SMILE FOR TOTAL HEALTH

A guide to your dental benefits: Small Group Maryland and Virginia Adult Second Level Point-of-Service (POS)

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

With the Second Level Point-of-Service (POS) plan, you have the freedom and flexibility to see any dentist inside or outside of the plan network. You may choose to see an in-plan dentist from among one of the largest dental provider networks[1] in the Mid-Atlantic area.[2] Or, if you prefer, you can visit any other licensed dentist not in the plan to receive your care. You have your choice of convenient private dental offices where you can receive care.

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

In-plan

You pay low copayments for preventive care procedures such as:

- Oral evaluation
- Routine cleaning
- Certain X-ray procedures

Out-of-plan

You pay the dentist the charged amount and submit a claim form to Kaiser Permanente for reimbursement. You will be reimbursed up to the maximum stated in the out-of-plan copayment schedule. The dentist's charges may be more than the amount Dominion National reimburses you under the copayment schedule. For more information, please refer to your *Evidence of Coverage* or you can find your plan on **dominionnational.com/kaiserdentists**.

New member? Get started by choosing a dentist.

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

Choose a dentist

In-plan dental providers

You may select any general dentist from among our network of participating dentists. When you choose a plan dentist, your out-of-pocket expenses are lower and there are no claims to submit.

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

For a list of participating in-plan dentists, including office hours, directions, languages spoken, etc., visit **dominionnational.com/kaiserdentists** or call Dominion Member Services at **855-733-7524** (TTY **711**), Monday through Friday, 7:30 a.m. to 6 p.m.

Out-of-plan dental providers

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

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

Deductibles and annual maximums

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

The maximum annual benefit applies to in-plan and out-of-plan benefits combined per member, per plan year. The annual maximums are $1,000 in-plan and $500 out-of-plan.

Make appointments

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

How can I submit a claim?

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

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

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

Dedicated member service

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

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

Fax: **855-485-0115**

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

Web: **dominionnational.com/kaiserdentists**

Online self-service options

Dominion provides members with secure online access to:

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

All changes are confirmed by email.

Dental benefits are underwritten by Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., and administered by Dominion National.

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

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
2020 Description of Benefits and Member Copayments
Second Level Point-of-Service (POS) Plan
Adult Services (age 19 and over)

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

Deductible
The deductible is the amount of charges that you must pay during a contract year for covered dental services before those services are covered under the dental plan. The deductible applies to in-plan and out-of-plan benefits combined per member, per contract year. Refer to the Point-of-Service Dental Rider for an example of how the combined deductible works. You must pay the full amount charged by the dentist for the services when you receive them, until you meet your deductible. After you meet the deductible, you pay the applicable fee shown below for services provided in-plan, and you will be reimbursed the amount shown below for services provided out-of-plan, up to the annual maximum benefit. You are responsible for the remaining balance for out-of-plan services, and for any amounts that exceed the annual maximum benefit.

<u>Deductible</u>
In-plan: $25 per member
Out-of-plan: $50 per member

Annual maximum benefit
The maximum benefit applies to in-plan and out-of-plan benefits combined per member, per contract year. Refer to the Point-of-Service Dental Rider for an explanation of how the combined annual maximum benefit works. Maximum benefit will not exceed $1,000 per contract year.

<u>Annual maximum</u>
In-plan: $1,000 per contract year
Out-of-plan: $500 per contract year

The Description of Benefits and Member Copayments is reviewed annually and is subject to change effective January 1 of each year.

The dental plan is administered by Dominion National.

PLEASE NOTE: The heading “IN-PLAN” means the cost that you pay in-plan to dentist. The heading “OUT-OF-PLAN” means the cost that you are reimbursed out-of-plan.

