extraction of non-pathologic, asymptomatic impacted teeth as determined by the Plan.
15. The Invisalign system and similar specialized braces are not a covered benefit. Patient copayments will apply to the routine orthodontic appliance portion of services only. Additional costs incurred will become the patient's responsibility.
16. Services which are provided without cost to Member by any federal, state, municipal, county, or other political subdivision (with the exception of Medicaid).
17. Services that cannot be performed because of the general health of the patient.
18. Implantation and related restorative procedures.
19. Procedures relating to the change and maintenance of vertical dimension or major restoration of ooclusion, 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.
20. 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.
21. Lab Fees for excisions and biopsies, except as may be otherwise covered in your medical plan that is described in the Agreement.
22. Experimental procedures, implantations, or pharmacological regimens.
23. Initial placement or replacement of fixed bridgework solely for the purpose of achieving periodontal stability.
24. Charges for second opinions, unless pre-authorized.
25. Procedures requiring fixed prosthodontic restoration, which are necessary for complete oral rehabilitation or reconstruction.
26. Occlusal guards, except for the purpose of controlling habitual grinding.
27. Dental services for children under age 19.

Limitations

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2. One (1) problem focused evaluation is covered per year.
3. Two (2) teeth cleanings and fluoride applications are covered per calendar year. One additional cleaning is covered during pregnancy and for diabetic patients.
4. One (1) topical fluoride or fluoride varnish is covered per calendar year.
5. Two (2) sets of bitewing X-rays are covered per calendar year.
6. One (1) set of full mouth X-rays or panoramic film is covered every three (3) years.
7. One (1) sealant or preventive resin restoration per tooth is covered per lifetime per patient, up to age 16 (limited to the permanent 1st and 2nd molars).
8. Replacement of a filling is covered if it is more than two (2) years from the original date of placement.
9. Replacement of a bridge, crown or denture is covered if it is more than seven (7) years from the date of original placement.
10. Crown and bridge fees apply to treatment involving five (5) 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%.
11. Relining and rebasing of dentures is limited to once every 24 months.
12. Retreatment of root canal is covered if it is more than two (2) years from the original treatment.
13. Root planing or scaling is covered once every 24 months per quadrant.
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, once per two years.
15. Full mouth debridement is limited to once per lifetime.
16. Procedure code D4381 is limited to one (1) benefit per tooth for three (3) 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.
17. Periodontal surgery of any type, including any associated material, is covered once every 36 months per quadrant or surgical site.
18. Periodontal maintenance after active therapy is covered twice per calendar year, within 24 months after definitive periodontal therapy.
19. Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation and in lieu or a covered D1110, limited to once per two years.
20. Coronectomy – intentional partial tooth removal, once per lifetime.

Maryland description of benefits and member copayments for pediatric services (up to age 19)

Annual Out-of-Pocket Maximum: Please refer to your medical plan for specific details.

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

Copayments 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 as otherwise described in the *Agreement* or *Evidence of Coverage*.

NOTE: The dental copayment schedule is reviewed annually and is subject to change at contract renewal. If you have any questions concerning this copayment schedule, contact Dominion for details at: **855-733-7524 (TTY 711)**, Monday through Friday, 7:30 a.m. to 6 p.m.

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 (including bitewings)	$26
D0220/30	Intraoral – periapical first film	$0
D0240	Intraoral – occlusal film	$0
D0250	Extraoral – first film and each add. film	$0
D0270-74	Bitewing X-rays – 1 to 4 films	$0
D0277	Vertical bitewings – 7 to 8 films	$0
D0290	Posterior/anterior or lateral skull bone film	$83
D0310	Sialography	$370
D0320	Temporomandibular joint arthrogram, incl. injection	$562
D0321	Other temporomandibular joint films, by report	$120
D0330	Panoramic film	$30

ADA CODE	DESCRIPTION OF SERVICES	YOU PAY TO DENTIST
D0340	Cephalometric film	$0
D0350	Oral/facial photographic images	$0
D0351	3-D photographic image	$0
D0460	Pulp vitality tests	$0
D0470	Diagnostic casts	$0
D0486	Accession of brush biopsy sample	$0
D1110	Prophylaxis (cleaning) – adult	$0
D1120	Prophylaxis (cleaning) – child	$0
D1206	Topical fluoride varnish for moderate/high risk caries patients	$0
D1208	Topical application of fluoride	$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
	SPACE MAINTAINERS	
D1510/20	Space maintainer – fixed/removable – unilateral	$143
D1515/25	Space maintainer – fixed/removable – bilateral	$198
D1550	Re-cementation of space maintainer	$34
D1555	Removal of fixed space maintainer, by non-originating dentist	$44
D1575	Distal shoe space maintainer – fixed – unilateral	$143
	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

ADA CODE	DESCRIPTION OF SERVICES	YOU PAY TO DENTIST
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
D2940	Sedative filling	$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
D3110/20	Pulp cap – direct/indirect (excl. final restoration)	$32
	CROWNS AND 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
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

ADA CODE	DESCRIPTION OF SERVICES	YOU PAY TO DENTIST
D2712	Crown – 3/4 resin-based composite (indirect)	$485
D2720/21/22	Crown – resin with metal	$495
D2740	Crown – porcelain/ceramic substrate	$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
D2952	Cast 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) – laborato	$449
D2980	Crown repair, by report	$102
	PROSTHETICS (DENTURES)	
D5110/20	Complete denture – maxillary/mandibular	$697
D5130/40	Immediate denture – maxillary/mandibular	$722
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
D5281	Rem. unilateral partial denture – one piece cast metal	$419
D5410/11	Adjust complete denture – maxillary/mandibular	$38

ADA CODE	DESCRIPTION OF SERVICES	YOU PAY TO DENTIST
D5421/22	Adjust partial denture – maxillary/mandibular	$38
D5510/5610	Repair broken denture base (complete/resin)	$87
D5520	Replace missing or broken teeth – complete denture	$87
D5620	Repair cast framework	$87
D5630/60	Clasp repaired, replaced or added	$115
D5640	Replace broken teeth – per tooth	$87
D5650	Add tooth to existing partial denture	$87
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
D5993	Cleaning and maintenance prosthetic appliance	$18
	BRIDGES AND PONTICS*	
D6058	Abutment supported porcelain/ceramic crown	$560
D6059/60/61	Abutment porcelain/metal crown – metal	$523
D6066	Implant porcelain/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

