SMILE
FOR TOTAL HEALTH

A guide to your dental benefits: Small Group Pediatric Dental HMO

The Pediatric Dental HMO plan emphasizes healthy smiles through the prevention and early detection of dental problems to avoid costly procedures in the future. The combination of predictable costs, no deductibles, and no annual maximums helps your child reach a state of good oral health without you facing the high treatment cost that's typical of many dental plans.

Your plan provides coverage 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.

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

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

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

New member? Get started by choosing a dentist.

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

Save on restorative care

More extensive care (fillings, crowns, dentures, root canals, periodontal treatment, oral surgery, etc.) is provided at copayments lower than the usual and customary charges for these services. When covered, specialty care is covered at the listed copayment whether performed by a participating general dentist or participating specialist. 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**.

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

KAISER PERMANENTE®

Choose a dentist

You may select any general dentist from among our participating dental providers for your child. 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 for your child. Make sure you bring your child's Kaiser Permanente medical ID card to the appointment. And you'll have virtually no paperwork or pre-existing condition exclusions to worry about.

Quality dental care

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

Dedicated customer service

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

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

Mailing address:
Dominion National
P.O. Box 21522
Eagan, MN 55121

Web: **dominionnational.com/kaiserdentists**

Online self-service options

Dominion provides members with secure online access to:

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

All changes are confirmed by email.

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

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

[Throughout this Appendix, the year, telephone numbers, days and hours of operation, company names, signature, name and title are bracketed to allow for updates without refiling.]

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
Pediatric Dental Plan
[2023] Schedule of Dental Fees

Description of Services & Fees for Pediatric Services (up to age 19)

Annual Out-of-Pocket Maximum

You pay the Copayment set forth below for covered dental services until you reach the Out-of-Pocket Maximum shown in the ***Summary of Cost Shares*** in this EOC. You will not be charged more than the amount of your Out-of-Pocket Maximum for any dental services. Please refer to your medical plan for specific details.

Procedures not shown in this list are not covered. Refer to the ***Pediatric Dental Plan Appendix*** for a complete description of the terms and conditions of your covered dental benefit. Please refer to the ***Pediatric Dental Plan Appendix*** for further details on the program along with exclusions and limitations.

Fees quoted in the "You Pay to Dentist" column apply only when performed by a participating General Dentist or Dental Specialist. If specialty care is required, your General Dentist must refer you to a participating specialist except as otherwise described in the ***Pediatric Dental Plan Appendix***.

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

ADA Code	Description of Services	You Pay to Dentist
Office Visit		
D9439	Office visit	$10
Diagnostic/Preventive		
D0120	Periodic oral eval - established patient	$0
D0140	Limited oral eval - problem focused	$0
D0145	Oral eval for a patient under 3 years of age	$0
D0150	Comprehensive oral eval - new or established patient	$0
D0160	Detailed and extensive oral eval - problem focused	$0
D0170	Re-evaluation - limited, problem focused	$0
D0210	Intraoral - complete series of radiographic images	$26
D0220/30	Intraoral - periapical first radiographic image	$0
D0240	Intraoral - occlusal radiographic image	$0
D0250	Extraoral – 2D projection radiographic image	$0
D0270-74	Bitewing x-rays - 1 to 4 radiographic images	$0
D0277	Vertical bitewings - 7 to 8 radiographic images	$0
D0310	Sialography	$370
D0320	Temporomandibular joint arthrogram, incl. injection	$562
D0321	Other temporomandibular joint films, by report	$120
D0330	Panoramic radiographic image	$30