ADA CODE	BENEFIT	IN-PLAN	OUT-OF-PLAN
DIAGNOSTIC/PREVENTIVE			
D0120	Periodic oral eval - established patient	$0	$20
D0140	Limited oral eval - problem focused	$0	$35
D0150	Comprehensive oral eval - new or established patient	$0	$31
D0180	Comp. periodontal eval - new or established patient	$0	$31
D0210	Intraoral - complete series of radiographic images	$0	$62
D0220	Intraoral - periapical first radiographic image	$0	$12
D0230	Intraoral - periapical each add. radiographic image	$0	$9
D0240	Intraoral - occlusal radiographic image	$0	$17
D0270	Bitewing x-rays - single radiographic image	$0	$10
D0272	Bitewing x-rays - two radiographic images	$0	$18
D0274	Bitewing x-rays - four radiographic images	$0	$23
D0277	Vertical bitewings - 7 to 8 radiographic images	$0	$23
D0330	Panoramic radiographic images	$0	$56
D0460	Pulp vitality tests	$0	$23
D0470	Diagnostic casts	$0	$46
D0999	Unspecified diagnostic procedure, by report	$5	NB
D1110	Prophylaxis (cleaning) - adult	$0	$42
D1206	Topical application of fluoride varnish	$0	$18
D1208	Topical application of fluoride – excluding varnish	$0	$18
D1330	Oral hygiene instructions	$0	$0
D1351	Sealant - per tooth	$0	$22
D1352	Prev resin rest. mod/high caries risk – perm. tooth	$0	$22
D1354	Interim caries arresting medicament application - per tooth	$0	$15
RESTORATIVE DENTISTRY (FILLINGS)			
D2140	Amalgam - one surface	$16	$40
D2150	Amalgam - two surfaces	$20	$50
D2160	Amalgam - three surfaces	$23	$62
D2161	Amalgam - >=4 surfaces	$33	$76
D2330	Resin-based composite - one surface, anterior	$19	$48
D2331	Resin-based composite - two surfaces, anterior	$23	$62
D2332	Resin-based composite - three surfaces, anterior	$33	$76
D2335	Resin-based composite - >=4 surfaces, anterior	$33	$86
D2391	Resin-based composite - one surface, posterior	$20	$55
D2392	Resin-based composite - two surfaces, posterior	$28	$66
D2393	Resin-based composite - three surfaces, posterior	$34	$82
D2394	Resin-based composite - >=4 surfaces, posterior	$38	$95
CROWNS & BRIDGES♦			
D2510	Inlay- metallic - one surface	$258	$167
D2520	Inlay- metallic - two surfaces	$291	$188
D2530	Inlay - metallic - three or more surfaces	$348	$220
D2542	Onlay - metallic-two surfaces	$234	$150
D2543	Onlay - metallic - three surfaces	$234	$150
D2544	Onlay - metallic - four or more surfaces	$234	$150

ADA CODE	BENEFIT	IN-PLAN	OUT-OF-PLAN
D2610	Inlay - porcelain/ceramic - one surface	$215	$210
D2620	Inlay - porcelain/ceramic - two surfaces	$321	$220
D2630	Inlay - porcelain/ceramic - >=3 surfaces	$365	$236
D2642	Onlay - porcelain/ceramic - two surfaces	$189	$124
D2643	Onlay - porcelain/ceramic - three surfaces	$189	$124
D2644	Onlay - porcelain/ceramic - >=4 surfaces	$189	$124
D2650	Inlay - resin-based composite - one surface	$215	$210
D2651	Inlay - resin-based composite - two surfaces	$321	$220
D2652	Inlay - resin-based composite - >=3 surfaces	$365	$236
D2710	Crown - resin based composite (indirect)	$159	$102
D2712	Crown - 3/4 resin-based composite (indirect)	$159	$102
D2740	Crown - porcelain/ceramic	$437	$279
D2750	Crown - porcelain fused to high noble metal	$428	$274
D2751	Crown - porcelain fused to predominantly base metal	$378	$241
D2752	Crown - porcelain fused to noble metal	$404	$258
D2780	Crown - 3/4 cast high noble metal	$418	$263
D2781	Crown - 3/4 cast predominantly base metal	$418	$263
D2782	Crown - 3/4 cast noble metal	$418	$263
D2790	Crown - full cast high noble metal	$418	$269
D2791	Crown - full cast predominately base metal	$373	$241
D2792	Crown - full cast noble metal	$397	$252
D2794	Crown - titanium	$418	$269
D2910	Recement inlay	$30	$20
D2915	Recement cast or prefab. post and core	$30	$20
D2920	Recement crown	$30	$20
D2932	Prefabricated resin crown	$96	$60
D2934	Prefab. esthetic coated primary tooth	$96	$60
D2940	Protective restoration	$33	$21
D2950	Core buildup, including any pins	$96	$60
D2951	Pin retention - per tooth, in addition to restoration	$18	$12
D2952	Post and core in addition to crown	$126	$81
D2954	Prefab. post and core in addition to crown	$107	$70
D2980	Crown repair necessitated by restorative material failure	$72	$48
D2981	Inlay repair necessitated by restorative material failure	$72	$48
D2982	Onlay repair necessitated by restorative material failure	$72	$48
ENDODONTICS			
D3110	Pulp cap - direct (excl. final restoration)	$7	$23
D3120	Pulp cap - indirect (excl. final restoration)	$6	$20
D3220	Therapeutic pulpotomy (excl. final restor.)	$23	$61
D3310	Endodontic therapy, anterior tooth	$101	$263
D3320	Endodontic therapy, premolar tooth (excl. final restor.)	$151	$312
D3330	Endodontic therapy, molar (excl. final restor.)	$189	$477
D3346	Retreat of prev. root canal therapy, anterior	$125	$305
D3347	Retreat of prev. root canal therapy, premolar	$184	$362
D3348	Retreat of prev. root canal therapy, molar	$217	$554

