

SMILE FOR TOTAL HEALTH

A guide to your dental benefits:
Small Group Adult \$30 Preventive
and Pediatric Dental HMO with
Cosmetic Dental



The Adult \$30 Preventive and Pediatric Dental HMO with Cosmetic Dental plans emphasize healthy smiles through the prevention and early detection of dental problems to avoid costly procedures in the future. The combination of predictable costs, no deductibles, and no annual maximums helps you reach a state of good oral health without facing the high cost of treatment typical of many dental plans.

Your plan provides coverage—or access to a fixed fee schedule for certain non-covered dental services—for more than 250 dental procedures through one of the largest dental provider networks¹ in the Mid-Atlantic area.² You have your choice of convenient dental offices where you can receive care.

Adults pay a \$30 copay for each covered preventive care office visit, which may include:

- Up to two oral exams per contract year
- Up to two cleanings per contract year
- One fluoride treatment per contract year
- Up to two dental bitewing X-rays per contract year

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

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

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.

The preventive care procedures covered in this plan account for over 65% of dental services most frequently performed for adults, and almost 90% of the most frequently performed services for children. Other listed dental services are available for the fixed fees shown on the fee schedule, which you pay directly to your provider as payment in full.

Save on restorative care

More extensive care (fillings, crowns, dentures, root canals, periodontal treatment, oral surgery, etc.) is offered at fixed fees lower than the usual and customary charges for these services. Only the services listed on the fee schedule are available for fixed fees, provided the services are performed by plan-participating dentists and specialists. For a complete list of covered benefits, services, exclusions, and limitations, and terms for the fixed fees, please refer to your *Evidence of Coverage*, or you can find your plan on dominionnational.com/kaiserdentists.

¹Over 2,000 dentists in the Maryland, Virginia, and Washington, DC, area who participate in the Dominion National network.

²When services are received from our contracted dental provider network.

³Discounted rates for dental services are negotiated by the Program Administrator with participating providers. These negotiated rates are reflected in the fee schedule as fixed fees.

Cosmetic dental services

The brilliant, healthy smile you've always wanted can now be yours through Kaiser Permanente's Cosmetic Dental Services. Our program offers discounted fees for cosmetic and other dental services including:

- Teeth whitening
- Crowns
- Veneers
- Bonding
- Invisalign®
- Orthodontics
- And more

You'll enjoy great benefits, including:

- **Network dentists**¹ who meet highly selective credentialing standards
- **Discounts** of up to 75% on dental procedures.³
- **No deductibles** or annual maximums
- **No surprises.** For the majority of services, the program fee schedule reflects negotiated discounts and shows exactly what you'll pay

Choose a dentist

You may select any general dentist from among our participating dental providers for yourself and/or eligible family members. Each eligible family member may use a different participating dentist. For a list of participating dentists or information about a dentist, including office hours, directions, languages spoken, etc., visit dominionnational.com/kaiserdentists or call Dominion Member Services at 855-733-7524 (TTY 711), Monday through Friday, 7:30 a.m. to 6 p.m.

Specialty care is also available in many locations. To receive treatment from a participating specialist, ask your participating general dentist to arrange a referral. Services received from non-participating dentists are not covered.

Make appointments

After your effective date of coverage, you can make an appointment with a participating general dentist. Make sure you bring your Kaiser Permanente medical ID card to your appointment. To receive cosmetic dental services, you will also need to print and bring your cosmetic services ID card to your appointment. And you'll have virtually no paperwork and no pre-existing condition exclusions to worry about.

Quality dental care

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

Dedicated customer service

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

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

Mailing address:

Dominion National
251 18th 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 Foundation Health Plan of the Mid-Atlantic States, Inc.
Adult \$30 Preventive and Cosmetic Dental Plan
2020 Discounted Schedule of Dental Fees**

The fees listed below do not accumulate to the medical out-of-pocket maximum.