ADA Code	Description of Services	You Pay to Dentist
D0340	2D cephalometric radiographic image	$0
D0350	2D oral/facial photographic image	$0
D0351	3D photographic image	$0
D0460	Pulp vitality tests	$0
D0470	Diagnostic casts	$0
D0486	Accession of brush biopsy sample	$0
D0600	Non-ionizing diagnostic procedure capable of quantifying, monitoring and recording changes in structure of enamel, dentin, and cementum	$0
D0601	Caries risk assessment & documentation, with a finding of low risk	$0
D0602	Caries risk assessment & documentation, with a finding of moderate risk	$0
D0603	Caries risk assessment & documentation, with a finding of high risk	$0
D0701	Panoramic radiographic image – image capture only	$0
D0702	2-D cephalometric radiographic image – image capture only	$0
D0703	2-D oral/facial photographic image obtained intra-orally or extra-orally – image capture only	$0
D0704	3-D photographic image – image capture only	$0
D0705	Extra-oral posterior dental radiographic image – image capture only	$0
D0706	Intraoral – occlusal radiographic image – image capture only	$0
D0707	Intraoral – periapical radiographic image – image capture only	$0
D0708	Intraoral – bitewing radiographic image – image capture only	$0
D0709	Intraoral – complete series of radiographic images – image capture only	$0
D1110	Prophylaxis (cleaning) - adult	$0
D1120	Prophylaxis (cleaning) - child	$0
D1206	Topical application of fluoride varnish	$0
D1208	Topical application of fluoride – excluding varnish	$0
D1310	Nutritional counseling for control of dental disease	$0
D1320/30	Oral hygiene instructions	$0
D1321	Counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use	$0
D1351	Sealant – per tooth	$21
D1352	Prev resin rest. mod/high caries risk – perm. tooth	$21
D1354	Application of caries arresting medicament - per tooth	$0
D1355	Caries preventive medicament application – per tooth	$21
Space Maintainers		
D1510/20	Space maintainer - fixed/removable – unilateral – per quadrant	$143
D1516	Space maintainer - fixed - bilateral, maxillary	$198
D1517	Space maintainer - fixed - bilateral, mandibular	$198
D1526	Space maintainer - removable - bilateral, maxillary	$198

ADA Code	Description of Services	You Pay to Dentist
D1527	Space maintainer - removable - bilateral, mandibular	$198
D1551	Re-cement or re-bond bilateral space maintainer – maxillary	$34
D1552	Re-cement or re-bond bilateral space maintainer – mandibular	$34
D1553	Re-cement or re-bond unilateral space maintainer – per quadrant	$34
D1556	Removal of fixed unilateral space maintainer – per quadrant	$44
D1557	Removal of fixed bilateral space maintainer – maxillary	$44
D1558	Removal of fixed bilateral space maintainer – mandibular	$44
D1575	Distal shoe space maintainer - fixed – unilateral – per quadrant	$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
D2390	Resin-based composite crown, anterior	$192
D2391	Resin-based composite - one surface, posterior	$73
D2392	Resin-based composite - two surfaces, posterior	$87
D2393	Resin-based composite - three surfaces, posterior	$102
D2394	Resin-based composite - >=4 surfaces, posterior	$123
Crowns 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

ADA Code	Description of Services	You Pay to Dentist
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
D2712	Crown - 3/4 resin-based composite (indirect)	$485
D2720/21/22	Crown - resin with metal	$495
D2740	Crown - porcelain/ceramic	$560
D2750/51/52	Crown - porcelain fused metal	$523
D2753	Crown - porcelain fused to titanium and titanium alloys	$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
D2928	Prefab. porcelain/ceramic crown – permanent tooth	$560
D2929	Prefab. porcelain/ceramic 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 primary tooth	$296
D2940	Protective restoration	$39
D2941	Interim therapeutic restoration, primary dentition	$31
D2950	Core buildup, including any pins	$125
D2951	Pin retention - per tooth, in addition to restoration	$22
D2952	Post and core in addition to crown	$186
D2954	Prefab. post and core in addition to crown	$154
D2955	Post removal (not in conj. with endo. therapy)	$105
D2960	Labial veneer (resin laminate) – direct	$434
D2961	Labial veneer (resin laminate) – indirect	$601
D2962	Labial veneer (porcelain laminate) – indirect	$449
D2980	Crown repair necessitated by restorative material failure	$102
D2981	Inlay repair necessitated by restorative material failure	$102
D2982	Onlay repair necessitated by restorative material failure	$102
D2983	Veneer repair necessitated by restorative material failure	$102
Endodontics		
D3110/20	Pulp cap - direct/indirect (excl. final restoration)	$32
D3220	Therapeutic pulpotomy (excl. final restor.)	$81
D3221	Pulpal debridement, prim. and perm. teeth	$94

