SMILE FOR TOTAL HEALTH

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

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

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

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

In-plan

You pay low copayments for preventive care procedures such as:

- Oral evaluations
- Routine cleaning
- Certain X-ray procedures
- Topical fluoride

Out-of-plan

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

New member? Get started by choosing a dentist.

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

Choose a dentist

In-plan dental providers

You may select any general dentist from among our network of participating dentists. When you choose 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.

[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.

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

Out-of-plan dental providers

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

Deductibles and annual maximums

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

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

Make appointments

On or after your effective date of coverage, you can make an appointment with any participating (in-plan) dentist. You can also choose to visit any other licensed dentist not in the plan to receive your care (out-of-plan). Make sure you bring your Kaiser Permanente medical ID card to your appointment. 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 Kaiser Permanente for reimbursement. You must submit the claim within 365 days of the date of service. Reimbursement is capped at the amount shown on the out-of-plan copayment schedule.

Claims should be mailed to:

Dominion National
P.O. Box 1126
Elk Grove, IL 60009

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

Dedicated customer service

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

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

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

Web: **dominionnational.com/kaiserdentists**

Online self-service options

Dominion provides members with secure online access to:

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

All changes are confirmed by email.

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

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

KAISER PERMANENTE®

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. 2101 E. Jefferson St., Rockville, MD 20852 2019MC1442 MAS 9/1/19-9/1/20

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

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

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

DEDUCTIBLE
IN–PLAN: $25 per Member
OUT–OF–PLAN: $50 per Member

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

ANNUAL MAXIMUM
IN–PLAN: $1,000 per calendar year
OUT–OF–PLAN: $500 per calendar year

The dental plan is administered by Dominion Dental Services USA, Inc.

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

ADA CODE	DESCRIPTION OF SERVICES	YOU PAY IN PLAN TO DENTIST	YOU ARE REIMBURSED OUT OF PLAN
	Diagnostic Services		
D0120	Periodic oral evaluation	5	17
D0140	Limited oral eval. – problem focused	7	27
D0150	Comprehensive oral eval.	7	26
D0180	Comp. perio. eval. – not in conj. with D0150 and limited to 2 per 18 months	7	26
D0210	Intraoral – complete series of radiographic images	19	48
D0220	Intraoral – periapical first of radiographic image	3	9
D0230	Intraoral – periapical each additional of radiographic image	2	7
D0240	Intraoral – occlusal of radiographic image	4	14
D0270	Bitewing – single of radiographic image	3	9
D0272	Bitewings – two of radiographic images	4	15
D0274	Bitewings – four of radiographic images	7	22
D0277	Vertical bitewings – 7 to 8 of radiographic images	7	22
D0330	Panoramic of radiographic images	18	44
D0460	Pulp vitality tests	5	18
D0470	Diagnostic casts (not in conj. with Ortho)	15	37
D0999	Unspecified diagnostic procedure, by report	5	N/B
	Preventive Services		
D1110	Prophylaxis – adult	14	34

