



POS PREFERRED LEVEL
DENTAL PLAN PROVIDER DIRECTORY 2013

Kaiser Permanente Dental Plan

Preferred Level Point-of-Service (POS) Plan Provider Directory

The benefit information provided in this directory is only a summary, and does not fully describe your dental coverage. For complete details of your coverage, please refer to group Evidence of Coverage with Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (Kaiser Permanente). In the event of ambiguity, or a conflict between this summary and the Evidence of Coverage, the Evidence of Coverage shall control.

Point-of-Service plan

The Preferred Level Point-of-Service (POS) Dental Plan offered by Kaiser Permanente and administered by Dominion Dental Services USA, Inc. (Dominion) provides cost-effective dental care. Our Preferred Level POS Dental Plan combines the features of a dental health maintenance organization plan with the flexibility of a traditional indemnity program. We emphasize healthy smiles through prevention and the early detection of dental problems. Our Preferred Level POS Dental Plan promotes healthy teeth and gums to reduce the need for costly procedures in the future.

Choosing a dentist

With this plan, you have the freedom to see a dentist inside the plan network or any dentist each time care is needed.

Anytime you see a participating dental provider, the in-plan coverage applies. Stay in the network for lower out-of-pocket expenses and no claim submissions. If you choose to see a dentist outside of the plan, the out-of-plan coverage applies, and you must submit a claim form for reimbursement. You will be reimbursed up to the maximum stated in the out-of-plan fee schedule. The provider may bill you for charges in excess of the maximum plan payment.

A list of participating in-plan general dentists is included in this directory. To locate the most up-to-date list of participating in-plan dental providers, please visit our website at DominionDental.com/kaiserdentists or call Dominion's Member Services Department toll free at 1-888-518-5338; TTY 711, Monday through Friday from 7:30 a.m. to 6 p.m.

Dominion's integrated voice response system is also available 24 hours a day for information about participating in-plan dental providers in your area or to help you select a participating in-plan dental provider.

Dedicated customer service

We also know that quality customer service is an important component of any dental plan. Knowledgeable Dominion Member Services Specialists are available Monday through Friday, 7:30 a.m. to 6 p.m. at 703-518-5338 or toll free at 1-888-518-5338 to answer questions about coverage or to help you find a participating dentist. Hearing-impaired members can use the Internet at IP-RELAY.com or call TTY 711 for assistance.

Dental claims

A complete list of covered dental services is included in this directory. Any service not listed is not covered by this plan.

If you receive care from an out-of-plan dentist, you may be expected to pay the full amount at the time of service, unless an agreement has been reached with the dentist. In order for claims to be considered, you must submit the claim within 365 days from the date of service.

Claims can be mailed to:

Dominion Dental Services USA, Inc.
P.O. Box 1126
Elk Grove Village, IL 60009

You will be reimbursed from Dominion in accordance with your plan's out-of-plan fee schedule. You can obtain claim forms from your dentist or by calling Dominion's Member Services Department toll free at 1-888-518-5338.

Extension of Benefits - Maryland

Extension of Benefits applies only to Kaiser Permanente for individuals and families members who live in the state of Maryland and employer group Kaiser Permanente members when the employer group is headquartered in the state of Maryland.

For members who meet the conditions above, in those instances when your coverage with us has terminated, we will extend covered dental services, without charging a premium when coverage has ended 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 agreement or *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 agreement or *Evidence of Coverage* and dental rider in effect at the time your coverage ended, for a period of:
 - 60 days following the date your coverage ended if the orthodontist has agreed to or is receiving monthly payments; or
 - Until the latter 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.

You must notify Kaiser Permanente in writing if you believe you qualify under this "Extension of Benefits" provision.

Limitations:

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

- Coverage ends because of failure by the member to pay dues;
- Coverage ends as the result of a member committing fraud or material misrepresentation;
- When coverage is provided by another health plan and that health plan's coverage:
 - (a) is provided at a cost less than or equal to the cost of the extended benefit available under the dental rider and,
 - (b) will not result in an interruption of covered dental services to you.