ADA Code	Description of Services	You Pay to Dentist
D3230	Pulpal therapy - resorbable filling, anterior, primary tooth	$160
D3240	Pulpal therapy - resorbable filling, posterior, primary tooth	$164
D3310	Endodontic therapy, anterior tooth (excl. final restor.)	$341
D3320	Endodontic therapy, premolar tooth (excl. final restor.)	$418
D3330	Endodontic therapy, molar (excl. final restor.)	$512
D3332	Incomp endo. Therapy-inop. or fractured tooth	$183
D3333	Internal root repair of perforation defects	$105
D3346	Retreat of prev. root canal therapy, anterior	$387
D3347	Retreat of prev. root canal therapy, premolar	$465
D3348	Retreat of prev. root canal therapy, molar	$558
D3351	Apexification/recalcification - initial visit	$202
D3352	Apexification/recalcification - interim med. repl.	$589
D3353	Apexification/recalcification - final visit	$449
D3355	Pulpal regeneration - initial visit	$202
D3356	Pulpal regeneration - interim medication replacement	$589
D3357	Pulpal regeneration - completion of treatment	$449
D3410	Apicoectomy - anterior	$323
D3421	Apicoectomy - premolar (first root)	$364
D3425	Apicoectomy - molar (first root)	$418
D3426	Apicoectomy - (each add. root)	$152
D3430	Retrograde filling - per root	$119
D3450	Root amputation - per root	$234
D3470	Intentional reimplantation	$718
D3471	Surgical repair of root resorption - anterior	$323
D3472	Surgical repair of root resorption – premolar	$364
D3473	Surgical repair of root resorption – molar	$418
D3501	Surgical exposure of root surface without apicoectomy or repair of root resorption – anterior	$323
D3502	Surgical exposure of root surface without apicoectomy or repair of root resorption – premolar	$364
D3503	Surgical exposure of root surface without apicoectomy or repair of root resorption – molar	$418
D3920	Hemisection, not inc. root canal therapy	$234
D3921	Decoronation or submergence of an erupted tooth	$100
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

ADA Code	Description of Services	You Pay to Dentist
D4211	Gingivectomy or gingivoplasty - <=3 teeth, per quad.	$100
D4230	Anatomical crown exposure, >=4 teeth per quad.	$454
D4231	Anatomical crown exposure, 1-3 teeth per quad.	$424
D4240	Gingival flap proc., inc. root planing - >3 cont. teeth, per quad	$345
D4241	Gingival flap proc, inc. root planing - <=3 cont. teeth, per quad	$106
D4249	Clinical crown lengthening - hard tissue	$576
D4260	Osseous surgery - >3 cont. teeth, per quad	$499
D4261	Osseous surgery - <=3 cont. teeth, per quad	$392
D4268	Surgical revision proc., per tooth	$358
D4274	Mesial/distal wedge procedure, single tooth	$308
D4322	Splint – intra-coronal; natural teeth or prosthetic crowns	$427
D4323	Splint – extra-coronal; natural teeth or prosthetic crowns	$377
D4341	Perio scaling and root planing - >3 cont teeth, per quad.	$109
D4342	Perio scaling and root planing - <= 3 teeth, per quad	$63
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation	$45
D4355	Full mouth debridement	$89
D4381	Localized delivery of antimicrobial agents	$98
D4910	Periodontal maintenance	$74
D4920	Unscheduled dressing change by non-treating dentist	$84
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	Maxillary/mandibular partial denture – resin base	$649
D5223/24	Maxillary/mandibular partial denture – cast metal	$750
D5225/26	Maxillary/mandibular partial denture - flexible base	$750
D5227/28	Immediate maxillary/mandibular partial denture - flexible base (including any clasps, rests and teeth)	$750
D5282	Rem. unilateral partial denture - one piece cast metal, maxillary	$419
D5283	Rem. unilateral partial denture - one piece cast metal, mandibular	$419
D5284	Rem. unilateral partial denture - one piece flexible base (including clasps and teeth) - per quadrant	$419
D5286	Rem. unilateral partial denture - one piece resin (including clasps and teeth) - per quadrant	$419
D5410/11	Adjust complete denture - maxillary/mandibular	$38
D5421/22	Adjust partial denture - maxillary/mandibular	$38