ADA CODE	BENEFIT	IN-PLAN	OUT-OF-PLAN
D3351	Apexification/recalcification - initial visit	$44	$108
D3352	Apexification/recalcification - interim med. repl.	$44	$108
D3353	Apexification/recalcification - final visit	$44	$108
D3355	Pulpal regeneration, initial visit	$44	$108
D3356	Pulpal regeneration, int. med. replacement	$44	$108
D3357	Pulpal regeneration, completion of treatment	$44	$108
D3410	Apicoectomy - anterior	$132	$338
D3421	Apicoectomy - premolar (first root)	$146	$370
D3425	Apicoectomy - molar (first root)	$165	$413
D3426	Apicoectomy - (each add. root)	$50	$129
D3427	Periradicular surg. w/o apicoectomy	$110	$318
D3428	Bone graft in conj. w/ periradicular surg., per tooth, single site	$140	$241
D3429	Bone graft in conj. w/ periradicular surg., each add. contiguous tooth in same site	$70	$121
D3430	Retrograde filling – per root	$44	$108
D3431	Biologic materials to aid soft/osseous tissue regen. in conj. w/ periradicular surg.	$70	$122
D3450	Root amputation - per root	$81	$210
D3920	Hemisection, not inc. root canal therapy	$76	$193
PERIODONTICS			
D4210	Gingivectomy or gingivoplasty - >3 cont. teeth, per quad.	$107	$269
D4211	Gingivectomy or gingivoplasty - <=3 teeth, per quad.	$33	$86
D4240	Gingival flap proc., inc. root planing - >3 cont. teeth, per quad	$132	$333
D4241	Gingival flap proc, inc. root planing - <=3 cont. teeth, per quad	$67	$167
D4249	Clinical crown lengthening - hard tissue	$146	$370
D4260	Osseous surgery - >3 cont. teeth, per quad	$208	$536
D4261	Osseous surgery - <=3 cont. teeth, per quad	$105	$269
D4263	Bone replacement graft, first site in quad.	$140	$241
D4264	Bone replacement graft, each add. site in quad.	$70	$121
D4265	Biologic materials	$70	$122
D4268	Surgical revision proc., per tooth	$132	$338
D4270	Pedicle soft tissue graft procedure	$140	$360
D4275	Soft tissue allograft	$165	$419
D4276	Comb. connec. tissue/double pedicle graft, per tooth	$140	$360
D4277	Free soft tissue graft, per tooth	$143	$317
D4278	Free soft tissue graft, each add. tooth	$71	$51
D4320	Provisional splinting - intracoronal	$44	$119
D4321	Provisional splinting - extracoronal	$44	$119
D4341	Perio scaling and root planing - >3 cont teeth, per quad.	$44	$119
D4342	Perio scaling and root planing - <= 3 teeth, per quad	$22	$60
D4346	Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	$22	$75
D4355	Full mouth debridement	$43	$108
D4910	Periodontal maintenance	$23	$62
PROSTHETICS (DENTURES)			
D5110	Complete denture - maxillary	$456	$290
D5120	Complete denture - mandibular	$456	$290
D5130	Immediate denture - maxillary	$492	$317