This Adult \$30 Preventive Dental and Cosmetic Dental Plan includes (a) coverage for preventive dental benefits for which fixed copayments are charged and (b) fixed fees for services that are not covered benefits but for which you are required to pay a pre-determined fee directly to the provider as payment in full. Procedures not shown in this list are not covered. Cosmetic Dental Services are also included in this Schedule of Dental Fees and are not covered benefits*. Please refer to the Adult and Cosmetic Dental Services Appendix for further details on the program along with exclusions and limitations.

Amounts quoted in the "You pay to Dentist" column apply only when performed by a participating general dentist. If specialty care is required, your general dentist must refer you to a participating specialist except for Cosmetic Services and as otherwise described in the Adult Dental Plan Appendix. Services received from non-participating dentists are not covered under this plan except for: (1) benefits provided under an authorized referral to a non-Participating dental provider under Section III.B of Appendix B; (b) dental emergencies as described in Section V. of Appendix B, ; and (3) Continuity of Care for new Members, as described in Section 2 of the contract form.

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

NOTE: The Schedule of Dental Fees is reviewed annually and is subject to change per the renewal period of this contract. Contact Dominion for details toll-free at 855-733-7524, Monday through Friday, 7:30 a.m. to 6 p.m., (TTY 711).

| ADA CODE | DESCRIPTION OF SERVICES | YOU PAY TO DENTIST | YOU PAY TO SPECIALIST |
|-------------|--|-----------------------|--------------------------|
| | <i>Diagnostic/Preventive</i> | | |
| D0120 | Periodic oral evaluation- established patient | FC\$30 | No Benefit |
| D0140 | Limited oral eval - problem focused | FC\$30 | No Benefit |
| D0150 | Comprehensive oral eval - new or established patient | FC\$30 | No Benefit |
| D0170 | Re-eval - limited, problem focused | FC\$30 | No Benefit |
| D0180 | Comp. periodontal eval - new or established patient | FC\$30 | No Benefit |
| D0210 | Intraoral – complete series of radiographic images | \$54 | \$69 |
| D0220 | Intraoral - periapical first radiographic image | FC\$30 | \$14 |
| D0230 | Intraoral - periapical each add. radiographic image | FC\$30 | \$11 |
| D0240 | Intraoral - occlusal radiographic image | FC\$30 | \$21 |
| D0250 | Extraoral – 2D projection radiographic image | FC\$30 | \$26 |
| D0270 | Bitewing - single radiographic image | FC\$30 | \$14 |
| D0272 | Bitewings - two radiographic images | FC\$30 | \$21 |
| D0273 | Bitewings - three radiographic images | FC\$30 | \$28 |
| D0274 | Bitewings - four radiographic images | FC\$30 | \$31 |
| D0277 | Vertical bitewings - 7 to 8 radiographic images | FC\$30 | \$47 |
| D0330 | Panoramic radiographic image | \$43 | \$43 |
| D0340 | 2D cephalometric radiographic image | FC\$30 | \$55 |
| D0350 | 2D oral/facial photographic images | FC\$30 | \$29 |
| D0351 | 3D photographic image | FC\$30 | \$32 |

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.