Description of Benefits and Member Copayments – Base Level POS Plan

ADA CODE	DESCRIPTION OF SERVICES	YOU PAY IN PLAN TO DENTIST	YOU ARE REIMBURSED OUT OF PLAN
D1120	Prophylaxis (cleaning) – child	7	22
D1206	Topical fluoride varnish	0	18
D1208	Topical application of fluoride – excluding varnish	0	18
D1330	Oral hygiene instructions	0	0
D1351	Sealant - per tooth	5	18
D1352	Prev.resin rest. mod/high caries risk – perm. tooth	5	18
D1354	Interim caries arresting medicament application - per tooth	0	15
D1510	Space maintainer – fixed – unilateral	42	110
D1516	Space maintainer – fixed – maxillary	78	200
D1517	Space maintainer – fixed – mandibular	78	200
D1520	Space maintainer – removable – unilateral	48	147
D1526	Space maintainer – removable – bilateral, maxillary	84	205
D1527	Space maintainer – removable – bilateral, mandibular	84	205
D1550	Re–cementation of space maintainer	7	22
D1575	Distal shoe space maintainers - fixed – unilateral	42	110
	Restorative Services		
D2140	Amalgam – 1 surface, prim. or perm.	39	25
D2150	Amalgam – 2 surfaces, prim. or perm.	49	33
D2160	Amalgam – 3 surfaces, prim. or perm.	61	39
D2161	Amalgam – 4 or more surfaces, prim. or perm.	76	48
D2330	Resin – based composite –1surface, ant.	47	30
D2331	Resin–based composite – 2 surfaces, ant.	61	39
D2332	Resin–based composite – 3 surfaces, ant.	76	48
D2335	Resin–based composite – 4 or more surfaces or involving Incisal angle (ant.)	82	55
D2391	Resin–based composite –1surface, post.	51	31
D2392	Resin–based composite – 2 surfaces, post.	67	45
D2393	Resin–based composite – 3 surfaces, post.	84	57
D2394	Resin–based composite – 4 or more surfaces, post.	97	66
D2510	Inlay – metallic – 1 surface	258	167
D2520	Inlay – metallic – 2 surfaces	291	188
D2530	Inlay – metallic – 3 or more surfaces	348	220
D2542	Onlay metallic – 2 surfaces	234	150
D2543	Onlay metallic – 3 surfaces	234	150
D2544	Onlay metallic – 4 or more surfaces	234	150
D2610	Inlay – porcelain/ceramic –1 surface	215	210
D2620	Inlay – porcelain/ceramic – 2 surfaces	321	220
D2630	Inlay – porcelain/ceramic – 3 or more surfaces	365	236
D2642	Onlay – porcelain/ceramic – two surfaces	189	124
D2643	Onlay – porcelain/ceramic – 3 surfaces	189	124
D2644	Dental onlay porcelain 4 or more surfaces	189	124
D2650	Inlay – resin–based composite –1 surface	215	210
D2651	Inlay – resin–based composite – 2 surfaces	321	220
D2652	Inlay – resin–based composite – 3 or more surfaces	365	236
D2710	Crown – resin (indirect)	159	102
D2712	Crown 3/4 resin–based composite (exclusive of veneers)	159	102

Description of Benefits and Member Copayments – Base Level POS Plan

ADA CODE	DESCRIPTION OF SERVICES	YOU PAY IN PLAN TO DENTIST	YOU ARE REIMBURSED OUT OF PLAN
D2740	Crown – porcelain/ceramic	437	279
D2750	Crown – porcelain fused to high noble metal	428	274
D2751	Crown – porcelain fused to predom. 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 predom. 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
D2930	Prefab. stainless steel crown – prim. tooth	96	60
D2931	Prefab. stainless steel crown – perm. tooth	96	65
D2932	Prefab. resin crown	96	60
D2934	Prefab. steel crown – prim. tooth	96	60
D2940	Protective restoration	33	21
D2941	Interim therapeutic restoration, prim. dentition	21	21
D2950	Core buildup, including any pins	96	60
D2951	Pin retention – per tooth, in add. to restoration	18	12
D2952	Post and core in add. to crown	126	81
D2954	Prefab. post and core in add. to crown	107	70
D2980	Crown repair necessitated by restorative material failure	72	48
D2981	Inlay repair necessitated by restorative material failure	72	48
D2982	Onlay repair necessitated by restorative material failure	72	48
	Endodontic Services		
D3110	Pulp cap – direct (excl. final restoration)	21	15
D3120	Pulp cap – indirect (excl. final restoration)	19	13
D3220	Therapeutic pulpotomy (excl. final restoration)	60	38
D3310	Endodontic therapy, anterior (excluding final restoration)	258	162
D3320	Endodontic therapy, premolar (excluding final restoration)	378	193
D3330	Endodontic therapy, molar tooth (excluding final restoration)	466	295
D3346	Retreatment of previous root canal therapy – anterior	320	187
D3347	Retreatment of previous root canal therapy – premolar	459	224
D3348	Retreatment of previous root canal therapy – molar	537	343
D3351	Apexification/recalcification – initial visit	107	70
D3352	Apexification/recalcification – interim medication replacement	107	70
D3353	Apexification/recalcification – final visit	107	70
D3355	Pulpal regeneration, initial visit	107	70
D3356	Pulpal regeneration, int. med. replacement	107	70
D3357	Pulpal regeneration, completion of treatment	107	70
D3410	Apicoectomy – anterior	329	210
D3421	Apicoectomy – premolar (first root)	359	231