ADA CODE	BENEFIT	IN-PLAN	OUT-OF-PLAN
D5140	Immediate denture - mandibular	$492	$317
D5211	Maxillary partial denture - resin base	$404	$258
D5212	Mandibular partial denture - resin base	$404	$258
D5213	Maxillary partial denture - cast metal	$499	$317
D5214	Mandibular partial denture - cast metal	$499	$317
D5221/22	Immediate Maxillary/mandibular – resin base	$404	$258
D5223/24	Immediate Maxillary/mandibular – cast metal	$499	$317
D5225	Maxillary partial denture - flexible base	$499	$317
D5226	Mandibular partial denture - flexible base	$499	$317
D5282	Rem. unilateral partial denture - one piece cast metal, maxillary	$272	$172
D5283	Rem. unilateral partial denture - one piece cast metal, mandibular	$272	$172
D5410	Adjust complete denture - maxillary	$22	$16
D5411	Adjust complete denture - mandibular	$22	$16
D5421	Adjust partial denture - maxillary	$22	$16
D5422	Adjust partial denture - mandibular	$22	$16
D5511	Repair broken complete denture base, mandibular	$51	$34
D5512	Repair broken complete denture base, maxillary	$51	$34
D5520	Replace missing or broken teeth - complete denture	$41	$27
D5611	Repair resin partial denture base, mandibular	$49	$31
D5612	Repair resin partial denture base, maxillary	$49	$31
D5621	Repair cast partial framework, mandibular	$60	$38
D5622	Repair cast partial framework, maxillary	$60	$38
D5630	Repair or replace broken retentive/clasping material – per tooth	$57	$37
D5640	Replace broken teeth - per tooth	$43	$28
D5650	Add tooth to existing partial denture	$55	$35
D5660	Add clasp to existing partial denture – per tooth	$63	$43
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$242	$155
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$242	$155
D5710	Rebase complete maxillary denture	$170	$108
D5711	Rebase complete mandibular denture	$170	$108
D5720	Rebase maxillary partial denture	$170	$108
D5721	Rebase mandibular partial denture	$170	$108
D5730	Reline complete maxillary denture (chairside)	$101	$65
D5731	Reline complete mandibular denture (chairside)	$101	$65
D5740	Reline maxillary partial denture (chairside)	$101	$65
D5741	Reline mandibular partial denture (chairside)	$101	$65
D5750	Reline complete maxillary denture (lab)	$140	$86
D5751	Reline complete mandibular denture (lab)	$140	$86
D5760	Reline maxillary partial denture (lab)	$140	$86
D5761	Reline mandibular partial denture (lab)	$140	$86
D5820	Interim partial denture - maxillary	$175	$113
D5821	Interim partial denture - mandibular	$175	$113
D5850	Tissue conditioning - maxillary	$49	$33
D5851	Tissue conditioning - mandibular	$45	$31
BRIDGES & 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	$22	$60