| ADA CODE | DESCRIPTION OF SERVICES | YOU PAY TO DENTIST | YOU PAY TO SPECIALIST |
|----------|---|--------------------|-----------------------|
| D0460 | Pulp vitality tests | FC\$30 | \$35 |
| D0470 | Diagnostic casts | FC\$30 | No Benefit |
| D1110 | Prophylaxis (cleaning) – adult | FC\$30 | No Benefit |
| D1110* | Additional cleaning (expecting mothers and Diabetics) | \$40 | \$40 |
| D1206 | Topical application of fluoride varnish | FC\$30 | No Benefit |
| D1208 | Topical application of fluoride – excluding varnish | FC\$30 | No Benefit |
| D1310 | Nutritional counseling for control of dental disease | FC\$30 | No Benefit |
| D1320 | Tobacco counseling for control and prev. of oral disease | FC\$30 | No Benefit |
| D1330 | Oral hygiene instructions | FC\$30 | No Benefit |
| D1352 | Prev resin rest. Mod/high caries risk – perm. Tooth | \$30 | No Benefit |
| D1354 | Interim caries arresting medicament application – per tooth | \$15 | No Benefit |
| | <i>Restorative Dentistry (Fillings)</i> | | |
| D2140 | Amalgam - 1 surface | \$68 | No Benefit |
| D2150 | Amalgam – 2 surfaces | \$88 | No Benefit |
| D2160 | Amalgam – 3 surfaces | \$105 | No Benefit |
| D2161 | Amalgam - >=4 surfaces | \$126 | No Benefit |
| D2330 | Resin-based composite -1 surface, anterior | \$83 | No Benefit |
| D2331 | Resin-based composite – 2 surfaces, anterior | \$105 | No Benefit |
| D2332 | Resin-based composite – 3 surfaces, anterior | \$129 | No Benefit |
| D2335 | Resin-based composite - >=4 surfaces, anterior | \$155 | No Benefit |
| D2390 | Resin-based composite crown, anterior | \$209 | No Benefit |
| D2391 | Resin-based composite – 1 surface, posterior | \$102 | No Benefit |
| D2392 | Resin-based composite - 2 surfaces, posterior | \$135 | No Benefit |
| D2393 | Resin-based composite 3 surfaces, posterior | \$164 | No Benefit |
| D2394 | Resin-based composite - >=4 surfaces, posterior | \$195 | No Benefit |
| | <i>Crowns & Bridges</i> | | |
| D2510 | Inlay – metallic – 1 surface | \$480 | No Benefit |
| D2520 | Inlay – metallic – 2 surfaces | \$544 | No Benefit |
| D2530 | Inlay – metallic – 3 or more surfaces | \$595 | No Benefit |
| D2542 | Onlay – metallic-2 surfaces | \$635 | No Benefit |
| D2543 | Onlay – metallic-3 surfaces | \$645 | No Benefit |
| D2544 | Onlay – metallic-4 or more surfaces | \$657 | No Benefit |
| D2610 | Inlay – porcelain/ceramic – 1 surface | \$541 | No Benefit |
| D2620 | Inlay – porcelain/ceramic – 2 surfaces | \$576 | No Benefit |
| D2630 | Inlay – porcelain/ceramic - >=3 surfaces | \$665 | No Benefit |
| D2642 | Onlay – porcelain/ceramic – 2 surfaces | \$616 | No Benefit |
| D2643 | Onlay – porcelain/ceramic – 3 surfaces | \$666 | No Benefit |
| D2644 | Onlay – porcelain/ceramic - >=4 surfaces | \$710 | No Benefit |
| D2650 | Inlay – resin-based composite – 1 surface | \$498 | No Benefit |
| D2651 | Inlay – resin-based composite – 2 surfaces | \$538 | No Benefit |
| D2652 | Inlay – resin-based composite - >=3 surfaces | \$699 | No Benefit |
| D2662 | Onlay – resin-based composite – 2 surfaces | \$568 | No Benefit |
| D2663 | Onlay – resin-based composite – 3 surfaces | \$699 | No Benefit |
| D2664 | Onlay – resin-based composite - >=4 surfaces | \$662 | No Benefit |
| D2710 | Crown – resin based composite (indirect) | \$277 | No Benefit |
| D2712 | Crown – 3/4 resin-based composite (exclusive of veneers) | \$255 | No Benefit |
| D2720 | Crown – resin with high noble metal | \$675 | No Benefit |
| D2721 | Crown – resin with predom. Base metal | \$601 | No Benefit |
| D2722 | Crown – resin with noble metal | \$628 | No Benefit |
| D2740 | Crown – porcelain/ceramic | \$730 | No Benefit |