ADA Code	Description of Services	You Pay to Dentist
D5511	Repair broken complete denture base, mandibular	$87
D5512	Repair broken complete denture base, maxillary	$87
D5520	Replace missing or broken teeth - complete denture	$87
D5611	Repair resin partial denture base, mandibular	$87
D5612	Repair resin partial denture base, maxillary	$87
D5621	Repair cast partial framework, mandibular	$87
D5622	Repair cast partial framework, maxillary	$87
D5630	Repair or replace broken retentive/clasping material – per tooth	$115
D5640	Replace broken teeth - per tooth	$87
D5650	Add tooth to existing partial denture	$87
D5660	Add clasp to existing partial denture – per tooth	$115
D5670/71	Replace all teeth and acrylic on cast metal framework	$287
D5710/11	Rebase complete maxillary/mandibular denture	$260
D5720/21	Rebase maxillary/mandibular partial denture	$260
D5725	Rebase hybrid prosthesis	$260
D5730/31	Reline complete maxillary/mandibular denture (direct)	$159
D5740/41	Reline maxillary/mandibular partial denture (direct)	$155
D5750/51	Reline complete maxillary/mandibular denture (indirect)	$224
D5760/61	Reline maxillary/mandibular partial denture (indirect)	$224
D5765	Soft liner for complete or partial removable denture – indirect	$50
D5810/11	Interim complete denture - maxillary/mandibular	$362
D5820/21	Interim partial denture (including retentive/clasping materials, rests, and teeth), maxillary/mandibular	$362
D5850/51	Tissue conditioning - maxillary/mandibular	$79
D5863	Overdenture - complete maxillary	$1694
D5864	Overdenture - partial maxillary	$1668
D5865	Overdenture - complete mandibular	$1694
D5866	Overdenture - partial mandibular	$1668
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 porc/metal crown- metal	$523
D6066	Implant supported crown – porcelain fused to high noble alloys	$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
D6082	Implant supported crown - porcelain fused to predominantly base alloys	$523

ADA Code	Description of Services	You Pay to Dentist
D6083	Implant supported crown - porcelain fused to noble alloys	$523
D6084	Implant supported crown – porcelain fused to titanium and titanium alloys	$523
D6210/11/12	Pontic - metal	$495
D6240/41/42	Pontic - porcelain fused metal	$523
D6245	Pontic - porcelain/ceramic	$560
D6250/51/52	Pontic - resin with metal	$495
D6545	Retainer - cast metal for resin bonded fixed prosthesis	$251
D6548	Ret. - porc./ceramic for resin bonded fixed prosthesis	$393
D6549	Resin retainer for resin bonded fixed prosthesis	$251
D6600	Retainer inlay - porc./ceramic, two surfaces	$427
D6601	Retainer inlay - porc./ceramic, >=3 surfaces	$445
D6602	Retainer inlay - cast high noble metal, two surfaces	$407
D6603	Retainer inlay - cast high noble metal, >=3 surfaces	$425
D6604	Retainer inlay - cast predominantly base metal, two surfaces	$407
D6605	Retainer inlay - cast predominantly base metal, >=3 surfaces	$425
D6606	Retainer inlay - cast noble metal, two surfaces	$407
D6607	Retainer inlay - cast noble metal, >=3 surfaces	$425
D6608	Retainer onlay -porc./ceramic, two surfaces	$479
D6609	Retainer onlay - porc./ceramic, three or more surfaces	$499
D6610	Retainer onlay - cast high noble metal, two surfaces	$458
D6611	Retainer onlay - cast high noble metal, >=3 surfaces	$524
D6612	Retainer onlay - cast predominantly base metal, two surfaces	$458
D6613	Retainer onlay - cast predominantly base metal, >=3 surfaces	$524
D6614	Retainer onlay - cast noble metal, two surfaces	$458
D6615	Retainer onlay - cast noble metal, >=3 surfaces	$524
D6720/21/22	Retainer crown - resin with metal	$495
D6740	Retainer crown - porcelain/ceramic	$560
D6750/51/52	Retainer crown - porcelain fused metal	$523
D6780	Retainer crown - 3/4 cast high noble metal	$470
D6781	Retainer crown - 3/4 cast predominantly base metal	$470
D6782	Retainer crown - 3/4 cast noble metal	$470
D6783	Retainer crown - 3/4 porc./ceramic	$511
D6790/91/92	Retainer crown - full cast metal	$495
D6930	Recement or rebond fixed partial denture	$69
D6980	Fixed partial denture repair, by report	$172
Oral Surgery		
D7111	Extraction, coronal remnants - primary tooth	$56