ADA CODE	BENEFIT	IN-PLAN	OUT-OF-PLAN
D6205	Pontic - indirect resin based composite	$159	$102
D6210	Pontic - cast high noble metal	$411	$263
D6211	Pontic - cast predominately base metal	$378	$226
D6212	Pontic - cast noble metal	$365	$231
D6214	Pontic - titanium	$411	$263
D6240	Pontic - porcelain fused to high noble metal	$418	$269
D6241	Pontic - porcelain fused to predominately base metal	$365	$231
D6242	Pontic - porcelain fused to noble metal	$397	$252
D6545	Ret. - cast metal for resin bonded fixed prosthesis	$159	$102
D6602	Retainer inlay - cast high noble metal, two surfaces	$319	$208
D6603	Retainer inlay - cast high noble metal, >=3 surfaces	$382	$242
D6604	Retainer inlay - cast predominantly base metal, two surfaces	$319	$208
D6605	Retainer inlay - cast predominantly base metal, >=3 surfaces	$330	$210
D6606	Retainer inlay - cast noble metal, two surfaces	$291	$188
D6607	Retainer inlay - cast noble metal, >=3 surfaces	$348	$220
D6610	Retainer onlay - cast high noble metal, two surfaces	$372	$162
D6611	Retainer onlay - cast high noble metal, >=3 surfaces	$407	$176
D6612	Retainer onlay - cast predominantly base metal, two surfaces	$320	$138
D6613	Retainer onlay - cast predominantly base metal, >=3 surfaces	$355	$153
D6614	Retainer onlay - cast noble metal, two surfaces	$337	$146
D6615	Retainer onlay - cast noble metal, >=3 surfaces	$372	$162
D6624	Retainer inlay - titanium	$382	$242
D6634	Retainer onlay - titanium	$407	$176
D6710	Retainer crown - indirect resin based composite	$159	$102
D6750	Retainer crown - porcelain fused to high noble metal	$428	$274
D6751	Retainer crown - porcelain fused to predominately base metal	$378	$241
D6752	Retainer crown - porcelain fused to noble metal	$404	$258
D6780	Retainer crown - 3/4 cast high noble metal	$397	$247
D6781	Retainer crown - 3/4 cast predominantly base metal	$397	$247
D6782	Retainer crown - 3/4 cast noble metal	$397	$247
D6790	Retainer crown - full cast high noble metal	$418	$269
D6791	Retainer crown - full cast predominately base metal	$373	$241
D6792	Retainer rown - full cast noble metal	$397	$252
D6794	Retainer crown - titanium	$410	$269
D6930	Recement fixed partial denture	$41	$27
ORAL SURGERY			
D7111	Extraction, coronal remnants - primary tooth	$11	$24
D7140	Extraction, erupted tooth or exposed root	$19	$47
D7210	Extraction, erupted tooth req elev,, etc.	$44	$108
D7220	Removal of impacted tooth - soft tissue	$50	$134
D7230	Removal of impacted tooth - partially bony	$63	$167
D7240	Removal of impacted tooth - completely bony	$76	$198
D7250	Surgical removal of residual tooth roots	$50	$124
D7260	Oroantral fistula closure	$120	$312
D7261	Primary closure of a sinus perforation	$120	$312
D7270	Tooth reimplant./stabiliz. of acc. evulsed/displaced tooth	$63	$177