How we protect your rights to privacy and confidentiality

We know that protecting your privacy rights is important. Therefore, we believe you should know how we keep your personal and medical information confidential and how we may use it. A more complete description of our privacy practices may be found in our notice of privacy practices. New subscribers receive a copy of this notice by mail at the time of enrollment. You may also obtain a copy by calling a member services representative or at any Kaiser Permanente medical center.

We have many guidelines in place to protect your rights to privacy and confidentiality. Here are a few examples:

1. Our physicians and employees sign confidentiality statements. This affirms their commitment to protect your information. Only those who "need to know" to make decisions about your health care are permitted to view your medical record.
2. Our physicians, employees, and other workforce members receive training on the state and federal standards for the use and disclosure of your protected health information.
3. Contractors also sign a statement that they will protect your information.
4. Your right to have confidential medical records is part of our members' rights and responsibilities.
5. You have the right to deny release of your information. This is so, except when: required by law; permitted for your treatment; permitted for payment of services; or allowed for health plan operations.
6. Except as permitted by law, we take out any information that could identify you before talking to your employer or employer representative about the use or cost of services.
7. Our staff will ask to see a valid photo ID when you request care or services at a Kaiser Permanente medical center. If you don't have a valid ID, we will ask you one or two questions that will help us confirm your identity.

Except as permitted by law, we must have your permission in writing before we can share your information for the reasons below. The release must explain the exact information to be shared and be signed by you. Your member services representative can give you more details and a release form.

1. Giving your employer or employer representative the status of your claims.
2. Sharing your medical information with an outside party, except when required or permitted for legal or regulatory reasons or as allowed for treatment, payment, or health plan operation purposes.

We may use your protected information in the following day-to-day operations of Kaiser Permanente. These tasks are in agreement with the Health Insurance Portability and Accountability Act (HIPAA) and the general release of information section in your agreement or *Evidence of Coverage*.

1. Talking with your employer representative about changes to your membership information.
2. Giving a parent the status of his or her child's claim (if the child is under 18 years of age and there is no legal reason not to do so).
3. Providing your name and address to our contracted mail houses. This is so you can receive our health mailings to prevent or manage chronic diseases, and other health care information.
4. Sharing information with government agencies or other insurers for liability or payment purposes.
5. Providing information as required or permitted by federal, state, or local laws.
6. Supporting medical research, as permitted by law.
7. Professional, tracking, or quality improvement tasks.

Note: "You" may also refer to your authorized representative.



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

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 calendar 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 calendar year. Refer to the Point-of-Service Dental Rider for an example of how the combined deductible works. You must pay the full amount charged by the dentist for the services when you receive them, until you meet your deductible. After you meet the deductible, you pay the applicable fee shown below for services provided in-plan, and you will be reimbursed the amount shown below for services provided out-of-plan, up to the annual maximum benefit. You are responsible for the remaining balance for out-of-plan services, and for any amounts that exceed the annual maximum benefit.

Deductible

In-plan: \$25 per member

Out-of-plan: \$50 per member

Annual maximum benefit

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

Annual maximum

In-plan: \$1,000 per calendar year

Out-of-plan: \$500 per calendar year

The 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 Dental Services USA, Inc.

Description of Benefits and Member Copayments – Preferred Level POS Plan

NOTE: THE DESCRIPTION OF BENEFITS AND MEMBER COPAYMENTS IS REVIEWED ANNUALLY AND IS SUBJECT TO CHANGE EFFECTIVE JANUARY 1 OF EACH YEAR.