ADA CODE	DESCRIPTION OF SERVICES	YOU PAY TO DENTIST
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. – porcelain/ceramic for resin bonded fixed prosthesis	$393
D6549	Resin retainer for resin bonded fixed prosthesis	$251
D6600	Inlay – porcelain/ceramic, two surfaces	$427
D6601	Inlay – porcelain/ceramic, >=3 surfaces	$445
D6602	Inlay – cast high noble metal, two surfaces	$407
D6603	Inlay – cast high noble metal, >=3 surfaces	$425
D6604	Inlay – cast predominantly base metal, two surfaces	$407
D6605	Inlay – cast predominantly base metal, >=3 surfaces	$425
D6606	Inlay – cast noble metal, two surfaces	$407
D6607	Inlay – cast noble metal, >=3 surfaces	$425
D6608	Onlay -porcelain/ceramic, two surfaces	$479
D6609	Onlay – porcelain/ceramic, three or more surfaces	$499
D6610	Onlay – cast high noble metal, two surfaces	$458
D6611	Onlay – cast high noble metal, >=3 surfaces	$524
D6612	Onlay – cast predominantly base metal, two surfaces	$458
D6613	Onlay – cast predominantly base metal, >=3 surfaces	$524
D6614	Onlay – cast noble metal, two surfaces	$458
D6615	Onlay – cast noble metal, >=3 surfaces	$524
D6720/21/22	Crown – resin with metal	$495
D6740	Crown – porcelain/ceramic	$560
D6750/51/52	Crown – porcelain fused metal	$523
D6780	Crown – 3/4 cast high noble metal	$470
D6781	Crown – 3/4 cast predominantly base metal	$470
D6782	Crown – 3/4 cast noble metal	$470
D6783	Crown – 3/4 porcelain/ceramic	$511
D6790/91/92	Crown – full cast metal	$495

ADA CODE	DESCRIPTION OF SERVICES	YOU PAY TO DENTIST
D6930	Recement fixed partial denture	$69
D6980	Fixed partial denture repair, by report	$172
	ADJUNCTIVE GENERAL SERVICES	
D9110	alliative (emergency) treatment of dental pain	$43
D9210/15	Local anesthesia	$0
D9211/12	Regional block anesthesia	$0
D9223	Deep sedation/general anesthesia each 15-minute increment	$103
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	$37
D9243	IV moderate conscious sedation/analgesia – each 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
D9910	Application of desensitizing medicament	$31
D9930	Treatment of complications (post-surgical)	$43
D9940	Occlusal guard, by report	$272
D9941	Fabrication of athletic mouthguard	$102
D9950	Occlusion analysis – mounted case	$104
D9951	Occlusal adjustment – limited	$66
D9952	Occlusal adjustment – complete	$266
D9986	Missed appointment	$50
	ENDODONTICS	
D3220	Therapeutic pulpotomy (excl. final restor.)	$81
D3221	Pulpal debridement, prim. and perm. teeth	$94
D3230	Pulpal therapy – resorbable filling, anterior	$160
D3240	Pulpal therapy – resorbable filling, posterior	$164
D3310	Endodontic therapy, anterior tooth	$341
D3320	Endodontic therapy, bicuspid tooth	$418
D3330	Endodontic therapy, molar	$512
D3332	Incomp endo. therapy-inop. or fractured tooth	$183

ADA CODE	DESCRIPTION OF SERVICES	YOU PAY TO DENTIST
D3333	Internal root repair of perforation defects	$105
D3346	Retreat of prev. root canal therapy, anterior	$387
D3347	Retreat of prev. root canal therapy, bicuspid	$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/periradicular surgery, anterior	$323
D3421	Apicoectomy/periradicular surgery, bicuspid (first root)	$364
D3425	Apicoectomy/periradicular surgery, molar (first root)	$418
D3426	Apicoectomy/periradicular surgery (each add. root)	$152
D3427	Periradicular surgery w/o apicoectomy	$266
D3430	Retrograde filling – per root	$119
D3450	Root amputation – per root	$234
D3470	Intentional reimplantation	$718
D3920	Hemisection, not including root canal therapy	$234
D3950	Canal prep/fitting of preformed dowel or post	$136
	PERIODONTICS	
D0180	Comp. periodontal evaluation – 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 procedure, including root planing – >3 cont. teeth, per quad.	$345
D4241	Gingival flap procedure, including root planing – <=3 cont. teeth, per quad.	$106
D4249	Clinical crown lengthening – hard tissue	$576
D4260	Osseous surgery – >3 cont. teeth, per quad.	$499

ADA CODE	DESCRIPTION OF SERVICES	YOU PAY TO DENTIST
D4261	Osseous surgery – <=3 cont. teeth, per quad.	$392
D4268	Surgical revision procedure, 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 chemotherapeutic agents	$98
D4910	Periodontal maintenance	$74
D4920	Unscheduled dressing change by non-treating dentist	$84
	ORAL SURGERY	
D7111	Extraction, coronal remnants – deciduous 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
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
D7285	Biopsy of oral tissue – hard (bone, tooth)	$387
D7286	Biopsy of oral tissue – soft (all others)	$295
D7290	Surgical repositioning of teeth	$407
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	$60

ADA CODE	DESCRIPTION OF SERVICES	YOU PAY TO DENTIST
D7310/20	Alveoloplasty, per quad.	$141
D7311/21	Alveoloplasty in conj. with/out extractions	$141
D7340	Vestibuloplasty – ridge ext. sec. epithel.	$923
D7350	Vestibuloplasty – ridge ext. including grafts, etc.	$1,776
D7410	Excision of benign lesion up to 1.25 cm	$278
D7440	Excision of malignant tumor – lesion diam. <=1.25 cm	$608
D7450	Removal of benign odon cyst/tumor – diam <=1.25 cm	$354
D7451	Removal of benign odon cyst/tumor – diam >1.25 cm	$543
D7460	Removal of benign nonodon cyst/tumor – diam <=1.25 cm	$516
D7461	Removal of benign nonodon cyst/tumor – diam >1.25 cm	$718
D7471	Removal of lateral exostosis	$351
D7472/73	Removal of torus palatinus/mandibularis	$480
D7510	Incision and drainage of abscess – intraoral soft tissue	$96
D7520	Incision/drainage of abscess – extra. soft tiss	$116
D7550	Partial ostect/sequestrect non-vital bone rem.	$336
D7960	Frenulectomy (frenectomy/frenotomy) – separate proc.	$263
D7970	Excision of hyperplastic tissue – per arch	$233
D7971	Excision of pericoronal gingiva	$131
	ORTHODONTICS – PREAUTHORIZATION 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 dentures	$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.
Only current ADA CDT codes are considered valid by Dominion Dental Services, Inc.

MARYLAND EXCLUSIONS AND LIMITATIONS

Exclusions

The following services are not covered:

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. Cosmetic, elective or aesthetic dentistry except as required due to accidental bodily injury to sound natural teeth as determined by the Plan.
4. Oral surgery requiring the setting of fractures or dislocations.
5. Services with respect to malignancies, cysts or neoplasms, hereditary, congenital, mandibular prognathism or development malformations where, in the opinion of the Plan, 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 from major disaster, epidemic, war, 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. Procedures not listed as covered benefits under this Plan.
11. Services obtained outside of the dental office in which enrolled and that are not preauthorized by such office or the Plan (with the exception of out-of-area emergencies).
12. 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.
13. Elective surgery including, but not limited to, extraction of non-pathologic, asymptomatic impacted teeth as determined by the Plan. The prophylactic removal of these teeth may be covered subject to review.
14. 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.
15. Non-medically necessary orthodontia and Phase I Treatment for Medically Necessary orthodontia are not covered benefits 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 #21 concerning Medically Necessary orthodontia.