ADA Code	Description of Services	You Pay to Dentist
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	Incisional biopsy of oral tissue - hard (bone, tooth)	$387
D7286	Incisional biopsy of oral tissue - soft (all others)	$295
D7290	Surgical repositioning of teeth	$407
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	$60
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. inc. grafts, etc	$1776
D7410	Excision of benign lesion up to 1.25 cm	$278
D7440	Exc. of malignant tumor- lesion diam. <=1.25cm	$608
D7450	Removal of benign odon cyst/tumor - diam <=1.25cm	$354
D7451	Removal of benign odon cyst/tumor - diam >1.25cm	$543
D7460	Removal of benign nonodon cyst/tumor-diam <=1.25cm	$516
D7461	Removal of benign nonodon cyst/tumor-diam >1.25cm	$718
D7471	Removal of lateral exostosis	$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
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	$25
D7961	Buccal/labial frenectomy (frenulectomy)	$263
D7962	Lingual frenectomy (frenulectomy)	$263
D7970	Excision of hyperplastic tissue - per arch	$233
D7971	Excision of pericoronal gingiva	$131

ADA Code	Description of Services	You Pay to Dentist
D7979	Non-surgical sialolithotomy	$43
Orthodontics (Pre-Authorization Required)		
D8070	Comp. ortho. treatment - transitional dentition	$3304
D8080	Comp. ortho. treatment - adolescent dentition	$3422
D8090	Comp. ortho. treatment - adult dentition	$3658
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
D8696	Repair of orthodontic appliances – maxillary	$100
D8697	Repair of orthodontic appliances – mandibular	$100
D8698	Re-cement or re-bond fixed retainer – maxillary	$174
D8699	Re-cement or re-bond fixed retainer – mandibular	$174
D8701	Repair of fixed retainer, includes reattachment – maxillary	$174
D8702	Repair of fixed retainer, includes reattachment – mandibular	$174
D8703	Replacement of lost or broken retainer – maxillary	$179
D8704	Replacement of lost or broken retainer – mandibular	$179
Adjunctive General Services		
D9110	Palliative (emergency) treatment of dental pain	$43
D9210/15	Local anesthesia	$0
D9211/12	Regional block anesthesia	$0
D9219	Evaluation for deep sedation or general anesthesia	$0
D9222	Deep sedation/general anesthesia - first 15 minutes	$103
D9223	Deep sedation/general anesthesia each subsequent 15-minute increment	$103
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	$37
D9239	Intravenous moderate sedation/analgesia – first 15 minutes	$103
D9243	IV moderate conscious sedation/analgesia – each subsequent 15-minute increment	$103
D9248	Non-intravenous conscious sedation	$145
D9310	Consultation (diagnostic service by nontreating dentist)	$43
D9410	House/extended care facility call	$200
D9420	Hospital call	$350
D9613	Infiltration of sustained release therapeutic drug, per quadrant	$190
D9910	Application of desensitizing medicament	$31
D9930	Treatment of complications (post-surgical)	$43
D9941	Fabrication of athletic mouthguard	$102
D9944	Occlusal guard – hard appliance, full arch	$272
D9945	Occlusal guard – soft appliance, full arch	$272
D9946	Occlusal guard – hard appliance, partial arch	$272