ADA CODE	DESCRIPTION OF SERVICES	YOU PAY IN-PLAN TO DENTIST	YOU ARE REIMBURSED OUT-OF-PLAN
	DIAGNOSTIC		
D0120	Periodic oral evaluation	\$0	\$19
D0140	Limited oral evaluation - problem focused	\$0	\$34
D0150	Comprehensive oral evaluation - new or established patient	\$0	\$30
D0180	Comprehensive periodontal evaluation - new or established patient - not in conjunction with D0150 and limited to once per 18 months	\$0	\$30
D0210	Intraoral - complete series (including bitewings)	\$0	\$60
D0220	Intraoral - periapical first film	\$0	\$11
D0230	Intraoral - periapical each additional film	\$0	\$8
D0240	Intraoral - occlusal film	\$0	\$16
D0270	Bitewing - single film	\$0	\$9
D0272	Bitewings - two films	\$0	\$17
D0274	Bitewings - four films	\$0	\$26
D0277	Vertical bitewings - seven to eight films	\$0	\$26
D0330	Panoramic film	\$0	\$54
D0460	Pulp vitality tests	\$0	\$22
D0470	Diagnostic casts (not in conjunction with orthodontics)	\$0	\$45
D0999	Unspecified diagnostic by report	\$5	No Benefit
	PREVENTIVE		
D1110	Prophylaxis - adult	\$0	\$41
D1120	Prophylaxis - child	\$0	\$27
D1201	Topical application of fluoride (including prophylaxis) - child	\$0	\$40
D1203	Topical application of fluoride (prophylaxis not included) - child	\$0	\$17
D1204	Topical application of fluoride excluding prophylaxis - adult	\$0	\$17
D1205	Topical application of fluoride including prophylaxis - age 14+	\$0	\$45
D1330	Oral hygiene instructions	\$0	\$0
D1351	Sealant - per tooth (up to 14 years of age)	\$0	\$21
D1510	Space maintainer - fixed - unilateral	\$0	\$137
D1515	Space maintainer - fixed - bilateral	\$0	\$252
D1520	Space maintainer - removable - unilateral	\$0	\$189
D1525	Space maintainer - removable - bilateral	\$0	\$252
D1550	Re-cementation of space maintainer	\$0	\$27
	RESTORATIVE		
D2140	Amalgam - one surface, primary or permanent	\$14	\$39
D2150	Amalgam - two surfaces, primary or permanent	\$18	\$49
D2160	Amalgam - three surfaces, primary or permanent	\$21	\$60
D2161	Amalgam - four or more surfaces, primary or permanent	\$29	\$74
D2330	Resin-based composite - one surface, anterior	\$17	\$47
D2331	Resin-based composite - two surfaces, anterior	\$21	\$60
D2332	Resin-based composite - three surfaces, anterior	\$29	\$74
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	\$29	\$84
D2391	Resin-based composite - one surface, posterior	\$18	\$53