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.

| ADA CODE | DESCRIPTION OF SERVICES | YOU PAY TO DENTIST | YOU PAY TO SPECIALIST |
|----------|---|--------------------|-----------------------|
| D2750 | Crown – porcelain fused to high noble metal | \$745 | No Benefit |
| D2751 | Crown – porcelain fused to predominantly base metal | \$640 | No Benefit |
| D2752 | Crown – porcelain fused to noble metal | \$679 | No Benefit |
| D2780 | Crown – 3/4 cast high noble metal | \$724 | No Benefit |
| D2781 | Crown – 3/4 cast predominantly base metal | \$566 | No Benefit |
| D2782 | Crown – 3/4 cast noble metal | \$611 | No Benefit |
| D2783 | Crown – 3/4 porcelain/ceramic | \$628 | No Benefit |
| D2790 | Crown – full cast high noble metal | \$675 | No Benefit |
| D2791 | Crown – full cast predominantly base metal | \$601 | No Benefit |
| D2792 | Crown – full cast noble metal | \$628 | No Benefit |
| D2794 | Crown – titanium | \$679 | No Benefit |
| D2910 | Recement inlay | \$68 | No Benefit |
| D2920 | Recement crown | \$68 | No Benefit |
| D2930 | Prefabricated stainless steel crown – primary tooth | \$141 | No Benefit |
| D2931 | Prefabricated stainless steel crown – permanent tooth | \$186 | No Benefit |
| D2932 | Prefabricated resin crown | \$254 | No Benefit |
| D2940 | Protective restoration | \$77 | No Benefit |
| D2941 | Interim therapeutic rest., prim. Dentition | \$49 | No Benefit |
| D2950 | Core buildup, including any pins | \$172 | No Benefit |
| D2951 | Pin retention – per tooth, in addition to restoration | \$40 | No Benefit |
| D2952 | Post and core in addition to crown | \$252 | No Benefit |
| D2954 | Prefab. post and core in addition to crown | \$224 | No Benefit |
| D2955 | Post removal (not in conj. With endo. Therapy) | \$194 | No Benefit |
| D2981 | Inlay repair necessitated by restorative material failure | \$138 | No Benefit |
| D2982 | Onlay repair necessitated by restorative material failure | \$138 | No Benefit |
| | Endodontic Services | | |
| D3110 | Pulp cap – direct (excl. final restoration) | \$47 | No Benefit |
| D3120 | Pulp cap – indirect (excl. final restoration) | \$47 | No Benefit |
| D3220 | Therapeutic pulpotomy (excl. final restor.) | \$104 | \$122 |
| D3221 | Pulpal debridement | \$123 | No Benefit |
| D3310 | Endodontic therapy, anterior tooth | \$436 | \$505 |
| D3320 | Endodontic therapy, premolar (excl. final restoration) | \$525 | \$604 |
| D3330 | Endodontic therapy, molar (excl. final restoration) | \$384 | \$789 |
| D3333 | Internal root repair of perforation defects | No Benefit | \$225 |
| D3346 | Retreat of prev. root canal therapy, ant. | No Benefit | \$609 |
| D3347 | Retreat of prev. root canal therapy, premolar | No Benefit | \$812 |
| D3348 | Retreat of prev. root canal therapy, molar | No Benefit | \$1047 |
| D3410 | Apicoectomy - anterior | \$422 | \$524 |
| D3421 | Apicoectomy - premolar (first root) | \$471 | \$655 |
| D3425 | Apicoectomy - molar (first root) | \$518 | \$687 |
| D3426 | Apicoectomy - (each add. root) | \$314 | \$371 |
| D3427 | Periradicular surg. w/o apicoectomy | \$402 | \$504 |
| D3430 | Retrograde filling – per root | \$118 | \$295 |
| D3450 | Root amputation - per root | \$205 | \$330 |
| D3920 | Hemisection, not inc. root canal therapy | \$258 | \$305 |
| D3950 | Canal prep/fitting of preformed dowel or post | \$154 | \$216 |
| | Periodontics | | |
| D4210 | Gingivectomy or gingivoplasty - >3 cont. teeth, per quad. | \$372 | \$439 |
| D4211 | Gingivectomy or gingivoplasty - <=3 teeth, per quad. | \$161 | \$190 |
| D4240 | Gingival flap proc., inc. root planing - >3 cont. teeth, per quad | \$479 | \$566 |