Limitations

Covered dental services are subject to the following 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) space maintainer is covered per 24 months, per quadrant (D1510 or D1520) or per arch (D1515 or D1525), per patientto preserve space between teeth for premature loss of a primary tooth (does not include use for orthodontic treatment).
8. One (1) distal shoe space maintainer, fixed, unilateral per lifetime.
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 is 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 (1) 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 or 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. General anesthesia is not covered with procedure codes D9230 or D9243. Intravenous conscious sedation is not covered with procedure codes D9223 or D9230. Non-intravenous conscious sedation is not covered with procedure codes D9223 or D9230. Analgesia (nitrous oxide) is not covered with procedure codes D9223 or D9243.
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.

Virginia description of benefits and member copayments for pediatric services (up to age 19)

Annual Out-of-Pocket Maximum: Please refer to your medical plan for specific details.

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

Copayments 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 as otherwise described in the *Agreement* or *Evidence of Coverage*.

NOTE: The dental copayment schedule is reviewed annually and is subject to change at contract renewal. If you have any questions concerning this copayment schedule, contact Dominion for details at: **855-733-7524 (TTY 711)**, Monday through Friday, 7:30 a.m. to 6 p.m.

ADA CODE	BENEFIT	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 (including bitewings)	$26
D0220/30	Intraoral – periapical first film and each additional	$0
D0240	Intraoral – occlusal film	$0
D0250	Extraoral – first film and each add. film	$0
D0270-74	Bitewing X-rays – 1 to 4 films	$0
D0277	Vertical bitewings – 7 to 8 films	$0
D0330	Panoramic film	$30
D0340	Cephalometric Film	$0
D0350	Oral/facial photographic images	$0
D0351	3-D photographic image	$0

ADA CODE	BENEFIT	YOU PAY TO DENTIST
D0460	Pulp vitality tests	$0
D0470	Diagnostic casts	$0
D1110	Prophylaxis (cleaning) – adult	$0
D1120	Prophylaxis (cleaning) – child	$0
D1206	Topical fluoride varnish for mod/high risk caries patients	$0
D1208	Topical application of fluoride	$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
	SPACE MAINTAINERS	
D1510/20	Space maintainer – fixed/removable – unilateral	$143
D1515/25	Space maintainer – fixed/removable – bilateral	$198
D1550	Re-cementation of space maintainer	$34
D1555	Removal of fixed space maintainer, by non-originating dentist	$44
D1575	Distal shoe space maintainer – fixed – unilateral	$143
	RESTORATIVE DENTISTRY (FILLINGS)	
	AMALGAM RESTORATIONS (SILVER)	
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

ADA CODE	BENEFIT	YOU PAY TO DENTIST
D2393	Resin-based composite – three surfaces, posterior	$102
D2394	Resin-based composite – >=4 surfaces, posterior	$123
D2940	Sedative filling	$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
D3110/20	Pulp cap – direct/indirect (excl. final restoration)	$32
	CROWNS AND 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
D2643/44	Onlay – porcelain/ceramic – >=3 surfaces	$499
D2650/51/52	Inlay – resin-based composite – >=1 surfaces	$440
D2662/63/64	Onlay – resin-based composite – >=2 surfaces	$444
D2710	Crown – resin based composite (indirect)	$272
D2712	Crown – 3/4 resin-based composite (indirect)	$485
D2720/21/22	Crown – resin with metal	$495
D2740	Crown – porcelain/ceramic substrate	$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

ADA CODE	BENEFIT	YOU PAY TO DENTIST
D2915	Recement cast or prefab. post and core	$82
D2920	Recement crown	$43
D2929	Porcelain/cermaic crown – prim. tooth	$560
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, prim. tooth	$296
D2952	Cast 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
D2962	Labial veneer – laboratory	$449
D2970	Temporary crown (fractured tooth)	$0
D2980	Crown repair, by report	$102
	PROSTHETICS (DENTURES)	
D5110/20	Complete denture – maxillary/mandibular	$697
D5130/40	Immediate denture – maxillary/mandibular	$722
D5211/12	Maxillary/mandibular partial denture – resin base	$649
D5213/14	Maxillary/mandibular partial denture – cast metal	$750
D5221/22	Immediate maxillary/mandibular – resin base	$649
D5223/24	Immediate maxillary/mandibular – cast metal	$750
D5225/26	Maxillary/mandibular partial denture – flexible base	$750
D5281	Rem. unilateral partial denture – one piece cast metal	$419
D5410/11	Adjust complete denture – maxillary/mandibular	$38
D5421/22	Adjust partial denture – maxillary/mandibular	$38
D5510/5610	Repair broken denture base (complete/resin)	$87
D5520	Replace missing or broken teeth – complete denture	$87
D5610	Repair resin denture base	$87
D5620	Repair cast framework	$87
D5630	Clasp repaired, replaced or added	$115

ADA CODE	BENEFIT	YOU PAY TO DENTIST
D5640	Replace broken teeth – per tooth	$87
D5650	Add tooth to existing partial denture	$87
D5660	Add clasp to existing partial denture	$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
D5951	Feeding aid	$1,395
	BRIDGES AND PONTICS♦	
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
D6205	Pontic – indirect resin based composite	$445
D6210-14	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	Ret. – cast metal for resin bonded fixed prosthesis	$251
D6548	Ret. – porcelain/ceramic for resin bonded fixed prosthesis	$393
D6549	Resin retainer for resin bonded fixed prosthesis	$251
D6600	Inlay – porcelain/ceramic, two surfaces	$427
D6601	Inlay – porcelain/ceramic, >=3 surfaces	$445
D6602	Inlay – cast high noble metal, two surfaces	$407
D6603	Inlay – cast high noble metal, >=3 surfaces	$425
D6604	Inlay – cast predominantly base metal, two surfaces	$407

ADA CODE	BENEFIT	YOU PAY TO DENTIST
D6605	Inlay – cast predominantly base metal, >=3 surfaces	$425
D6606	Inlay – cast noble metal, two surfaces	$407
D6607	Inlay – cast noble metal, >=3 surfaces	$425
D6608	Onlay – porcelain/ceramic, two surfaces	$479
D6609	Onlay – porcelain/ceramic, three or more surfaces	$499
D6610	Onlay – cast high noble metal, two surfaces	$458
D6611	Onlay – cast high noble metal, >=3 surfaces	$524
D6612	Onlay – cast predominantly base metal, two surfaces	$458
D6613	Onlay – cast predominantly base metal, >=3 surfaces	$524
D6614	Onlay – cast noble metal, two surfaces	$458
D6615	Onlay – cast noble metal, >=3 surfaces	$524
D6710	Crown – indirect resin based composite	$445
D6720/21/22	Crown – resin with metal	$495
D6740	Crown – porcelain/ceramic	$560
D6750/51/52	Crown – porcelain fused metal	$523
D6780	Crown – 3/4 cast high noble metal	$470
D6781	Crown – 3/4 cast predominantly base metal	$470
D6782	Crown – 3/4 cast noble metal	$470
D6783	Crown – 3/4 porcelain/ceramic	$511
D6790-94	Crown – full cast metal	$495
D6930	Recement fixed partial denture	$69
D6975	Coping – metal	$325
D6980	Fixed partial denture repair, by report	$172
	ADJUNCTIVE GENERAL SERVICES	
D9110	Palliative (emergency) treatment of dental pain	$43
D9210/15	Local anesthesia	$0
D9211/12	Regional block anesthesia	$0
D9223	Deep sedation/general anesthesia each 15-minute increment	$103
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	$37
D9243	IV moderate conscious sedation/analgesia – each 15-minute increment	$103