Description of Benefits and Member Copayments – Preferred Level POS Plan

ADA CODE	DESCRIPTION OF SERVICES	YOU PAY IN-PLAN TO DENTIST	YOU ARE REIMBURSED OUT-OF-PLAN
D2392	Resin-based composite - two surfaces, posterior	\$25	\$64
D2393	Resin-based composite - three surfaces, posterior	\$30	\$80
D2394	Resin-based composite - four or more surfaces, posterior	\$34	\$93
D2510	Inlay - metallic - one surface	\$91	\$257
D2520	Inlay - metallic - two surfaces	\$102	\$294
D2530	Inlay - metallic - three or more surfaces	\$125	\$347
D2542	Onlay - metallic - two surfaces	\$86	\$231
D2543	Onlay - metallic - three surfaces	\$86	\$231
D2544	Dental onlay - metallic - four or more surfaces	\$86	\$231
D2610	Inlay - porcelain/ceramic - one surface	\$79	\$331
D2620	Inlay - porcelain/ceramic - two surfaces	\$119	\$347
D2630	Inlay - porcelain/ceramic - three or more surfaces	\$131	\$368
D2642	Onlay - porcelain/ceramic - two surfaces	\$68	\$189
D2643	Onlay - porcelain/ceramic - three surfaces	\$68	\$189
D2644	Dental onlay - porcelain - four or more surfaces	\$68	\$189
D2650	Inlay - resin-based composite - one surface	\$79	\$331
D2651	Inlay - resin-based composite - two surfaces	\$119	\$347
D2652	Inlay - resin-based composite - three or more surfaces	\$131	\$368
D2710	Crown - resin (indirect)	\$57	\$158
D2712	Crown 3/4 resin-based composite (exclusive of veneers)	\$57	\$158
D2740	Crown - porcelain/ceramic substrate	\$158	\$436
D2750	Crown - porcelain fused to high noble metal	\$153	\$425
D2751	Crown - porcelain fused to predominantly base metal	\$136	\$378
D2752	Crown - porcelain fused to noble metal	\$148	\$404
D2780	Crown - 3/4 cast high noble metal	\$148	\$415
D2781	Crown - 3/4 cast predominantly base metal	\$148	\$415
D2782	Crown - 3/4 cast noble metal	\$148	\$415
D2790	Crown - full cast high noble metal	\$153	\$420
D2791	Crown - full cast predominantly base metal	\$136	\$373
D2792	Crown - full cast noble metal	\$142	\$394
D2794	Crown - titanium	\$153	\$420
D2910	Recement inlay	\$12	\$30
D2915	Recement cast or prefabricated post and core	\$12	\$30
D2920	Recement crown	\$11	\$29
D2930	Prefabricated stainless steel crown - primary tooth	\$34	\$95
D2931	Prefabricated stainless steel crown - permanent tooth	\$34	\$100
D2932	Prefabricated resin crown	\$34	\$89
D2934	Prefabricated steel crown primary	\$34	\$95
D2940	Sedative filling	\$12	\$32
D2950	Core buildup, including any pins	\$34	\$89
D2951	Pin retention - per tooth, in addition to restoration	\$5	\$17
D2952	Cast post and core in addition to crown	\$45	\$126
D2954	Prefabricated post and core in addition to crown	\$40	\$110
D2980	Crown repair, by report	\$28	\$74
	ENDODONTICS		
D3110	Pulp cap - direct (excluding final restoration)	\$7	\$22
D3120	Pulp cap - indirect (excluding final restoration)	\$6	\$19
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	\$21	\$59

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D3310	Anterior (excluding final restoration)	\$91	\$257
D3320	Bicuspid (excluding final restoration)	\$136	\$305
D3330	Molar (excluding final restoration)	\$170	\$467
D3346	Retreatment of previous root canal therapy - anterior	\$112	\$299
D3347	Retreatment of previous root canal therapy - bicuspid	\$165	\$354
D3348	Retreatment of previous root canal therapy - molar	\$195	\$543
D3351	Apexification/recalcification - initial visit	\$40	\$105
D3352	Apexification/recalcification - interim medication replacement	\$40	\$105
D3353	Apexification/recalcification - final visit	\$40	\$105
D3410	Apicoectomy/periradicular surgery - anterior	\$119	\$331
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	\$131	\$362
D3425	Apicoectomy/periradicular surgery - molar (first root)	\$148	\$404
D3426	Apicoectomy/periradicular surgery (each additional root)	\$45	\$126
D3430	Retrograde filling - per root	\$40	\$105
D3450	Root amputation - per root	\$74	\$205
D3920	Hemisection (including any root removal), not including root canal therapy	\$67	\$189
	PERIODONTICS		
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth per quadrant	\$98	\$263
D4211	Gingivectomy or gingivoplasty - one to three teeth per quadrant	\$29	\$84
D4240	Gingival flap procedure, including root planing - four or more contiguous	\$119	\$326
D4241	Gingival flap procedure, including root planing - one to three teeth per quadrant	\$60	\$163
D4249	Clinical crown lengthening - hard tissue	\$131	\$362
D4260	Osseous surgery (including flap entry and closure) - four or more per quadrant	\$187	\$525
D4261	Osseous surgery (including flap entry and closure) - one to three teeth per quadrant	\$94	\$263
D4263	Bone replacement graft - first site in quadrant	\$125	\$236
D4265	Biologic material to aid in soft/osseous tissue	\$63	\$119
D4268	Surgical revision procedure, per tooth	\$119	\$331
D4270	Pedicle soft tissue graft procedure	\$125	\$352
D4271	Free soft tissue graft proc - including donor site	\$148	\$410
D4275	Soft tissue allograft	\$148	\$410
D4276	Combined connective tissue and double pedicle	\$125	\$352
D4320	Provisional splinting - intracoronal	\$40	\$116
D4321	Provisional splinting - extracoronal	\$40	\$116
D4341	Periodontal scaling and root planing - four or more contiguous teeth or bounded teeth spaces per quadrant	\$40	\$116
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	\$20	\$58
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	\$40	\$105
D4910	Periodontal maintenance	\$21	\$60
	PROSTHETICS REMOVABLE		
D5110	Complete denture - maxillary	\$165	\$452
D5120	Complete denture - mandibular	\$165	\$452
D5130	Immediate denture - maxillary	\$175	\$494
D5140	Immediate denture - mandibular	\$175	\$494
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests, and teeth)	\$142	\$399
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests, and teeth)	\$142	\$399
D5213	Axillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth)	\$182	\$499
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth)	\$182	\$499