ADA CODE	DESCRIPTION OF SERVICES	YOU PAY IN PLAN TO DENTIST	YOU ARE REIMBURSED OUT OF PLAN
D3425	Apicoectomy – molar (first root)	404	258
D3426	Apicoectomy (each add. root)	126	81
D3427	Periradicular surg. w/o apioectomy	307	189
D3428	Bone graft in conj. w/ periradicular surg., per tooth, single site	354	150
D3429	Bone graft in conj. w/ periradicular surg., each add. contiguous tooth in same site	177	75
D3430	Retrograde filling – per root	107	70
D3431	Biologic materials to aid soft/osseous tissue regn. in conj. w/ periradicular surg.	70	76
D3450	Root amputation – per root	205	129
D3920	Hemisection (incl. any root removal)	189	119
	Periodontic Services		
D4210	Gingivectomy or gingivoplasty – 4 or more teeth per quadrant	266	172
D4211	Gingivectomy or gingivoplasty –1 to 3 teeth, per quadrant	82	55
D4240	Gingival flap procedure, including root planing – 4 or more contiguous teeth	321	204
D4241	Gingival flap procedure, incl. root planing – 1 to 3 teeth, per quadrant	161	102
D4249	Clinical crown lengthening – hard tissue	365	231
D4260	Osseous (bone) surgery – 4 or more per quad.	530	338
D4261	Osseous (bone) surgery – 1 to 3 teeth, per quad.	266	170
D4263	Bone replacement graft – first site in quad.	354	150
D4264	Bone replacement graft, each add. site in quad.	177	75
D4265	Biologic material to aid in soft/osseous tissue	70	76
D4268	Surgical revision procedure, per tooth	335	215
D4270	Pedicle soft tissue graft procedure	354	226
D4275	Soft tissue allograft	411	263
D4276	Combined connective tissue and double pedicle	354	226
D4277	Free soft tissue graft, per tooth	389	161
D4278	Free soft tissue graft, each add. tooth	129	51
D4320	Provisional splinting – intracoronal	113	76
D4321	Provisional splinting – extracoronal	113	76
D4341	Perio scaling and root planing – 4 or more per quad.	113	76
D4342	Perio scaling and root planing – 1 to 3 teeth, per quad.	57	38
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation	7	17
D4355	Full mouth debridement	0	0
D4910	Periodontal maintenance	60	38
	Prosthetics – Removable		
D5110	Complete denture – maxillary	456	290
D5120	Complete denture – mandibular	456	290
D5130	Immediate denture – maxillary	492	317
D5140	Immediate denture – mandibular	492	317
D5211	Maxillary partial denture – resin base (incl. any conventional clasps, rests and teeth)	404	258
D5212	Mandibular partial denture – resin base (incl. any conventional clasps, rests and teeth)	404	258
D5213	Maxillary partial denture – cast metal framework with resin denture bases (incl. any conventional clasps, rests and teeth)	499	317
D5214	Mandibular partial denture – cast metal framework with resin denture bases (incl. any conventional clasps, rests and teeth)	499	317
D5221	Immediate maxillary partial denture	404	258

Description of Benefits and Member Copayments – Base Level POS Plan

ADA CODE	DESCRIPTION OF SERVICES	YOU PAY IN PLAN TO DENTIST	YOU ARE REIMBURSED OUT OF PLAN
D5222	Immediate mandibular partial denture	404	258
D5223	Immediate maxillary partial denture	499	317
D5224	Immediate mandibular partial denture	499	317
D5225	Maxillary partial denture	499	317
D5226	Mandibular partial denture	499	317
D5282	Removable unilateral partial denture – one piece cast metal, maxillary	272	172
D5283	Removable unilateral partial denture – one piece cast metal, mandibular	272	172
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/broken teeth (each tooth)	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 compl. maxillary denture (chairside)	101	65
D5731	Reline compl. mandibular denture (chairside)	101	65
D5740	Reline maxillary part. denture (chairside)	101	65
D5741	Reline mandibular part. denture (chairside)	101	65
D5750	Reline compl. maxillary denture (lab)	140	86
D5751	Reline compl. mandibular denture (lab)	140	86
D5760	Reline maxillary part. denture (lab)	140	86
D5761	Reline mandibular part. denture (lab)	140	86
D5820	Interim part. denture (maxillary)	175	113
D5821	Interim part. denture (mandibular)	175	113
D5850	Tissue conditioning, maxillary	49	33
D5851	Tissue conditioning, mandibular	45	31
	Prosthetics – Fixed		
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure	57	38
D6205	Pontic – indirect resin based composite	159	102
D6210	Pontic – cast high noble metal	411	263
D6211	Pontic – cast pred. base metal	378	226