ADA CODE	BENEFIT	YOU PAY TO DENTIST
D9248	Non-intravenous conscious sedation	$145
D9310	Consultation (diagnostic service by nontreating dentist)	$43
D9420	Hospital call	$350
D9440	Office visit after regularly scheduled hours	$90
D9610	Therapeutic parenteral drug, single admin.	$26
D9612	Therapeutic parenteral drug, 2 or more admin., diff. med.	$70
D9630	Drugs or medicaments dispensed in the office for home use	$42
D9910	Application of desensitizing medicament	$31
D9920	Behavior management, by report	$68
D9930	Treatment of complications (post-surgical)	$43
D9940	Occlusal guard, by report	$272
D9950	Occlusion analysis – mounted case	$104
D9951	Occlusal adjustment – limited	$66
D9952	Occlusal adjustment – complete	$266
D9986	Missed appointment	$50
	ENDODONTICS	
D3220	Therapeutic pulpotomy (excl. final restor.)	$81
D3221	Pulpal debridement, prim. and perm. teeth	$94
D3230	Pulpal therapy – resorbable filling, anterior	$160
D3240	Pulpal therapy – resorbable filling, posterior	$164
D3310	Endodontic therapy, anterior tooth	$341
D3320	Endodontic therapy, bicuspid tooth	$418
D3330	Endodontic therapy, molar	$512
D3333	Internal root repair of perforation defects	$105
D3346	Retreat of prev. root canal therapy, anterior	$387
D3347	Retreat of prev. root canal therapy, bicuspid	$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

ADA CODE	BENEFIT	YOU PAY TO DENTIST
D3410	Apicoectomy/periradicular surgery, anterior	$323
D3421	Apicoectomy/periradicular surgery, bicuspid (first root)	$364
D3425	Apicoectomy/periradicular surgery, molar (first root)	$418
D3426	Apicoectomy/periradicular surgery (each add. root)	$152
D3427	Periradicular surgery w/o apicoectomy	$266
D3428	Bone graft in conj. w/ periradicular surg., per tooth, single site	$743
D3429	Bone graft in conj. w/ periradicular surg., add. contiguous tooth, same site	$582
D3430	Retrograde filling – per root	$119
D3355	Pulpal regeneration – initial visit	$202
D3356	Pulpal regeneration – interim medication replacement	$589
D3357	Pulpal regeneration – completion of treatment	$449
D3450	Root amputation – per root	$234
D3920	Hemisection, not including root canal therapy	$234
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
D4240	Gingival flap proc., including root planing – >3 cont. teeth, per quad.	$345
D4241	Gingival flap proc., including 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
D4263	Bone replacement graft – retained natural tooth – first site in quad.	$743
D4264	Bone replacement graft – retained natural tooth – each add. site in quad.	$582
D4268	Surgical revision proc., per tooth	$358
D4270	Pedicle soft tissue graft procedure	$643
D4273	Subepithelial connective tissue graft proc.	$800
D4274	Mesial/distal wedge procedure, single tooth	$308

ADA CODE	BENEFIT	YOU PAY TO DENTIST
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft	$654
D4278	Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant, or edentulous tooth position in same graft site	$100
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 chemotherapeutic agents	$98
D4910	Periodontal maintenance	$74
	ORAL SURGERY	
D7111	Extraction, coronal remnants – deciduous 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
D7251	Coronectomy-intentional partial tooth removal	$217
D7260	Oroantral fistula closure	$578
D7261	Primary closure of a sinus perforation	$465
D7270	Tooth reimplant./stabiliz. of acc. evulsed/displaced tooth	$226
D7280	Exposure of an unerupted tooth	$153
D7282	Mobil. of erupted/malpositioned tooth to aid eruption	$231
D7283	Place. of device to facilitate erupt. of impacted tooth	$144
D7285	Biopsy of oral tissue – hard (bone, tooth)	$387
D7286	Biopsy of oral tissue – soft (all others)	$295

ADA CODE	BENEFIT	YOU PAY TO DENTIST
D7288	brush biopsy – transepithelial sample collect	$93
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	$60
D7310/20	Alveoloplasty, per quad.	$141
D7311/21	Alveoloplasty in conjunction with/out extractions	$141
D7450	Rem. of benign odon cyst/tumor – diam <=1.25 cm	$354
D7451	Rem. of benign odon cyst/tumor – diam >1.25 cm	$543
D7471	Removal of lateral exostosis	$351
D7472/73	Removal of torus palatinus/mandibularis	$480
D7485	Surgical reduction of osseous tuberosity	$568
D7510	Incision/drainage of abscess – intra. soft tissue	$96
D7511	Incision/drainage of abscess – intra. soft tissue, comp.	$112
D7880	Occlusal orthotic device, "by report"	$272
D7960	Frenulectomy (frenectomy/frenotomy) – separate proc.	$263
D7963	Frenuloplasty	$293
D7970	Excision of hyperplastic tissue – per arch	$233
D7971	Excision of pericoronal gingiva	$131
D7972	Surgical reduction of fibrous tuberosity	$521
	ORTHODONTICS – PREAUTHORIZATION REQUIRED	
D8020	Lim. ortho treatment – transitional dentition	$3,304
D8030	Lim. ortho treatment of – adolescent dentition	$3,422
D8040	Lim. ortho treatment – adult dentition	$3,658
D8070	Comp. ortho. treatment – transitional dentition	$3,304
D8080	Comp. ortho. treatment – adolescent dentition	$3,422
D8090	Comp. ortho. treatment – adult dentition	$3,658
D8210	Removable appliance therapy – includes appliances for thumb sucking and tongue thrusting	$770
D8220	Fixed appliance therapy – includes appliances for thumb sucking and tongue thrusting	$783
D8660	Pre-orthodontic treatment visit	$413
D8670	Periodic orthodontic treatment visit (as part of contract)	$118
D8680	Orthodontic ret. (rem. of appl./placement of retainer[s])	$413

ADA CODE	BENEFIT	YOU PAY TO DENTIST
D8692	Replacement of lost or broken retainer	$179
D8694	Repair of fixed retainers, includes reattachment	$174
D8999	Unspecified orthodontic procedure, by report	$0

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

Only current ADA CDT codes are considered valid by Dominion Dental Services, Inc.
Current Dental Terminology © American Dental Association.

Specialty care is provided at the listed copayment whether performed by a Participating General Dentist or a Participating Specialist. Referrals to a specialist must be made by a member's Participating General Dentist.