Description of Benefits and Member Copayments – Preferred Level POS Plan

ADA CODE	DESCRIPTION OF SERVICES	YOU PAY IN-PLAN TO DENTIST	YOU ARE REIMBURSED OUT-OF-PLAN
D5225	Maxillary partial denture	\$182	\$499
D5226	Mandibular partial denture	\$182	\$499
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth)	\$98	\$58
D5410	Adjust complete denture - maxillary	\$7	\$23
D5411	Adjust complete denture - mandibular	\$7	\$23
D5421	Adjust partial denture - maxillary	\$7	\$23
D5422	Adjust partial denture - mandibular	\$7	\$23
D5510	Repair broken complete denture base	\$18	\$51
D5520	Replace missing or broken teeth - complete denture (each tooth)	\$15	\$42
D5610	Repair resin denture base	\$18	\$49
D5620	Repair cast framework	\$21	\$59
D5630	Repair or replace broken clasp	\$20	\$57
D5640	Replace broken teeth - per tooth	\$16	\$43
D5650	Add tooth to existing partial denture	\$19	\$54
D5660	Add clasp to existing partial denture	\$22	\$63
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	\$86	\$239
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	\$86	\$239
D5710	Rebase complete maxillary denture	\$62	\$168
D5711	Rebase complete mandibular denture	\$62	\$168
D5720	Rebase maxillary partial denture	\$62	\$168
D5721	Rebase mandibular partial denture	\$62	\$168
D5730	Reline complete maxillary denture (chairside)	\$34	\$100
D5731	Reline complete mandibular denture (chairside)	\$34	\$100
D5740	Reline maxillary partial denture (chairside)	\$34	\$100
D5741	Reline mandibular partial denture (chairside)	\$34	\$100
D5750	Reline complete maxillary denture (laboratory)	\$51	\$137
D5751	Reline complete mandibular denture (laboratory)	\$51	\$137
D5760	Reline maxillary partial denture (laboratory)	\$51	\$137
D5761	Reline mandibular partial denture (laboratory)	\$51	\$137
D5820	Interim partial denture (maxillary)	\$62	\$179
D5821	Interim partial denture (mandibular)	\$62	\$179
D5850	Tissue conditioning, maxillary	\$18	\$51
D5851	Tissue conditioning, mandibular	\$16	\$48
	PROSTHETICS FIXED		
D6205	Pontic - indirect resin-based composite	\$57	\$158
D6210	Pontic - cast high noble metal	\$148	\$410
D6211	Pontic - cast predominantly base metal	\$136	\$357
D6212	Pontic - cast noble metal	\$131	\$362
D6214	Pontic - titanium	\$148	\$410
D6240	Pontic - porcelain fused to high noble metal	\$148	\$415
D6241	Pontic - porcelain fused to predominantly base metal	\$131	\$362
D6242	Pontic - porcelain fused to noble metal	\$142	\$394
D6545	Retainer - cast metal for resin-bonded fixed prosthesis	\$57	\$158
D6602	Inlay - cast high noble metal, two surfaces	\$112	\$323
D6603	Inlay - cast high noble metal, three or more surfaces	\$138	\$381
D6604	Inlay - cast predominantly base metal, two surfaces	\$112	\$323
D6605	Inlay - cast predominantly base metal, three or more surfaces	\$119	\$330
D6606	Inlay - cast noble metal, two surfaces	\$102	\$294