Description of Benefits and Member Copayments – Base Level POS Plan

ADA CODE	DESCRIPTION OF SERVICES	YOU PAY IN PLAN TO DENTIST	YOU ARE REIMBURSED OUT OF PLAN
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 predom. metal	365	231
D6242	Pontic – porcelain fused to noble metal	397	252
D6545	Retainer – cast metal for resin bonded fixed	159	102
D6602	Retainer inlay – cast high noble metal, 2 surfaces	319	208
D6603	Retainer inlay – cast high noble metal, 3 or more surfaces	382	242
D6604	Retainer inlay – cast predom. base metal, 2 surfaces	319	208
D6605	Retainer inlay – cast predom. base metal, 3 or more surfaces	330	210
D6606	Retainer inlay – cast noble metal, 2 surfaces	291	188
D6607	Retainer inlay – cast noble metal, 3 or more surfaces	348	220
D6610	Retainer onlay – cast high noble metal, 2 surfaces	372	162
D6611	Retainer onlay cast high noble metal, 3 or more surfaces	407	176
D6612	Retainer onlay – cast predom. base metal, 2 surfaces	320	138
D6613	Retainer onlay – cast predom. base metal, 3 or more surfaces	355	153
D6614	Retainer onlay – cast noble metal, 2 surfaces	337	146
D6615	Retainer onlay cast noble metal, 3 or more 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 predom. 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 predom. 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 predom. base metal	373	241
D6792	Retainer crown – 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	23	16
D7140	Extraction, erupted tooth or exposed root	47	30
D7210	Extraction, erupted tooth req. elev	107	70
D7220	Removal of impacted tooth – soft tissue	132	86
D7230	Removal of impacted tooth – part. bony	165	102
D7240	Removal of impacted tooth – compl. bony	195	124
D7250	Removal of residual tooth roots	120	76
D7260	Oroantral fistula closure	302	193
D7261	Primary closure of a sinus perforation	302	193
D7270	Tooth reimplantation and/or stabilization of accidentally avulsed or displaced tooth	159	108
D7280	Exposure of an unerupted tooth	253	162
D7282	Mobiliz. of erupted or malpos. tooth–aid erupted	215	134

Description of Benefits and Member Copayments – Base Level POS Plan

ADA CODE	DESCRIPTION OF SERVICES	YOU PAY IN PLAN TO DENTIST	YOU ARE REIMBURSED OUT OF PLAN
D7283	Placement of device	126	81
D7285	Incisional biopsy of oral tissue – hard (bone, tooth)	120	81
D7286	Incisional biopsy of oral tissue – soft (all others)	140	91
D7287	Cytology sample collection	70	46
D7288	Brush biopsy – transepithelial sample collection	70	46
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	33	23
D7310	Alveoloplasty in conj. with extractions – per quad.	126	81
D7311	Alveoloplasty in conj. with extractions	63	41
D7320	Alveoloplasty not in conj. with extractions – per quad.	170	108
D7321	Alveoloplasty not in conj. with extractions	86	55
D7410	Excision of benign lesion up to 1.25 cm	170	108
D7411	Excision of benign lesion > 1.25 cm	272	172
D7412	Excision of benign lesion, complicated	299	189
D7450	Removal of benign odon cyst/tumor – diam <= 1.25cm	159	102
D7451	Removal of benign odon cyst/tumor – diam > 1.25cm	291	183
D7460	Removal of benign nonodon cyst/tumor – diam <=1.25cm	175	113
D7461	Removal of benign nonodon cyst/tumor – diam > 1.25cm	329	210
D7471	Removal of lateral exostosis	258	167
D7472	Removal of torus palatinus	258	167
D7473	Removal of torus mandibularis	258	167
D7485	Reduction of osseous tuberosity	258	167
D7510	Incision and drainage of abscess – intraoral soft tissue	82	55
D7511	Incision and drainage of abscess – intraoral	103	68
D7520	Incision/drainage of abscess – extra. soft tissue	120	76
D7521	Incision and drainage of abscess	150	94
D7530	Foreign body removal from muc./skin/subcut tissue	96	60
D7550	Partial ostect/sequestrect non–vital bone removal	132	156
D7910	Suture of recent small wounds up to 5 cm	43	28
D7911	Complicated suture – up to 5 cm	69	43
D7960	Frenulectomy (frenectomy or frenotomy) – separate procedure	215	134
D7963	Frenuloplasty	0	0
D7970	Excision of hyperplastic tissue – per arch	146	91
D7971	Excision of pericoronal gingiva	88	54
D7972	Surgical reduction of fibrous tuberosity	146	87
D7979	Non-surgical sialolithotomy	29	18
	Orthodontics		
D8070	Comp ortho treatment of the trans dentition	N/B	N/B
D8080	Comp. ortho treatment of the adol. dentition	N/B	N/B
D8670	Periodic orthodontic treatment visit	N/B	N/B
	Additional Procedures		
D9110	Palliative (emergency) treatment of dental pain – minor procedure	29	18
D9210	Local anesthesia not in conjunction with operative or surgical procedures	0	0
D9219	Evaluation for deep sedation or general anesthesia	0	0
D9222	Deep sedation/general anesthesia – first 15 min increment	27	44
D9223	Deep sedation/general anesthesia – each subsequent 15 min increment	27	44