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| ADA CODE | DESCRIPTION OF SERVICES | YOU PAY TO DENTIST | YOU PAY TO SPECIALIST |
|----------|---|--------------------|-----------------------|
| D4241 | Gingival flap proc, inc. root planing - <=3 cont. teeth, per quad | \$121 | \$239 |
| D4260 | Osseous surgery - >3 cont. teeth, per quad | \$709 | \$836 |
| D4261 | Osseous surgery - <=3 cont. teeth, per quad | \$452 | \$534 |
| D4268 | Surgical revision proc., per tooth | \$389 | \$562 |
| D4274 | Mesial/distal wedge procedure, single tooth | \$329 | \$466 |
| D4341 | Perio scaling and root planing - >3 cont teeth, per quad. | \$137 | \$194 |
| D4342 | Perio scaling and root planing - <= 3 teeth, per quad | \$99 | \$117 |
| D4346 | Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation | \$76 | \$103 |
| D4355 | Full mouth debridement | \$121 | \$175 |
| D4381 | Localized delivery of antimicrobial agents | \$22 | \$44 |
| D4910 | Periodontal maintenance | \$82 | \$110 |
| | Prosthetics (Dentures) | | |
| D5110 | Complete denture - maxillary | \$845 | No Benefit |
| D5120 | Complete denture - mandibular | \$845 | No Benefit |
| D5130 | Immediate denture - maxillary | \$910 | No Benefit |
| D5140 | Immediate denture - mandibular | \$910 | No Benefit |
| D5211 | Maxillary partial denture - resin base | \$653 | No Benefit |
| D5212 | Mandibular partial denture - resin base | \$653 | No Benefit |
| D5213 | Maxillary partial dent. - cast metal | \$906 | No Benefit |
| D5214 | Mandibular partial dent. - cast metal | \$906 | No Benefit |
| D5221 | Immediate maxillary partial denture – resin base including any conventional clasps, rests and teeth | \$653 | No Benefit |
| D5222 | Immediate mandibular partial denture – resin base including any conventional clasps, rests and teeth | \$653 | No Benefit |
| D5223 | Immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) | \$906 | No Benefit |
| D5224 | Immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) | \$906 | No Benefit |
| D5225 | Maxillary partial denture - flexible base | \$904 | No Benefit |
| D5226 | Mandibular partial denture flexible base | \$1004 | No Benefit |
| D5282 | Removable unilateral partial denture - one piece cast metal, maxillary | \$510 | No Benefit |
| D5283 | Removable unilateral partial denture - one piece cast metal, mandibular | \$510 | No Benefit |
| D5410 | Adjust complete denture - maxillary | \$79 | No Benefit |
| D5411 | Adjust complete denture - mandibular | \$79 | No Benefit |
| D5421 | Adjust partial denture - maxillary | \$79 | No Benefit |
| D5422 | Adjust partial denture - mandibular | \$79 | No Benefit |
| D5511 | Repair broken complete denture base, mandibular | \$101 | No Benefit |
| D5512 | Repair broken complete denture base, maxillary | \$101 | No Benefit |
| D5520 | Replace missing or broken teeth - complete denture | \$77 | No Benefit |
| D5611 | Repair resin partial denture base, mandibular | \$102 | No Benefit |
| D5612 | Repair resin partial denture base, maxillary | \$102 | No Benefit |
| D5621 | Repair cast partial framework, mandibular | \$147 | No Benefit |
| D5622 | Repair cast partial framework, maxillary | \$147 | No Benefit |
| D5630 | Repair or replace broken retentive/clasping material – per tooth | \$139 | No Benefit |