VIRGINIA EXCLUSIONS AND LIMITATIONS

Exclusions

The following services are not covered under this 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. Cosmetic, elective or aesthetic dentistry except as required due to accidental bodily injury to sound natural teeth as determined by the Plan.
4. Oral surgery requiring the setting of fractures or dislocations.
5. Services with respect to malignancies, cysts or neoplasms, hereditary, congenital, mandibular prognathism or development malformations where, in the opinion of the Plan, 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 from major disaster, epidemic, war, 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. Procedures not listed as covered benefits under this Plan.
11. Services obtained outside of the dental office in which enrolled and that are not preauthorized by such office or the Plan (with the exception of out-of-area emergencies).
12. Services related to the treatment of TMD (temporomandibular disorder) except if TMD is caused by severe, dysfunctional, handicapping malocclusion that requires medically necessary orthodontia services.
13. 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.
14. Elective surgery including, but not limited to, extraction of non-pathologic, asymptomatic impacted teeth as determined by the Plan. The prophylactic removal of these teeth for medically necessary orthodontia services may be covered subject to review.
15. Non-medically necessary orthodontia and Phase I Treatment codes D8010 and D8050 for medically necessary orthodontia are not covered benefits under this policy. Discounts are provided to members through the Plan's agreements with its participating orthodontists. 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.

Limitations

Covered dental services are subject to the following limitations:

1. One (1) evaluation (D0120, D0145 or D0150) per 6 months, per patient.
2. One (1) teeth cleaning (D1110 or D1120) is covered per 6 months, per patient.
3. One (1) fluoride treatment is covered per 6 months, per patient.
4. One (1) sealant per tooth, per lifetime, per patient (limited to occlusal surfaces of posterior permanent teeth without restorations or decay).
5. One (1) space maintainer (D1510, D1520, D1515 or D1525) is covered per 12 months, per quadrant (unilateral) or per arch (bilateral), per patient.
6. One (1) distal shoe space maintainer, fixed, unilateral per lifetime.
7. Replacement of a filling is covered if it is more than twelve (12) months from the date of original placement.
8. Replacement of a crown, denture or labial veneer is covered if it is more than five (5) years from the date of original placement.
9. Replacement of a primary stainless steel crown is covered if it is more than three (3) years from the date of original placement, per tooth, per patient.
10. 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%.
11. Relining and rebasing of dentures is covered once per 24 months, per patient, only after six (6) months of initial placement.
12. Root canal treatment is covered once per tooth, per lifetime, per patient. Retreatment of root canal is covered once per tooth, per lifetime, per patient, not within 24 months, when done by the same provider/location.
13. Periodontal scaling and root planing (D4341 or D4342), osseous surgery (D4260 or D4261) and gingivectomy or gingivoplasty (D4210 or D4211) are limited to one (1) per 24 months, per quadrant, per patient.
14. Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation and in lieu or a covered D1110, limited to once per two years.
15. Full mouth debridement is covered once per 12 months, per patient.
16. 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.
17. Procedure Code D4381 is limited to one (1) benefit per tooth for three (3) teeth per quadrant; or a total of 12 teeth for all four (4) quadrants per twelve (12) months, per patient. Must have pocket depths of five (5) millimeters or greater.
18. Periodontal surgery of any type, including any associated material, is covered once every 24 months, per quadrant or surgical site, per patient.
19. Periodontal maintenance after active therapy is covered four (4) times per 12 months, per patient.
20. Coronectomy, intentional partial tooth removal, one (1) per lifetime.
21. 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.
22. 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. General anesthesia is not covered with procedure codes D9230 or D9243. Intravenous conscious sedation is not covered with procedure codes D9223 or D9230. Non-intravenous conscious sedation is not covered with procedure codes D9223 or D9230. Analgesia (nitrous oxide) is not covered with procedure codes D9223 or D9243.
23. Occlusal guard, by report, (for grinding and clenching of teeth).
24. Apexification, apicoectomy and clinical crown lengthening are each covered once per patient, per lifetime.
25. Orthodontics is only covered if medically necessary as determined by the Plan. Patient copayments will apply to the routine orthodontic appliance portion of services only. Additional costs incurred will become the patient's responsibility.

DC description of benefits and member copayments for pediatric services (up to age 19)

Annual Out-of-Pocket Maximum: Please refer to your medical plan for specific details.

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

Copayments 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 as otherwise described in the *Agreement* or *Evidence of Coverage*.

NOTE: The dental copayment schedule is reviewed annually and is subject to change at contract renewal. If you have any questions concerning this copayment schedule, contact Dominion for details at: **855-733-7524 (TTY 711)**, Monday through Friday, 7:30 a.m. to 6 p.m.

ADA CODE	BENEFIT	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
D0180	Comp. periodontal eval – new or established patient	$0
D0210	Intraoral – complete series (including bitewings)	$26
D0220/30	Intraoral – periapical film and each add.	$0
D0240	Intraoral – occlusal film	$0
D0250	Extraoral – first film and each add. film	$0
D0270-74	Bitewing X-rays – 1 to 4 films	$0
D0277	Vertical bitewings – 7 to 8 films	$0
D0330	Panoramic film	$30
D0340	Cephalometric film	$0
D0350	Oral/facial photographic images	$0

ADA CODE	BENEFIT	YOU PAY TO DENTIST
D0351	3-D photographic image	$0
D0391	Interpretation of diagnostic image only	$0
D0460	Pulp vitality tests	$0
D0470	Diagnostic casts	$0
D1110	Prophylaxis (cleaning) – adult	$13
D1120	Prophylaxis (cleaning) – child	$10
D1206	Topical fluoride varnish	$0
D1208	Topical application of fluoride	$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
	SPACE MAINTAINERS	
D1510/20	Space maintainer – fixed/removable – unilateral	$143
D1515/25	Space maintainer – fixed/removable – bilateral	$198
D1550	Re-cementation of space maintainer	$34
D1575	Distal shoe space maintainer – fixed – unilateral	$143
	RESTORATIVE DENTISTRY (FILLINGS)	
	AMALGAM RESTORATIONS (SILVER)	
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

ADA CODE	BENEFIT	YOU PAY TO DENTIST
D2392	Resin-based composite – two surfaces, posterior	$87
D2393	Resin-based composite – three surfaces, posterior	$102
D2394	Resin-based composite – >=4 surfaces, posterior	$123
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
D3110/20	Pulp cap – direct/indirect (excl. final restoration)	$32
	CROWNS AND BRIDGES♦	
D2510/20	Inlay – metallic – <=2 surfaces	$407
D2530	Inlay – metallic – three or more surfaces	$425
D2542	Onlay – metallic-two surfaces	$458
D2543/44	Onlay – metallic – 2-3 surfaces	$524
D2610/20	Inlay – porcelain/ceramic – <=2 surfaces	$427
D2630	Inlay – porcelain/ceramic – >=3 surfaces	$445
D2642	Onlay – porcelain/ceramic – two surfaces	$479
D2643/44	Onlay – porcelain/ceramic – >=3 surfaces	$499
D2650/51/52	Inlay – resin-based composite – >=1 surfaces	$440
D2662/63/64	Onlay – resin-based composite – >=2 surfaces	$444
D2710	Crown – resin based composite (indirect)	$272
D2712	Crown – 3/4 resin-based composite (indirect)	$485
D2720/21/22	Crown – resin with metal	$495
D2740	Crown – porcelain/ceramic substrate	$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
D2929	Porcelain/ceramic crown – prim. tooth	$560
D2930	Prefab. stainless steel crown – prim. tooth	$110