ADA Code	Description of Services	You Pay to Dentist
D9950	Occlusion analysis - mounted case	$104
D9951	Occlusal adjustment - limited	$66
D9952	Occlusal adjustment - complete	$266
D9986	Missed appointment	$50
D9995	Teledentistry – synchronous; real-time encounter	$0
D9996	Teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review	$0
D9997	Dental case management - patients with special health care needs	$50

*All fees exclude the cost of noble and precious metals. An additional fee of up to [$100] may 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

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

By: ________[Signature]__________

[Name]
[Title]

Pediatric Dental Plan Appendix

This Pediatric Dental Plan Appendix for Members under age 19 is effective as of the date of your Kaiser Permanente Membership Agreement (Agreement) and shall terminate as of the date your Agreement terminates, or the date is the end of the month in which the Member attains age 19, whichever is earlier.

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

Definitions

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

Covered Dental Services: A range of diagnostic, preventive, restorative, endodontic, periodontic, removable prosthodontics, maxillofacial prosthetics, fixed prosthodontics, orthodontics for children with severe dysfunctional, handicapping malocclusion and adjunctive general services. Reference the Services that are covered under this Pediatric Dental Plan Appendix as listed in the ***Pediatric Dental Plan Schedule of Dental Fees*** attached to this Agreement.

Covered Preventive Care Dental Services: These include, but are not limited to: oral evaluation, cleaning and certain diagnostic X-rays.

Dental Administrator: The entity that has entered into a contract with the Health Plan to provide or arrange for the provision of Covered Dental Services. The name and information about the Dental Administrator can be found under "General Provisions" below.

Dental Fee: The discounted fee that a Participating Dental Provider charges you for a Covered Dental Service. Dental Fees are reviewed annually and subject to change upon renewal and only with sixty (60) days advance notice.

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

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

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

General Provisions

Subject to the terms, conditions, limitations, and exclusions specified in this Appendix, you may receive Covered Preventive Care Dental and Covered Dental Services from Participating Dental Providers. You may receive Covered Dental Services from a non-Participating Dental Provider for emergencies, urgent care received outside the Health Plan's Service Area, and Services obtained pursuant to a referral to a non-participating specialist.

The Health Plan has entered into an agreement with the Dental Administrator to provide Covered Preventive Care Dental Services and certain other Covered Dental Services through its Participating Dental Providers.

Attached is a list of Covered Preventive Care Dental Services and other Covered Dental Services and the associated Dental Fees that you will be charged for each Service. You will pay a $10 fixed copayment for each office visit.

You will pay Dental Fees for certain other Covered Dental Services you receive from Participating Dental Providers. You will pay the applicable Dental Fee directly to the Participating Dental Provider at the time Services are rendered. The Participating Dental Provider has agreed to accept that Dental Fee as payment in full of the Member's responsibility for that procedure. Neither the Health Plan nor Dental Administrator are responsible for payment of these fees or for any fees incurred as the result of receipt of non-Covered Dental Services or any other non-covered dental service.

Covered Dental Services are not subject to a Deductible. Copayments and Dental Fees set forth in the attached ***Pediatric Dental Plan Schedule of Dental Fees*** apply toward the Out-of-Pocket Maximum in the ***Summary of Services and Cost Shares Appendix*** of this Agreement.

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

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

Within the Washington DC Metropolitan Area: [301-468-6000)]
Outside the Washington DC metropolitan area: [800-777-7902]
TTY number is: [TTY 711]

[Dental Administrator

The Health Plan has entered into an agreement with [Dominion Dental Services USA, Inc., d/b/a Dominion National ("Dominion National")], to provide Covered Dental Services as described in this Appendix. You may obtain a list of Participating Dental Providers, Covered Dental Services and Dental Fees by contacting [Dominion National Service Team Associates], [Monday through Friday from 7:30 a.m. to 6 p.m. (Eastern Time)], at the following telephone numbers:

Toll-Free Number: [855-733-7524]
TTY Line: [TTY 711]

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

[DominionNational.com/kaiserdentists]

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

Missed Appointment Fee

Participating Dental Providers may charge you an administrative fee if you miss a scheduled dental appointment without giving twenty-four (24) hours advance notice. The fee may vary depending on the Participating Dental Provider, however in no event shall the missed appointment fee exceed $50 for a single visit. If the Participating Dental Provider charges less than $50 for a missed appointment, the member will only be responsible for the amount charged.