Description of Benefits and Member Copayments – Preferred Level POS Plan

ADA CODE	DESCRIPTION OF SERVICES	YOU PAY IN-PLAN TO DENTIST	YOU ARE REIMBURSED OUT-OF-PLAN
D6607	Inlay - cast noble metal, three or more surfaces	\$125	\$347
D6610	Onlay - cast high noble metal, two surfaces	\$92	\$247
D6611	Onlay cast high noble metal $\geq$ three surfaces	\$101	\$270
D6612	Onlay - cast predominantly base metal, two surfaces	\$79	\$212
D6613	Onlay - cast predominantly base metal, three or more surfaces	\$88	\$235
D6614	Onlay - cast noble metal, two surfaces	\$83	\$224
D6615	Onlay cast noble metal $\geq$ three surfaces	\$92	\$247
D6624	Inlay - titanium	\$138	\$381
D6634	Onlay - titanium	\$101	\$270
D6710	Crown - indirect resin based composite	\$57	\$158
D6750	Crown - porcelain fused to high noble metal	\$153	\$425
D6751	Crown - porcelain fused to predominantly base metal	\$136	\$378
D6752	Crown - porcelain fused to noble metal	\$148	\$404
D6780	Crown - 3/4 cast high noble metal	\$142	\$389
D6781	Crown - 3/4 cast predominantly base metal	\$142	\$389
D6782	Crown - 3/4 cast noble metal	\$142	\$389
D6790	Crown - full cast high noble metal	\$153	\$420
D6791	Crown - full cast predominantly base metal	\$136	\$373
D6792	Crown - full cast noble metal	\$142	\$394
D6794	Crown - titanium	\$153	\$420
D6930	Recement fixed partial denture	\$15	\$42
	ORAL SURGERY		
D7111	Coronal remnants - deciduous tooth	\$9	\$23
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	\$17	\$46
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	\$40	\$105
D7220	Removal of impacted tooth - soft tissue	\$45	\$131
D7230	Removal of impacted tooth - partially bony	\$57	\$163
D7240	Removal of impacted tooth - completely bony	\$68	\$194
D7250	Surgical removal of residual tooth roots (cutting procedure)	\$45	\$121
D7260	Oroantral fistula closure	\$108	\$305
D7261	Primary closure of a sinus perforation	\$108	\$305
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	\$57	\$173
D7280	Surgical access of an unerupted tooth	\$91	\$257
D7282	Mobiliz. of erupted or malpos. tooth - aid erupted	\$79	\$215
D7283	Placement of device	\$46	\$129
D7285	Biopsy of oral tissue - hard (bone, tooth)	\$45	\$126
D7286	Biopsy of oral tissue - soft (all others)	\$51	\$142
D7287	Cytology sample collection	\$26	\$71
D7288	Brush biopsy - transepithelial sample collect	\$26	\$63
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	\$12	\$36
D7310	Alveoloplasty in conjunction with extractions - four or more teeth per quadrant	\$45	\$126
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces per quadrant	\$22	\$63
D7320	Alveoloplasty not in conjunction with extractions - per quadrant	\$62	\$173
D7321	Alveoloplasty not in conjunc w/extractions	\$31	\$87
D7410	Excision of benign lesion up to 1.25 cm	\$62	\$168
D7411	Excision of benign lesion $>$ 1.25 cm	\$96	\$273
D7412	Excision of benign lesion, complicated	\$106	\$300