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.

| ADA CODE | DESCRIPTION OF SERVICES | YOU PAY TO DENTIST | YOU PAY TO SPECIALIST |
|--------------------------------|--|--------------------|-----------------------|
| D5640 | Replace broken teeth - per tooth | \$88 | No Benefit |
| D5650 | Add tooth to existing partial denture | \$131 | No Benefit |
| D5660 | Add clasp to existing partial denture – per tooth | \$160 | No Benefit |
| D5670 | Replace all teeth and acrylic on cast metal framework (maxillary) | \$559 | No Benefit |
| D5671 | Replace all teeth and acrylic on cast metal framework (mandibular) | \$559 | No Benefit |
| D5710 | Rebase complete maxillary denture | \$344 | No Benefit |
| D5711 | Rebase complete mandibular denture | \$331 | No Benefit |
| D5720 | Rebase maxillary partial denture | \$265 | No Benefit |
| D5721 | Rebase mandibular partial denture | \$265 | No Benefit |
| D5730 | Reline complete maxillary denture (chairside) | \$214 | No Benefit |
| D5731 | Reline complete. mandibular denture (chairside) | \$215 | No Benefit |
| D5740 | Reline maxillary partial denture (chairside) | \$212 | No Benefit |
| D5741 | Reline mandibular partial denture (chairside) | \$212 | No Benefit |
| D5750 | Reline complete maxillary denture (laboratory) | \$260 | No Benefit |
| D5751 | Reline complete mandibular denture (lab) | \$258 | No Benefit |
| D5760 | Reline maxillary partial denture (lab) | \$250 | No Benefit |
| D5761 | Reline mandibular partial denture (lab) | \$249 | No Benefit |
| D5810 | Interim complete denture (maxillary) | \$549 | No Benefit |
| D5811 | Interim complete denture (mandibular) | \$400 | No Benefit |
| D5820 | Interim partial denture (maxillary) | \$424 | No Benefit |
| D5821 | Interim partial denture (mandibular) | \$429 | No Benefit |
| D5850 | Tissue conditioning, maxillary | \$120 | No Benefit |
| D5851 | Tissue conditioning, mandibular | \$121 | No Benefit |
| Bridges & Pontics ♦ | | | |
| D6000- D6199 | ALL IMPLANT SERVICES - 15% DISCOUNT (incl. D0360-D0363 cone beam imaging w/ implants) | | |
| D6081 | Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure | \$99 | No Benefit |
| D6210 | Pontic - cast high noble metal | \$610 | No Benefit |
| D6211 | Pontic - cast predom. base metal | \$624 | No Benefit |
| D6212 | Pontic - cast noble metal | \$586 | No Benefit |
| D6214 | Pontic – titanium | \$571 | No Benefit |
| D6240 | Pontic - porcelain fused to high noble metal | \$755 | No Benefit |
| D6241 | Pontic - porcelain fused to predom. base metal | \$653 | No Benefit |
| D6242 | Pontic - porcelain fused to noble metal | \$679 | No Benefit |
| D6245 | Pontic - porcelain./ceramic | \$741 | No Benefit |
| D6250 | Pontic - resin with high noble metal | \$745 | No Benefit |
| D6251 | Pontic - resin with predom.base metal | \$707 | No Benefit |
| D6252 | Pontic - resin with noble metal | \$717 | No Benefit |
| D6545 | Retainer - cast metal for resin bonded fixed prosthesis | \$270 | No Benefit |
| D6548 | Ret. - porc./ceramic for resin bonded fixed prosthesis | \$481 | No Benefit |
| D6549 | Resin retainer for resin bonded fixed prosthesis | \$270 | No Benefit |
| D6600 | Retainer inlay - porc./ceramic, two surfaces | \$400 | No Benefit |
| D6601 | Retainer inlay - porc./ceramic, >=3 surfaces | \$426 | No Benefit |
| D6602 | Retainer inlay - cast high noble metal, 2 surfaces | \$422 | No Benefit |
| D6603 | Retainer inlay - cast high noble metal, >=3 surfaces | \$468 | No Benefit |
| D6604 | Retainer inlay - cast predom. base metal, 2 surfaces | \$422 | No Benefit |
| D6605 | Retainer inlay - cast predom. base metal, >=3 surfaces | \$404 | No Benefit |