Specialist Referrals

Participating Specialist Referrals

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

Non-Participating Specialist Referrals

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

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

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

If during the term of this contract none of the Participating Dental Providers can render necessary care and treatment to the Member due to circumstances not reasonably within the control of the Plan, such as complete or partial destruction of facilities, war, riot, civil insurrection, labor disputes, or the disability of a significant number of the Participating Dental Providers, then the Member may see treatment from an independent licensed dentist of his/her own choosing. The Plan will pay the Member for the expenses incurred for the dental services with the following limitations: The Plan will pay the Member for services which are listed in the Schedule of Dental Fees as "No Charge", to the extent that such fees are reasonable and customary for dentists in the same geographic area; the Plan will also pay the Member for those services for which there is a Copayment, to the extent that the reasonable and customary fees for such services exceed the Copayment for such services as set forth in the Schedule of Dental Fees. The Plan agrees to be subject to the jurisdiction of the Maryland Insurance Commissioner in any determination of the impossibility of providing services by Participating Dental Providers. Please note that the Plan may require the Member to submit a written proof of loss.

Standing Referrals to Dental Specialists

If you suffer from a life-threatening, degenerative, chronic or disabling disease or condition that requires specialized care, your General Dentist may determine, in consultation with you and the Dental Specialist, that you would be best served through the continued care of a Dental Specialist. In such instances, the General Dentist will issue a standing referral to the Dental Specialist.

The standing referral will be made in accordance with a written treatment plan developed by the General Dentist, Dental Specialist, and you. The treatment plan may limit the number of visits to the Dental Specialist or the period of time in which visits to the Dental Specialist are authorized. The Health Plan retains the right to require the Dental Specialist to provide the General Dentist with ongoing communication regarding your treatment and dental health status.

Extension of Benefits

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

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

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

Extension of Benefits Limitations

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

1. When coverage ends because of your failure to pay Premiums;
2. When coverage ends as the result of you committing fraud or material misrepresentation;
3. When coverage is provided by a succeeding health plan and that health plan's coverage:
   a. Is provided at a cost to you that is less than or equal to the cost to you of the extended benefit available under this Appendix; and
   b. Will not result in an interruption of the Covered Dental Services you are receiving.

Dental Emergencies Outside the Service Area

When a dental emergency occurs outside the Service Area, the Dental Administrator will reimburse the non-participating provider directly. If the Member has already paid the charges, the Dental Administrator will reimburse the Member (upon proof of payment) instead of paying the provider directly for Covered Dental Services that may have been provided. Reimbursement to the member or provider is not to exceed $100 per incident. Services are limited to those procedures not excluded under Plan limitations and exclusions.

Proof of payment must be submitted to the Dental Administrator by the provider within one hundred eighty (180) days of treatment. The Dental Administrator will allow Members to submit claims up to one (1) year after the date of service. However, a Member's legal incapacity shall suspend the time to submit a claim, and the suspension period ends when legal capacity is regained. Failure to submit a claim within one (1) year after the date of Services does not invalidate or reduce the amount of the claim if it was not reasonably possible to submit the claim within one (1) year after the date of Services, and the claim is submitted within two (2) years after the date of service. Benefits payable under this contract for any loss will be paid immediately or within the time required by state regulations after receipt of proof of loss that contains the required supporting documentation. If the Dental Administrator fails to pay claim within the time required

by state regulations, it will pay interest from the date on which payment is required to the date the claim is paid.

Proof of payment should be mailed to:

[Dominion National
P.O. Box 211424
Eagan, MN 55121]

Coverage is provided for emergency dental treatment as may be required to alleviate pain, bleeding, or swelling. You must receive all post-emergency care from your Participating Dental Provider.