ADA CODE	BENEFIT	IN-PLAN	OUT-OF-PLAN
D7280	Exposure of an unerupted tooth	$101	$263
D7282	Mobil. of erupted/malpositioned tooth to aid eruption	$88	$220
D7283	Place. of device to facilitate erupt. of impacted tooth	$51	$132
D7285	Incisional biopsy of oral tissue - hard (bone, tooth)	$50	$129
D7286	Incisional biopsy of oral tissue - soft (all others)	$57	$145
D7287	Exfoliative cytological sample collection	$29	$73
D7288	brush biopsy - transepithelial sample collect	$29	$73
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	$14	$37
D7310	Alveoloplasty in conjunction with extractions - per quadrant	$50	$129
D7311	Alveoloplasty in conj. with extractions	$24	$65
D7320	Alveoloplasty not in conjunction with extractions - per quadrant	$69	$177
D7321	Alveoloplasty not in conjunc w/ extractions	$35	$89
D7410	Excision of benign lesion up to 1.25 cm	$69	$172
D7411	Excision of benign lesion > 1.25 cm	$107	$279
D7412	Excision of benign lesion, complicated	$118	$306
D7450	Removal of benign odon cyst/tumor - diam <=1.25cm	$63	$162
D7451	Removal of benign odon cyst/tumor - diam >1.25cm	$113	$295
D7460	Removal of benign nonodon cyst/tumor-diam <=1.25cm	$69	$177
D7461	Removal of benign nonodon cyst/tumor-diam >1.25cm	$132	$333
D7471	Removal of lateral exostosis	$101	$263
D7472	Removal of torus palatinus	$101	$263
D7473	Removal of torus mandibularis	$101	$263
D7485	Reduction of osseous tuberosity	$101	$263
D7510	Incision and drainage of abscess - intraoral soft tissue	$33	$81
D7511	Incision/drainage of abscess - intra. soft tissue, comp.	$40	$101
D7520	Incision/drainage of abscess - extra. soft tissue	$50	$124
D7521	Incision/drainage of abscess - extra. soft tissue, comp.	$63	$155
D7530	Removal of foreign body from mucosa/skin/subcutaneous alveolar tissue	$38	$97
D7550	Partial ostect/sequestrect non-vital bone rem.	$50	$247
D7910	Suture of recent small wounds up to 5 cm	$18	$45
D7911	Complicated suture, <= 5 cm	$33	$76
D7960	Frenulectomy (frenectomy/frenotomy) - separate proc.	$82	$215
D7963	Frenuloplasty	$81	$215
D7970	Excision of hyperplastic tissue - per arch	$57	$145
D7971	Excision of pericoronal gingiva	$33	$81
D7972	Surgical reduction of fibrous tuberosity	$57	$145
D7979	Non-surgical sialolithotomy	$13	$30
ADJUNCTIVE GENERAL SERVICES			
D9110	Palliative (emergency) treatment of dental pain	$13	$30
D9210	Local anesthesia not in conj. w/ operative/surg. procedures	$0	$0
D9219	Evaluation for deep sedation or general anesthesia	$0	$0
D9222	Deep sedation/general anesthesia - first 15 minutes	$27	$71
D9223	Deep sedation/general anesthesia each subsequent 15 min. increment	$27	$71
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	$7	$22
D9239	Intravenous moderate sedation/analgesia – first 15 minutes	$27	$71
D9243	IV moderate conscious sedation/analgesia – each subsequent 15 min. increment	$27	$71

ADA CODE	BENEFIT	IN-PLAN	OUT-OF-PLAN
D9310	Consultation (diagnostic service by nontreating dentist)	$15	$48
D9440	Office visit after regularly scheduled hours	$30	NB
D9613	Infiltration of sustained release therapeutic drug – single or multiple sites	$190	$95
D9910	Application of desensitizing medicament	$5	$17
D9944	Occlusal guard – hard appliance, full arch	$82	$283
D9945	Occlusal guard – soft appliance, full arch	$82	$283
D9946	Occlusal guard – hard appliance, partial arch	$82	$283
D9942	Repair and/or reline of occlusal guard	$24	$86
D9951	Occlusal adjustment - limited	$16	$61
D9952	Occlusal adjustment - complete	$62	$252
D9986	Missed appointment	$50	$50
D9995	Teledentistry – synchronous; real-time encounter	$20	$20
D9996	Teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review	$20	$20

⬩ 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.

KAISER PERMANENTE®

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

POINT-OF-SERVICE DENTAL RIDER

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

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

I. DEFINITIONS

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

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

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

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

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

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

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

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

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

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

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

II. GENERAL PROVISIONS

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

B. Health Plan has entered into an Agreement with Dental Administrator under which Dental Administrator will provide or arrange for the administration of Covered Dental Services to Members.

C. You will receive a list of Participating Dental Providers from the Health Plan or from Dental Administrator. To receive "In-Plan" Covered Dental Services you should select a Participating Dental Provider who is a "General Dentist" for you and your covered family members. Specialty care is also available should further covered Services be necessary; however, you must be referred to a Dental Specialist by your General Dentist. Please refer to the Description of Benefits and Member Copayments for those fees you will pay for In-Plan Services.

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

D. A Non-Participating Dental Provider, at his or her discretion may: (1) require payment at the time Services are received; (2) bill you directly for the Services received, or (3) bill Dental Administrator directly for the Services you received.

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

The default payment is to the Provider. If you have already paid the provider for services rendered, it is your responsibility to file a claim with Dental Administrator for payment and/or reimbursement. For information on how to submit a claim, please see the "Submission of Claims" section in this Rider.