ADA CODE	BENEFIT	YOU PAY TO DENTIST
D2931	Prefab. stainless steel crown – perm. tooth	$121
D2932	Prefabricated resin crown	$140
D2952	Cast 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
D2980-83	Crown, inlay, onlay or veneer repair, by report	$102
D2990	Resin infitration lesion	$41
	PROSTHETICS (DENTURES)	
D5110/20	Complete denture – maxillary/mandibular	$697
D5130/40	Immediate denture – maxillary/mandibular	$722
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
D5281	Rem. unilateral partial denture – one piece cast metal	$419
D5410/11	Adjust complete denture – maxillary/mandibular	$38
D5421/22	Adjust partial denture – maxillary/mandibular	$38
D5510/5610	Repair broken denture base (complete/resin)	$87
D5520	Replace missing or broken teeth – complete denture	$87
D5620	Repair cast framework	$87
D5630/60	Clasp repaired, replaced or added	$115
D5640	Replace broken teeth – per tooth	$87
D5650	Add tooth to existing partial denture	$87
D5660	Add clasp to existing partial denture	$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

ADA CODE	BENEFIT	YOU PAY TO DENTIST
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
	BRIDGES AND PONTICS♦	
D6010	Surgical placement of implant body, endosteal	$1,716
D6011	Second stage implant surgery	$200
D6012	Surgical placement of interim implant body	$1,782
D6013	Surgical placement of mini implant	$572
D6040	Surgical placement, eposteal implant	$3,564
D6050	Surgical placement, transosteal implant	$4,455
D6055	Dental implant supported connecting bar	$1,611
D6056	Prefabricated abutment	$456
D6058	Abutment supported porcelain/ceramic crown	$560
D6059/60/61	Abutment porcelain/metal crown – metal	$523
D6062-64	Abutment cast metal crown – metal	$495
D6065	Implant supported porcelain/ceramic crown	$560
D6066/67	Implant porcelain/metal or metal crown (titanium/alloy/noble)	$523
D6068	Abutment supported retainer for porcelain/ceramic	$788
D6069	Abutment supported retainer for porcelain/high noble	$843
D6070	Abutment supported retainer for porcelain/pred. base	$695
D6071	Abutment supported retainer for porcelain/noble	$704
D6072	Abutment supp retainer for cast high noble	$788
D6073	Abutment supported retainer for cast high noble	$749
D6074	Abutment supported retainer for cast noble metal	$758
D6075	Implant supported retainer for ceramic FPD	$874
D6076	Implant supported retainer for porcelain/metal FPD	$823
D6077	Implant supported retainer for cast metal FPD	$872
D6080	Implant maintenance procedures	$61

ADA CODE	BENEFIT	YOU PAY TO DENTIST
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
D6090	Repair implant supported prosthesis	$362
D6091	Replacement of precision attachment	$34
D6095	Repair implant abutment, by report	$391
D6100	Implant removal, by report	$241
D6101	Debridement peri-implant defect	$90
D6102	Debridement and osseous contouring peri-implant defect	$180
D6103	Bone graft repair peri-implant defect	$600
D6104	Bong graft at time of implant placement	$600
D6190	Radiographic surgical implant index, by report	$0
D6210-14	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	Ret. – cast metal for resin bonded fixed prosthesis	$251
D6548	Ret. – porcelain/ceramic for resin bonded fixed prosthesis	$393
D6549	Resin Retainer for resin bonded fixed prosthesis	$251
D6600	Inlay – porcelain/ceramic, two surfaces	$427
D6601	Inlay – porcelain/ceramic, >=3 surfaces	$445
D6602	Inlay – cast high noble metal, two surfaces	$407
D6603	Inlay – cast high noble metal, >=3 surfaces	$425
D6604	Inlay – cast predominantly base metal, two surfaces	$407
D6605	Inlay – cast predominantly base metal, >=3 surfaces	$425
D6606	Inlay – cast noble metal, two surfaces	$407
D6607	Inlay – cast noble metal, >=3 surfaces	$425
D6608	Onlay – porcelain/ceramic, two surfaces	$479
D6609	Onlay – porcelain/ceramic, three or more surfaces	$499
D6610	Onlay – cast high noble metal, two surfaces	$458
D6611	Onlay – cast high noble metal, >=3 surfaces	$524

ADA CODE	BENEFIT	YOU PAY TO DENTIST
D6612	Onlay – cast predominantly base metal, two surfaces	$458
D6613	Onlay – cast predominantly base metal, >=3 surfaces	$524
D6614	Onlay – cast noble metal, two surfaces	$458
D6615	Onlay – cast noble metal, >=3 surfaces	$524
D6720/21/22	Crown – resin with metal	$495
D6740	Crown – porcelain/ceramic	$560
D6750/51/52	Crown – porcelain fused metal	$523
D6780	Crown – 3/4 cast high noble metal	$470
D6781	Crown – 3/4 cast predominantly base metal	$470
D6782	Crown – 3/4 cast noble metal	$470
D6783	Crown – 3/4 porcelain/ceramic	$511
D6790/91/92	Crown – full cast metal	$495
D6930	Recement fixed partial denture	$69
D6980	Fixed partial denture repair, by report	$172
	ADJUNCTIVE GENERAL SERVICES	
D9110	Palliative (emergency) treatment of dental pain	$43
D9210/15	Local anesthesia	$0
D9211/12	Regional block anesthesia	$0
D9223	Deep sedation/general anesthesia each 15-minute increment	$103
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	$37
D9243	IV moderate conscious sedation/analgesia – each 15-minute increment	$103
D9310	Consultation (diagnostic service by nontreating dentist)	$43
D9910	Application of desensitizing medicament	$31
D9930	Treatment of complications (post-surgical)	$43
D9940	Occlusal guard, by report	$272
D9950	Occlusion analysis – mounted case	$104
D9951	Occlusal adjustment – limited	$66
D9952	Occlusal adjustment – complete	$266
D9986	Missed appointment	$50