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.

| ADA CODE | DESCRIPTION OF SERVICES | YOU PAY TO DENTIST | YOU PAY TO SPECIALIST |
|----------|---|--------------------|-----------------------|
| D6606 | Retainer inlay - cast noble metal, two surfaces | \$384 | No Benefit |
| D6607 | Retainer inlay - cast noble metal, >=3 surfaces | \$426 | No Benefit |
| D6608 | Retainer onlay -porc./ceramic, two surfaces | \$437 | No Benefit |
| D6609 | Retainer onlay - porc./ceramic, >=3 surfaces | \$458 | No Benefit |
| D6610 | Retainer onlay - cast high noble metal, 2 surfaces | \$501 | No Benefit |
| D6611 | Retainer onlay - cast high noble metal, >=3 surfaces | \$548 | No Benefit |
| D6612 | Retainer onlay - cast predom. base metal, 2 surfaces | \$431 | No Benefit |
| D6613 | Retainer onlay - cast predom. base metal, >=3 surfaces | \$478 | No Benefit |
| D6614 | Retainer onlay - cast noble metal, two surfaces | \$454 | No Benefit |
| D6615 | Retainer onlay - cast noble metal, >=3 surfaces | \$501 | No Benefit |
| D6624 | Retainer inlay – titanium | \$468 | No Benefit |
| D6634 | Retainer onlay – titanium | \$548 | No Benefit |
| D6720 | Retainer crown - resin with high noble metal | \$747 | No Benefit |
| D6740 | Retainer crown - porc./ceramic | \$741 | No Benefit |
| D6750 | Retainer crown - porc. fused to high noble metal | \$639 | No Benefit |
| D6751 | Retainer crown - porc. fused to predom. base metal | \$571 | No Benefit |
| D6752 | Retainer crown - porc. fused to noble metal | \$599 | No Benefit |
| D6780 | Retainer crown - 3/4 cast high noble metal | \$724 | No Benefit |
| D6781 | Retainer crown - 3/4 cast predom. base metal | \$566 | No Benefit |
| D6782 | Retainer crown - 3/4 cast noble metal | \$578 | No Benefit |
| D6783 | Retainer crown - 3/4 porc./ceramic | \$808 | No Benefit |
| D6790 | Retainer crown - full cast high noble metal | \$675 | No Benefit |
| D6791 | Retainer crown - full cast predom. base metal | \$601 | No Benefit |
| D6792 | Retainer rown - full cast noble metal | \$628 | No Benefit |
| D6794 | Retainer crown – titanium | \$659 | No Benefit |
| D6930 | Recement fixed partial denture | \$88 | No Benefit |
| D6940 | Stress breaker | \$205 | No Benefit |
| D6980 | Fixed partial denture repair, by report | \$206 | No Benefit |
| | Oral Surgery | | |
| D7111 | Extraction, coronal remnants - primary tooth | \$72 | \$85 |
| D7140 | Extraction, erupted tooth or exposed root | \$83 | \$97 |
| D7210 | Extraction, erupted tooth req. elev, etc. | \$149 | \$176 |
| D7220 | Removal of impacted tooth - soft tissue | \$183 | \$216 |
| D7230 | Removal of impacted tooth - partially bony | \$250 | \$295 |
| D7240 | Removal of impacted tooth - completely bony | \$295 | \$347 |
| D7241 | Removal of imp. tooth - completely bony, with unusual surg. complications | \$363 | \$429 |
| D7250 | Removal of residual tooth roots | \$167 | \$199 |
| D7251 | Coronectomy - intentional partial tooth removal | \$363 | \$429 |
| D7270 | Tooth reimplant./stabiliz. of acc. evulsed/displaced tooth | \$279 | \$330 |
| D7280 | Exposure of an unerupted tooth | \$312 | \$369 |
| D7282 | Mobiliz. of erupted or malpos. tooth to aid eruption | \$96 | \$210 |
| D7285 | Incisional biopsy of oral tissue - hard (bone, tooth) | \$196 | \$231 |
| D7286 | Incisional biopsy of oral tissue - soft | \$184 | \$216 |
| D7291 | Transseptal fiberotomy/supra crestal fiberotomy, by report | \$142 | \$169 |
| D7310 | Alveoloplasty in conj. with extractions - per quadrant | \$150 | \$177 |
| D7311 | Alveoloplasty in conj. w/ extractions | \$130 | \$154 |
| D7320 | Alveoloplasty not in conj. with extractions - per quadrant | \$193 | \$227 |
| D7321 | Alveoloplasty not in conj. w/ extractions | \$40 | \$84 |
| D7471 | Removal of lateral exostosis | \$314 | \$370 |
| D7472 | Removal or torus palatinus | \$263 | \$311 |