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

Toll-Free Number: 855-733-7524

TTY Line: TTY 711

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

DominionNational.com/kaiserdentists

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

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

III. SPECIALIST REFERRALS

A. Participating Specialist Referrals

If, in the judgment of a General Dentist, you require the Services of a specialist, you may be referred to a Dental Specialist who has agreed to provide Covered Dental Services to you. You must have a referral from a General Dentist to a Dental Specialist to receive the In-Plan benefit. You may receive a standing referral to the Dental Specialist if (i) the General Dentist determines, in consultation with the specialist, that you need continuing care from the specialist, (ii) you have a disease that is life threatening, degenerative, chronic, or disabling and requires specialized dental care and (iii) the specialist has expertise in treating life threatening, degenerative, chronic, or disabling disease or condition and is part of the provider panel. The fees shown on the Description of Benefits and Member Copayments for Covered Dental Services will apply to the Services provided by the Dental Specialist.

B. Non-Participating Specialist Referrals

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

1. Neither Health Plan nor Dental Administrator have a Dental Specialist who possesses the professional training and expertise to treat the condition or disease; or
2. Neither Health Plan nor Dental Administrator is able to provide reasonable access to a Dental Specialist with the professional training and expertise to treat the condition or disease without unreasonable delay or travel.

The Member's cost share will be calculated as if the Non-Participating Dental Provider specialist rendering the Covered Dental Services were a Participating Dental Provider.

IV. EXTENSION OF BENEFITS

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

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

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

Extension of Benefits Limitations:

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

1. Coverage ends because of your failure to pay premium
2. Coverage ends as the result of you committing fraud or material misrepresentation;
3. When coverage is provided by another health plan and that health plan's coverage;
   a. is provided at a cost to you that is less than or equal to the cost to you of the extended benefit available under this Rider; and
   b. will not result in an interruption of Covered Dental Services to you.

V. DENTAL EMERGENCIES OUTSIDE THE SERVICE AREA

When a dental emergency occurs outside the Service Area, Dental Administrator will reimburse the non-participating provider directly. If the member has already paid the charges, the Dental Administrator will reimburse the member (upon proof of payment) instead of paying the provider directly for Covered Dental Services that may have been provided. Reimbursement to the member is not to exceed $100 per incident. Services are limited to those procedures not excluded under Plan Limitations and Exclusions. Proof of payment must be submitted to Dental Administrator by provider within one hundred eighty (180) days of treatment. The Dental Administrator will allow Members to submit claims up to one (1) year after the date of service. However, a Member's legal incapacity shall suspend the time to submit a claim; and the suspension period ends when legal capacity is regained. Failure to submit a claim within one (1) year after the date of services does not invalidate or reduce the amount of the claim if it was not reasonably possible to submit the claim within one (1) year after the date of services; and the claim is submitted within two (2)

years after the date of service. Proof of loss should be mailed to: Dominion National, 251 18th Street South, Suite 900, Arlington, Virginia 22202, ATTN: Accounting Dept. Coverage is provided for emergency dental treatment as may be required to alleviate pain, bleeding, or swelling. In all cases, if post-emergency care is required, you may receive all post-emergency care from your Participating Dental Provider or a Non-Participating Dental Provider.

VI. ANNUAL DEDUCTIBLE

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

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

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

VII. ANNUAL MAXIMUM BENEFIT

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

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

VIII. SUBMISSION OF CLAIMS

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

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

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

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

Benefits payable under the Small Group Evidence of Coverage for any loss will be paid not more than 30 days after receipt of written proof of loss. If a claim is denied in whole or in part, the written notice of the denial will contain the reasons for denial and reference to the pertinent provisions of the Small Group Evidence of Coverage and this Rider.