ADA CODE	BENEFIT	YOU PAY TO DENTIST
	ENDODONTICS	
D3220	Therapeutic pulpotomy (excl. final restor.)	$81
D3221	Pulpal debridement, prim. and perm. teeth	$94
D3222	Partial pulpotomy for apexogenesis	$160
D3230	Pulpal therapy – resorbable filling, anterior	$160
D3240	Pulpal therapy – resorbable filling, posterior	$164
D3310	Endodontic therapy, anterior tooth	$341
D3320	Endodontic therapy, bicuspid tooth	$418
D3330	Endodontic therapy, molar	$512
D3333	Internal root repair of perforation defects	$105
D3346	Retreat of prev. root canal therapy, anterior	$387
D3347	Retreat of prev. root canal therapy, bicuspid	$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/periradicular surgery, anterior	$323
D3421	Apicoectomy/periradicular surgery, bicuspid (first root)	$364
D3425	Apicoectomy/periradicular surgery, molar (first root)	$418
D3426	Apicoectomy/periradicular surgery (each add. root)	$152
D3427	Periradicular surgery w/o apicoectomy	$266
D3430	Retrograde filling – per root	$119
D3450	Root amputation – per root	$234
D3920	Hemisection, not including root canal therapy	$234
D3950	Canal prep/fitting of preformed dowel or post	$136
	PERIODONTICS	
D4210	Gingivectomy or gingivoplasty – >3 cont. teeth, per quad.	$279

ADA CODE	BENEFIT	YOU PAY TO DENTIST
D4211	Gingivectomy or gingivoplasty – <=3 teeth, per quad.	$100
D4212	Gingivectomy or gingivoplasty, rest., per tooth	$40
D4240	Gingival flap proc., including root planing – >3 cont. teeth, per quad.	$345
D4241	Gingival flap proc., including 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
D4270	Pedicle soft tissue graft procedure	$643
D4273	Subepithelial connective tissue graft proc.	$800
D4274	Mesial/distal wedge procedure, single tooth	$308
D4277	Free soft tissue graft, per tooth	$654
D4278	Free soft tissue graft, each add. tooth	$100
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	$51
D4355	Full mouth debridement	$89
D4381	Localized delivery of chemotherapeutic agents	$98
D4910	Periodontal maintenance	$74
	ORAL SURGERY	
D7111	Extraction, coronal remnants – deciduous tooth	$56
D7140	Extraction, erupted tooth or exposed root	$69
D7210	Extraction, erupted tooth req. bone cut	$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 impacted tooth – completely bony, with unusual surg. complications	$217
D7250	Removal of residual tooth roots	$141
D7251	Coronectomy-intentional partial tooth removal	$217

ADA CODE	BENEFIT	YOU PAY TO DENTIST
D7270	Tooth reimplant./stabiliz. of acc. evulsed/displaced tooth	$226
D7280	Exposure of an unerupted tooth	$153
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	$60
D7310/20	Alveoloplasty, per quad.	$141
D7321	Alveoloplasty not in conjunc w/ extractions	$141
D7471	Removal of lateral exostosis	$351
D7510	Incision and drainage of abscess – intraoral soft tissue	$96
D7910	Suture of recent small wounds up to 5 cm	$59
D7921	Collection application of blood concentrate	$40
D7960	Frenulectomy (frenectomy/frenotomy) – separate proc.	$263
D7971	Excision of pericoronal gingiva	$131
	ORTHODONTICS – PREAUTHORIZATION REQUIRED	
D8010/20	Lim. ortho treatment – prim./trans. dentition	$3,304
D8030	Lim. ortho treatment – adolescent dentition	$3,422
D8050/60	Intercep. ortho treatment – prim./trans. dentition	$3,304
D8070	Comp. ortho. treatment – transitional dentition	$3,304
D8080	Comp. ortho. treatment – adolescent dentition	$3,422
D8090	Comp. ortho. treatment – adult dentition	$3,658
D8210	Removable appliance therapy	$770
D8220	Fixed appliance therapy	$783
D8660	Pre-orthodontic treatment visit	$413
D8670	Periodic ortho. treatment visit (as part of contract)	$118
D8680	Orthodontic ret. (rem. of appl./placement of retainer[s])	$413
D8694	Repair of fixed retainers, includes reattachment	$174

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DC EXCLUSIONS AND LIMITATIONS

Exclusions

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2. Services which are not necessary for the patient's dental health as determined by the Plan.
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4. Oral surgery requiring the setting of fractures or dislocations.
5. Services with respect to malignancies, cysts or neoplasms, hereditary, congenital, mandibular prognathism or development malformations where, in the opinion of the Dental Administrator, 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 from major disaster, epidemic, war, 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. Procedures not listed as covered benefits under this Plan.
11. Services obtained outside of the dental office in which enrolled and that are not preauthorized by such office or the Plan (with the exception of out-of-area emergencies dental services.).
12. Services related to the treatment of TMD (temporomandibular disorder) except if TMD is caused by severe, dysfunctional, handicapping malocclusion that requires medically necessary orthodontia services.
13. 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.
14. Elective surgery including, but not limited to, extraction of non-pathologic, asymptomatic impacted teeth as determined by the Plan. The prophylactic removal of these teeth for medically necessary orthodontia services may be covered subject to review.
15. Non-medically necessary orthodontia and Phase I Treatment codes D8010 and D8050 for medically necessary orthodontia are not covered benefits under this policy. A iscount is provided to members through the Plan's agreements with its participating orthodontists. 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 below limitation concerning medically necessary orthodontia.

Limitations

Covered dental services are subject to the following limitations:

1. One evaluation (D0120, D0140, D0145, D0150, D0160, D0180) is covered per six months, per patient. D0150 limited to once in 12 months
2. One (1) teeth cleaning (D1110 or D1120) is covered per six months, per patient.
3. One (1) fluoride application is covered per six months, per patient
4. One (1) set of bitewing X-rays is covered per six (6) months, per patient starting at age two.
5. One (1) set of full mouth X-rays or panoramic film is covered every five (5) years, per patient, starting at age six. Panoramic X-rays are limited to ages 6-18. No more than one set of X-rays are covered per visit.
6. One (1) sealant per tooth is covered per 36 months, per patient up to age 18 (limited to occlusal surfaces of posterior permanent teeth without restorations or decay).
7. One (1) space maintainer (D1510, D1520, D1515 or D1525) is covered per 24 months per patient, per arch.
8. One (1) distal shoe space maintainer, fixed, unilateral per lifetime.
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 primary stainless steel crown (under age 15), crown, denture, or other prosthodontic appliance is covered if it is more than five (5) years from the date of original placement.
11. 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%.
12. Relining and rebasing of dentures is covered once per 24 months, per patient.
13. Root canal treatment is covered once per tooth per lifetime.
14. Periodontal scaling and root planing (D4341 or D4342), limited to one (1) per 24 months, per patient, per quadrant.
15. Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation and in lieu or a covered D1110, limited to once per two years.
16. Osseous surgery (D4260 or D4261), gingival flap procedure (D4240), and gingivectomy or gingivoplasy (D4210 – D4212) are limited to one (1) per 36 months.
17. Full mouth debridement is covered once per lifetime, 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 quadrants per twelve (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 is covered twice per calendar year in addition to adult prophylaxis, within 24 months after definitive periodontal therapy.
22. Coronectomy, intentional partial tooth removal, one (1) per lifetime.
23. Denture rebase and denture reline is limited to 1 in a 36 month period 6 months after initial placement.
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. General anesthesia

is not covered with procedure codes D9230 or D9243. Intravenous conscious sedation is not covered with procedure codes D9223 or D9230. Non-intravenous conscious sedation is not covered with procedure codes D9223 or D9230. Analgesia (nitrous oxide) is not covered with procedure codes D9223 or D9243.