Pre-Authorization of Benefits

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

Exclusions and Limitations

Exclusions

The following Services are not covered under this Appendix:

1. Services which are covered under worker's compensation or employer's liability laws.
2. Services which are not necessary for the patient's dental health as determined by the Plan.
3. Surgery or related services for cosmetic purposes to improve appearance, but not to restore bodily function or correct deformity resulting from disease, trauma, or congenital or developmental anomalies.
4. Oral surgery requiring the setting of fractures or dislocations.
5. Dispensing of drugs.
6. Unless otherwise specified in covered services, dental work or treatment which includes hospital or professional care in connection with:
   a. The operation or treatment for the fitting or wearing of dentures;
   b. Orthodontic care or malocclusion;
   c. Operations on, or for treatment of, or to the teeth or supporting tissues of the teeth, except for the removal of tumors and cysts or treatment of injury to natural teeth due to an accident, if the treatment is received within six (6) months of the accident; and
   d. Dental implants.
7. Procedures not listed as covered benefits under this Plan.
8. Services obtained outside of the dental office in which enrolled and that are not preauthorized or otherwise approved by such office or the Plan (with the exception of urgent care services which are covered outside the plan's service area and out-of-area emergencies).
9. Services performed by a Participating Specialist without a referral from a Participating General Dentist (with the exception of orthodontics). A referral form is required. Participating dentists should refer to Specialty Care Referral Guidelines.

10. Any bill, or demand for payment, for a dental service that the appropriate regulatory board determines was provided as a result of a prohibited referral. "Prohibited referral" means a referral prohibited by Section 1-302 of the Maryland Health Occupations Article.
11. Non-medically necessary orthodontia is not a covered benefit under this policy. The provider agreements create no liability for payment by the Plan, and payments by the Member for these services do not contribute to the Out-of-Pocket Maximum. The Invisalign system and similar specialized braces are not a covered benefit. See limitation No. 26 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) application of caries arresting medicament per primary tooth is covered per lifetime.
8. One (1) space maintainer per twenty-four (24) months, per quadrant (D1510, D1520 or D1575) or per arch (D1516, D1517, D1526 or D1527), per patient to preserve space between teeth for premature loss of a primary tooth (does not include use for orthodontic treatment).
9. Replacement of a filling is covered if it is more than three (3) years from the date of original placement.
10. Replacement of a crown or denture is covered if it is more than five (5) years from the date of original placement.
11. Replacement of a prefabricated resin and stainless-steel crown (D2930, D2932, D2933, D2934) is covered if it is more than three (3) years from the date of original placement, per tooth, per patient.
12. Crown and bridge fees apply to treatment involving five (5) or fewer units when presented in a single treatment plan.
13. Relining and rebasing of dentures is covered once per twenty-four (24) months, per patient, only after six (6) months of initial placement.
14. Soft liner for complete or partial removable denture – indirect, limited to one (1) per 12 months.
15. Root canal treatment and retreatment of previous root canal are covered once per tooth per lifetime.
16. 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 twenty-four (24) months, per patient, per quadrant.

17. 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 (2) years.
18. Full mouth debridement is covered once per twenty-four (24) months, per patient.
19. 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.
20. Procedure Code D4381 is limited to one (1) benefit per tooth for three (3) teeth per quadrant; or a total of twelve (12) teeth for all four (4) quadrants per twelve (12) months. Must have pocket depths of five (5) millimeters or greater.
21. Periodontal surgery of any type, including any associated material, is covered once every twenty-four (24) months, per quadrant or surgical site.
22. Periodontal maintenance after active therapy is covered two (2) times per calendar year.
23. Coronectomy, intentional partial tooth removal, one (1) per tooth per lifetime.
24. 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.
25. Anesthesia requires a narrative of medical necessity be maintained in patient records. Non-intravenous conscious sedation is not covered in conjunction with analgesia.
26. 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.
27. Teledentistry, synchronous (D9995) or asynchronous (D9996), must be accompanied by a covered procedure.

Only current ADA CDT codes are considered valid by the Dental Administrator.

Current Dental Terminology © American Dental Association.

This Appendix is subject to all the terms and conditions of the Evidence of Coverage to which this Appendix is attached. This Appendix does not change any of those terms and conditions, unless specifically stated in this Appendix.

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

By: ________[Signature]___________

[Name]
[Title]