Description of Benefits and Member Copayments – Base Level POS Plan

ADA CODE	DESCRIPTION OF SERVICES	YOU PAY IN PLAN TO DENTIST	YOU ARE REIMBURSED OUT OF PLAN
D9230	inhalation of nitrous oxide/analgesia, anxiolysis	21	15
D9239	Intravenous moderate sedation/analgesia – first 15 min increment	27	44
D9243	Intravenous moderate sedation/analgesia – each subsequent 15 min increment	27	44
D9310	Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)	36	30
D9440	Office visit – after reg.scheduled hours	30	NB
D9613	Infiltration of sustained release therapeutic drug – single or multiple sites	190	95
D9910	App.of desensitizing medication	16	10
D9942	Repair and/or reline of occlusal guard	61	55
D9944	Occlusal guard – hard appliance, full arch	198	170
D9945	Occlusal guard – soft appliance, full arch	198	170
D9946	Occlusal guard – hard appliance, partial arch	198	170
D9951	Occlusal adjustment – limited	37	38
D9952	Occlusal adjustment – complete	159	162
D9986	Missed appointment	50	50
D9995	Teledentistry – synchronous; real-time encounter	20	20
D9996	Teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review	20	20

KAISER PERMANENTE®

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

POINT-OF-SERVICE ADULT DENTAL RIDER

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

The following dental Services, for adults age 19 or older, shall be added to the Group Evidence of Coverage (EOC) to which this POS Adult Dental Rider (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 calendar year.

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

Deductible: The amount of charges you must pay during a calendar year for Covered Dental Services before Health Plan starts paying its cost share for these Services. The Deductible is shown on the attached Description of Benefits and Member Copayments.

Dental Administrator: 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 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 In-Plan 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, referrals to a Dental Specialist for specialty care services are strongly advised so as to assist with communications from the general dentist to the treating specialist. Please refer to the Description of Benefits and Member Copayments for those fees you will pay for In-Plan Services.

To receive Out-of-Plan Covered Dental Services, you may go to any Non-Participating Dental Provider. Please refer to the Description of Benefits and Member Copayments for 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.

It is also 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) at 703-518-5338, 1-855-733-7524 toll-free, or 711 (TTY).

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:

www.DominionNational.com/Kaiserdentists

Dominion National also provides many other secure features online at www.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. Referrals to a Dental Specialist for specialty care services are strongly advised so as to assist with communications from the general dentist to the treating specialist. The fees shown on the Description of Benefits and Member Copayments for Covered Dental Services will apply to the Services provided by the Dental Specialist.

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

A. 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 Adult 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 Adult 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.

B. 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 or non-participating 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 Dental Administrator. 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.

VI. ANNUAL DEDUCTIBLE

You are responsible for payment of a combined Deductible In-Plan and Out-of-Plan each calendar 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 calendar year. If a Member goes Out-of-Plan after having met the In-Plan Deductible, the In-Plan Deductible will apply toward the Out-of-Plan Deductible, and the Member will have to meet the balance of the Out-of-Plan Deductible before the Service will be covered.

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

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 calendar year. The Annual Maximum Benefit amount that Health Plan is obligated to pay, for each Member, each calendar year is listed in the Description of Benefits and Member Copayments. The amount that applies toward the Annual Maximum Benefit for In-Plan dental Services is based on the fee that the Dental Administrator has negotiated with the Participating Dental Provider, reduced by the fee you pay for the Covered Dental Service, if any, as shown on the Description of Benefits and Member Copayments. The amount that applies toward the annual Maximum Benefit for Out-of-Plan dental Services is the amount listed under "You Are Reimbursed Out-of-Plan" on the Description of Benefits and Member Copayments. You may call 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 calendar year. Dental Services provided In-Plan will continue to be covered until the Member has reached the In-Plan Annual Maximum Benefit. Once the In-Plan Annual Maximum Benefit has been reached, no additional dental Services will be covered for that Member for the rest of the calendar year.