25. Occlusal guards are covered by report for patients 13 years of age or older when the purpose of the occlusal guard is for the treatment of bruxism or diagnoses other than temporomandibular dysfunction (TMD). Occlusal guards are limited to one per 12 consecutive month period.
26. Deep sedation/general anesthesia and intravenous conscious sedation are covered (by report) only when provided in connection with a covered procedure(s) when determined to be medically or dentally necessary for documented handicapped or uncontrollable patients or justifiable medical or dental conditions.
27. Fixed partial dentures, buildups, and posts and cores for members under 16 years of age are only covered if deemed necessary by the Plan.
28. Onlays, crowns, and posts and cores for members 12 years of age or younger are only covered if deemed necessary by the Plan. Cast posts and cores (D2952) are processed as an alternate benefit of a prefabricated post and core. Posts are eligible only when provided as part of a crown buildup or implant and are considered integral to the buildup or implant.
29. Orthodontics is only covered if medically necessary as determined by the Plan. Patient copayments will apply to the routine orthodontic appliance portion of services only. Additional costs incurred will become the patient's responsibility.

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (Kaiser Health Plan) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Kaiser Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. We also:

- Provide no cost aids and services to people with disabilities to communicate effectively with us,such as:
  - Qualified sign language interpreters
  - Written information in other formats, such as large print, audio, and accessible electronicformats
- Provide no cost language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call the number provided below.

District of Columbia	**800-777-7902**
Maryland	**800-777-7902**
Virginia	**800-777-7902**
TTY	**711**

If you believe that Kaiser Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Kaiser Civil Rights Coordinator, 2101 East Jefferson Street, Rockville, MD 20852, telephone number: **800-777-7902.** You can file a grievance by mail or phone. If you need help filing a grievance, the Kaiser Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf,* or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, **800-368-1019, 800-537-7697 (TDD).** Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (Kaiser Health Plan), cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivo de la raza, color, nacionalidad de origen, edad, discapacidad o sexo. El Kaiser Health Plan no excluye a las personas o las trata de forma diferente por motivo de la raza, color, nacionalidad de origen, edad, discapacidad o sexo. Recuerde también:

- Nosotros les brindamos ayuda y servicios sin costo alguno a las personas que tienen unadiscapacidad que les impide comunicarse con nosotros en forma eficaz, tales como:
  - Intérpretes calificados de lenguaje de señas
  - Información por escrito en otros formatos, tales como letra grande, audio y otrosformatos electrónicos accesibles
- Brindamos servicios de idiomas sin costo alguno a personas cuyo idioma principal no sea elinglés, tales como:
  - Intérpretes calificados
  - Información por escrito en otros idiomas

If you need these services, call the number provided below.

District of Columbia	**800-777-7902**
Maryland	**800-777-7902**
Virginia	**800-777-7902**
Línea TTY	**711**

Si cree que el Kaiser Health Plan no le ha brindado dichos servicios o ha incurrido en discriminación en contra suya de otra manera por motivo de la raza, color, nacionalidad de origen, edad, discapacidad o sexo, usted puede presentar una queja ante el Kaiser Civil Rights Coordinator, 2101 East Jefferson Street, Rockville, MD 20852, número de teléfono: **800-777-7902.** Puede presentar una queja por correo opor teléfono. Si necesita ayuda para presentar una queja, el Kaiser Civil Rights Coordinator estádisponible para ayudarle. También puede presentar una queja de derechos civiles ante el Departamento de Salud y Servicios Humanos de los Estados Unidos (U.S. Department of Health and Human Services), la Oficina de Derechos Civiles (Office for Civil Rights) a través del Portal de Quejas de la Oficina de Derechos Civiles, disponible en *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf,* o por correo electrónico o por teléfono: Departamento de Salud y Servicios Humanos de los Estados Unidos, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, **800-368-1019, 800-537-7697 (TDD).** Los formularios de queja están disponibles en *http://www.hhs.gov/ocr/office/file/index.html*.

NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (Kaiser Health Plan) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Kaiser Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. We also:

- Provide no cost aids and services to people with disabilities to communicate effectively with us, such as:
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  - Written information in other formats, such as large print, audio, and accessible electronic formats

- Provide no cost language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call **1-800-777-7902** (TTY: **711**)

If you believe that Kaiser Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by mail or phone at: Kaiser Permanente, Appeals and Correspondence Department, Attn: Kaiser Civil Rights Coordinator, 2101 East Jefferson St., Rockville, MD 20852, telephone number: 1-800-777-7902.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

HELP IN YOUR LANGUAGE

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-800-777-7902** (TTY: **711**).

አማርኛ (Amharic) ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ **1-800-777-7902** (TTY: **711**).

العربية (Arabic) ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-800-777-7902** (TTY: **711**).

Ɓăsɔ̀ɔ̀ Wùdù (Bassa) Dè dɛ nìà kɛ dyédé gbo: Ɔ jǔ ké m̀ Ɓàsɔ́ɔ̀-wùdù-po-nyɔ̀ jǔ ní, nìí, à wudu kà kò dò po-poò ɓéìn m̀ gbo kpáa. Đá **1-800-777-7902** (TTY: **711**)

বাংলা (Bengali) লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন **1-800-777-7902** (TTY: **711**)।

中文 (Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-800-777-7902**（TTY：**711**）。

فارسی (Farsi) توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-800-777-7902** (TTY: **711**) تماس بگیرید.

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-777-7902** (TTY: **711**).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.
Rufnummer: **1-800-777-7902** (TTY: **711**).

ગુજરાતી (Gujarati) સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો **1-800-777-7902** (TTY: **711**).

Kreyòl Ayisyen (Haitian Creole) ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-800-777-7902** (TTY: **711**).

हिन्दी (Hindi) ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1-800-777-7902** (TTY: **711**) पर कॉल करें।

Igbo (Igbo) NRỤBAMA: Ọ bụrụ na ị na asụ Igbo, ọrụ enyemaka asụsụ, n'efu, dịịrị gị. Kpọọ **1-800-777-7902** (TTY: **711**).

Italiano (Italian) ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-800-777-7902** (TTY: **711**).

日本語 (Japanese) 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-800-777-7902**（TTY: **711**）まで、お電話にてご連絡ください。

한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-800-777-7902** (TTY: **711**) 번으로 전화해 주십시오.

Naabeehó (Navajo) Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih **1-800-777-7902** (TTY: **711**).

Português (Portuguese) ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **1-800-777-7902** (TTY: **711**).

Русский (Russian) ВНИМАНИЕ: если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-777-7902** (TTY: **711**).

Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-777-7902** (TTY: **711**).

Tagalog (Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad.
Tumawag sa **1-800-777-7902** (TTY: **711**).

ไทย (Thai) เรียน: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-800-777-7902** (TTY: **711**).

اُردو (Urdu) خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں **1-800-777-7902** (TTY: **711**).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-777-7902** (TTY: **711**).

Yorùbá (Yoruba) AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi **1-800-777-7902** (TTY: **711**).

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