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

IX. EXCLUSIONS AND LIMITATIONS

A. Exclusions

The following services are excluded under this Rider:

1. Services which are covered under worker's compensation or employer's liability laws.
2. Services that are provided without cost to member by any federal, state, municipal, county, or other subdivision's program (with the exception of Medicaid).
3. Services which are not necessary for the patient's dental health as determined by the Plan.
4. Cosmetic, elective, or aesthetic dentistry except as required due to accidental bodily injury to sound natural teeth as determined by the Plan.
5. Oral surgery requiring the setting of fractures or dislocations, except as may be otherwise covered in your medical plan, which is described in the Evidence of Coverage.
6. Drugs obtainable with or without a prescription, except as may be otherwise covered in your medical plan, which is described in the Evidence of Coverage.
7. Hospitalization for any dental procedure.
8. Treatment required for conditions resulting from major disaster, epidemic, war or acts of war, whether declared or undeclared, or while on active duty as a member of the armed forces of any nation.
9. Replacement due to loss or theft of prosthetic appliance.
10. Implantation and related restorative procedures.
11. Procedures not listed as a covered benefit under this Plan.
12. Services related to the treatment of TMD (Temporomandibular Disorder).
13. Elective surgery, including, but not limited to, extraction of non–pathologic, asymptomatic impacted teeth as determined by the Plan.
14. Procedures relating to the change and maintenance of vertical dimension or major restoration of occlusion, or to alter the occlusion (bite) through full mouth adjustment/grinding of the teeth. This does not exclude minor occlusal adjustments on individual teeth to remove high spots or smooth out rough or sharp areas.
15. Treatment of malignancies, neoplasm, or congenital malformations, except as may be otherwise covered in your medical plan, which is described in the Evidence of Coverage.
16. Lab fees for excisions and biopsies, except as may be otherwise covered in your medical plan, which is described in the Evidence of Coverage.
17. Experimental procedures, implantations, or pharmacological regimens.
18. Initial placement or replacement of fixed bridgework solely for the purpose of achieving periodontal stability.
19. Charges for second opinions, unless preauthorized.
20. Procedures requiring fixed prosthodontic restoration, which are necessary for complete oral rehabilitation or reconstruction.

21. Orthodontia treatment for adults.
22. Occlusal guards, except for the purpose of controlling habitual grinding.

B. Limitations

Covered Dental Services are subject to the following limitations:

1. Two evaluations per Plan Year including a maximum of one comprehensive evaluation per 36 months.
2. One emergency or problem focused exam (D0140) per Plan Year.
3. Two prophylaxes (cleaning, scaling and polishing teeth) per Plan Year.
4. Bitewing x-rays, two per Plan Year.
5. Emergency palliative treatment is covered if no services other than an exam and x-rays were performed on the same date of service.
6. One (1) interim caries arresting medicament application per primary tooth is covered per lifetime.
7. Amalgam and composite fillings excluding posterior composite fillings (anterior restorations of mesiolingual, distolingual, mesiobuccal and distobuccal surfaces considered single surface restorations), are limited to once per tooth per surface every 24 months.
8. Diagnostic x-rays, full or panoramic, are limited to once per 60 months.
9. Root canal therapy is not covered if pulp chamber was opened before effective date of coverage.
10. Retrograde fillings are limited to once per root per lifetime.
11. Two periodontal maintenance visits following surgery per Plan Year (D4341 is not considered surgery).
12. One scaling and root planing per quadrant (D4341 or D4342) per 24 months.
13. One pedicle or free soft tissue graft per site per lifetime.
14. One appliance (night guard) per 5 years (within 6 months of osseous surgery).
15. One full mouth debridement per lifetime.
16. One study model per 36 months.
17. Recementing bridges, inlays, onlays and crowns is limited to once per tooth per 12 months after the first 12 months.
18. One repair of dentures or fixed bridgework per 24 months.
19. Replacement of removable dentures or fixed bridges that cannot be repaired is covered after 7 years from the date of last placement.
20. Cast metal, porcelain/ceramic and resin-base inlays, onlays and crowns for tooth with extensive caries or fracture that is unable to be restored with an amalgam or composite filling.
21. Replacement of existing inlay, onlay, or crown is covered after 7 years of the restoration initially placed or last replaced (will not apply if replacement is necessary due to the extraction of functioning natural teeth after the effective date of coverage).
22. One relining or rebasing of existing removable dentures is covered per 24 months only after 24 months from the date of last placement, unless an immediate prosthesis replacing at least 3 teeth.
23. Teledentistry, synchronous (D9995) or asynchronous (D9996), limited to two per calendar year (when available).

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

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

By: ______________________________

Mark Ruszczyk
Vice President, Marketing, Sales & Business Development