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 provider's office. Claims can be submitted to Dominion National, P.O. Box 1126, Elk Grove Village, IL 60009. If you would like to request a claim form you may go online at www.dominionnational.com or 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, you may submit proof of loss by submitting, within the one (1) 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 receipt of the covered Services. Failure to submit such a request within one (1) year of receipt of the covered Services will not invalidate or reduce the amount of the claim, if it was not reasonably possible to submit the request within the aforementioned time frame. If it is not reasonably possible to submit the claim within one (1) year after the date of service, it shall be sent to us no later than two (2) years from the time, proof is otherwise required. A Member's legal incapacity shall suspend the time to submit a claim. Such suspension period ends when legal capacity is regained.

Benefits payable under the 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 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 "Health Care Service Review, Appeals and Grievances" section of the 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 and/or Employer's Liability laws.
2. Services which are provided without cost to Member by any federal, state, municipal, county, or other subdivision's program (with the exception of Medicaid).
3. Services which are not necessary for the patient's dental health as determined by the Plan.
4. Cosmetic, elective or aesthetic dentistry except as required due to accidental bodily injury to sound 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 as described in the Evidence of Coverage.
6. Drugs obtainable with or without a prescription, except as may be otherwise covered in your medical plan that is described in the Evidence of Coverage.
7. Hospitalization for any dental procedure.
8. Treatment required for conditions resulting from major disaster, epidemic, war or acts of war, whether declared or undeclared, or while on active duty as a member of the armed forces of any nation.
9. Replacement due to loss or theft of prosthetic appliance.
10. Services that cannot be performed because of the general health of the patient.
11. Implantation and related restorative procedures.
12. Procedures not listed as a Covered benefit under this Plan.
13. Services related to the treatment of TMD (Temporomandibular disorder).
14. Elective surgery including, but not limited to extraction of non-pathologic, asymptomatic impacted teeth as determined by the Plan.
15. Procedures relating to the change and maintenance of vertical dimension or major restoration of occlusion, or to alter the occlusion (bite) through full mouth adjustment/grinding of the teeth. This

does not exclude minor occlusal adjustments on individual teeth to remove high spots or smooth out rough or sharp areas.

16. Dental expenses incurred prior to your effective date of coverage.
17. Treatment of malignancies, neoplasm or congenital malformations, except as may be otherwise covered in your medical plan as described in the Evidence of Coverage.
18. Lab fees for excisions and biopsies, except as may be otherwise covered in your medical plan which is described in the Evidence of Coverage.
19. Experimental procedures, implantations, or pharmacological regimens.
20. Initial placement or replacement of fixed bridgework solely for the purpose of achieving periodontal stability.
21. Charges for second opinions, unless pre-authorized.
22. Procedures requiring fixed prosthodontic restoration, which are necessary for complete oral rehabilitation or reconstruction.
23. Occlusal guards, except for the purpose of controlling habitual grinding.

B. Limitations

Covered Dental Services are subject to the following 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. Two (2) teeth cleanings and fluoride applications are covered per calendar year.
4. One (1) interim caries arresting medicament application per primary tooth per lifetime.
5. Crown and bridge fees apply to treatment involving five or fewer units when presented in a single treatment plan. Additional crown or bridge units, beginning with the sixth unit, are available at the provider's Usual, Customary and Reasonable (UCR) fee, minus 25%.
6. One (1) set of full mouth x-rays or panoramic film is limited to one set every three years.
7. Retreatment of root canal within 2 years of the original treatment.
8. Coverage for periodontal surgery of any type, including any associated material is covered once every 36 months per quadrant or surgical site.
9. Coverage for root planing or scaling is limited to once every 24 months per quadrant.
10. Full mouth debridement is covered once per lifetime.
11. Periodontal maintenance after active therapy is limited to twice per 12 months within 24 months after definitive periodontal therapy.
12. Coverage for relining of dentures is limited to once every 12 months.
13. Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation and in lieu of a covered D1110, limited to once per two years.
14. Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure.
15. Teledentistry, synchronous (D9995) or asynchronous (D9996), limited to two per calendar year (when available).

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

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

By: _____

Mark Ruszczyk
Vice President, Marketing, Sales & Business Development