Description of Benefits and Member Copayments – Preferred Level POS Plan

ADA CODE	DESCRIPTION OF SERVICES	YOU PAY IN-PLAN TO DENTIST	YOU ARE REIMBURSED OUT-OF-PLAN
D7450	Removal of benign odont cyst/tumor - diam<=1.25cm	\$57	\$158
D7451	Removal of benign odont cyst/tumor - diam>1.25cm	\$102	\$289
D7460	Removal of benign nonodont cyst/tumor-diam<=1.25cm	\$62	\$173
D7461	Removal of benign nonodont cyst/tumor-diam>1.25cm	\$119	\$326
D7471	Removal of lateral exostosis	\$91	\$257
D7472	Removal of torus palatinus	\$91	\$257
D7473	Removal of torus mandibularis	\$91	\$257
D7485	Surgical reduction of osseous tuberosity	\$91	\$257
D7510	Incision and drainage of abscess - intraoral soft tissue	\$29	\$79
D7511	Incision and drainage of abscess - intraoral	\$36	\$99
D7520	Incision/drainage of abscess - extra. soft tissue	\$45	\$121
D7521	Incision and drainage of abscess	\$57	\$151
D7530	Foreign body removal from muc./skin/subcut tissue	\$34	\$95
D7550	Partial ostect/sequestrect non-vital bone removal	\$45	\$242
D7910	Suture of recent small wounds up to 5 cm	\$16	\$44
D7911	Complicated suture - up to 5 cm	\$29	\$74
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure	\$74	\$210
D7963	Frenuloplasty	\$74	\$210
D7970	Excision of hyperplastic tissue - per arch	\$51	\$142
D7971	Excision of pericoronal gingiva	\$34	\$89
D7972	Surgical reduction of fibrous tuberosity	\$51	\$142
	ORTHODONTICS		
D8070	Comprehensive orthodontic treatment of the transitional dentition	\$2,098	No Benefit
D8080	Comprehensive orthodontic treatment of the adolescent dentition	\$2,098	No Benefit
D8670	Periodic orthodontic treatment visit (as part of contract)	\$0	No Benefit
	ADDITIONAL PROCEDURES		
D9110	Palliative (emergency) treatment of dental pain - minor procedure	\$11	\$29
D9210	Local anesthesia not in conjunction with operative or surgical procedures	\$0	\$0
D9220	Deep sedation/general anesthesia - first 30 minutes	\$62	\$173
D9221	Deep sedation/general anesthesia - each additional 15 minutes	\$19	\$54
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	\$7	\$21
D9241	Intrav conscious sedation/analgesia - first 30 minutes	\$51	\$142
D9242	Intrav conscious sedation/analgesia - each additional 15 minutes	\$0	\$142
D9310	Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)	\$13	\$47
D9440	Office visit - after regularly scheduled hours	\$27	No Benefit
D9910	Application of desensitizing medicament	\$5	\$16
D9940	Occlusal guard, by report	\$74	\$278
D9942	Repair and/or relin of occlusal guard	\$22	\$84
D9951	Occlusal adjustment - limited	\$14	\$59
D9952	Occlusal adjustment - complete	\$57	\$247

POS Exclusions and Limitations

EXCLUSIONS – Neither health plan nor dental administrator provides coverage for the following:

1. Services for injuries or conditions that 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 that, in the opinion of the attending dentist, are not necessary for the patient's dental health.
4. Cosmetic, elective, or aesthetic dentistry.
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 for conditions resulting from major disaster, epidemic, or war, including declared or undeclared war or acts of war.
9. Replacement due to loss or theft of prosthetic appliance.
10. Services that cannot be performed because of the general health of the patient.
11. Implantation and related restorative procedures.
12. Services not listed as a covered dental service.
13. Services related to the treatment of TMD (Temporomandibular disorder).
14. Elective surgery, including, but not limited to, extraction of non-pathologic, asymptomatic impacted teeth.
15. Procedures relating to the change and maintenance of vertical dimension or major restoration of occlusion, or to alter the occlusion (bite) through full mouth adjustment/grinding of the teeth. This does not exclude minor occlusal adjustments on individual teeth to remove high spots or smooth out rough or sharp areas.
16. Dental expenses incurred in connection with any dental procedure that was started prior to your effective date of coverage. Examples include orthodontic work in progress, teeth prepared for crowns, and root canal therapy in progress.
17. Treatment of malignancies, neoplasm, or congenital malformations, except as may be otherwise covered in your medical plan, which is described in the *Evidence of Coverage*.
18. Lab fees for excisions and biopsies, except as may be otherwise covered in your medical plan, which is described in the *Evidence of Coverage*.
19. Experimental procedures, implantations, or pharmacological regimens.
20. Initial placement or replacement of fixed bridgework solely for the purpose of achieving periodontal stability.
21. Charges for second opinions, unless preauthorized.
22. Procedures requiring fixed prosthodontic restoration, which are necessary for complete oral rehabilitation or reconstruction.
23. Orthodontic treatment for adults.
24. Occlusal guards, except for the purpose of controlling habitual grinding.

Description of Benefits and Member Copayments – Preferred Level POS Plan

LIMITATIONS

1. Replacement of a bridge, crown, or denture within 5 years after the date it was originally installed.
2. Replacement of filling within 2 years after original date of placement.
3. Coverage for periodic oral exams, prophylaxes (cleanings), and fluoride applications is limited to two times per plan year.
4. Crown and bridge fees apply to treatment involving five or fewer units when presented in a single treatment plan. Additional crown or bridge units, beginning with the sixth unit, are available at the provider's Usual, Customary, and Reasonable (UCR) fee, minus 25 percent.
5. Full mouth X-rays or panoramic film is limited to one set every three years.
6. Retreatment of root canal within 2 years of the original treatment.
7. Coverage for sealants (D1351) is limited to the first and second permanent molars for children under the age of 16 once every 24 months.
8. Coverage for periodontal surgery of any type, including any associated material (D4210, D4211, D4240, D4241, D4249, D4260, D4261, D4263, D4265, D4268, D4270, D4271, D4275, D4276) is covered once every 36 months per quadrant or surgical site.
9. Coverage for root planing or scaling (D4341, D4342) is limited to once every 24 months per quadrant.
10. Full mouth debridement (D4355) is limited to once every 36 months.
11. Periodontal maintenance after active therapy (D4910) is limited to twice per 12 months within 24 months after definitive periodontal therapy.
12. Coverage for relining of dentures (D5730, D5731, D5740, D5741, D5750, D5751, D5760, and D5761) is limited to once every 12 months.
13. Replacement of teeth missing prior to your effective date of coverage, by fixed or removable prosthetic appliances, will not be covered until you have been continuously covered under this dental benefit for at least 12 consecutive months.
14. Orthodontic benefits are for members ages 19 and under; adult orthodontic care is not covered. Any treatment exceeding 24 months is the responsibility of the patient. The entire member fee is listed as D8070 or D8080. The actual timing and amount of each payment will be determined by the orthodontist.

Claims can be mailed to:

Dominion Dental Services USA, Inc.
P.O. Box 1126
Elk Grove Village, IL 60009

File electronically using our Payor ID of DOM01.

Kaiser Permanente Second Level Point-of-Service (POS) Plan
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Note: This list is subject to change without notice. You may seek treatment from any licensed dentist. If you seek treatment from an In-Plan dentist, please verify the dentist continues to participate as an In-Plan point-of-service dentist. For additional information on the status of the above dentists as well as new dentists, please visit our Web site at DominionDental.com/kaiserdentists, or call our Member Services Department toll-free at 888-518-5338, Monday - Friday, 7:30 a.m. - 6 p.m. (TTY 711).

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