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.

| ADA CODE | DESCRIPTION OF SERVICES | YOU PAY TO DENTIST | YOU PAY TO SPECIALIST |
|----------|---|--------------------|-----------------------|
| D7473 | Removal or torus mandibularis | \$271 | \$320 |
| D7485 | Reduction of osseous tuberosity | \$297 | \$351 |
| D7510 | Incision and drainage of abscess - intraoral soft tissue | \$108 | \$127 |
| D7511 | Incision and drainage of abscess – intraoral soft tissue comp. | \$226 | \$260 |
| D7910 | Suture of recent small wounds up to 5 cm | \$246 | \$290 |
| D7960 | Frenulectomy (frenectomy or frenotomy) - separate proc. | \$266 | \$314 |
| D7963 | Frenuloplasty | \$99 | \$245 |
| D7970 | Excision of hyperplastic tissue - per arch | \$456 | \$539 |
| D7971 | Excision of pericoronal gingiva | \$225 | \$265 |
| D7972 | Surgical reduction of fibrous tuberosity | \$78 | \$185 |
| D7979 | Non-surgical sialolithotomy | \$30 | \$75 |
| | Orthodontics- Pre- Authorization Required | | |
| D8070 | Comp. ortho treatment of the trans dentition | \$3304 | \$3304 |
| D8090 | Comp. ortho. treatment - adult dentition | \$3658 | \$3658 |
| D8660 | Pre-orthodontic treatment visit | \$413 | \$413 |
| D8670 | Periodic ortho. treatment visit (as part of contract) | \$118 | \$118 |
| D8680 | Orthodontic retention (rem. of appl. and placement of retainers) | \$516 | \$516 |
| | Adjunctive General Services | | |
| D9110 | Palliative (emergency) treatment of dental pain | \$30 | \$75 |
| D9210 | Local anesthesia not in conj. Operative/surg. procedures | \$0 | No Benefit |
| D9211 | Regional block anesthesia | \$0 | No Benefit |
| D9212 | Trigeminal division block anesthesia | \$0 | No Benefit |
| D9215 | Local anesthesia in conj. w/ operative/surg. procedures | \$0 | No Benefit |
| D9219 | Evaluation for deep sedation or general anesthesia | \$0 | No Benefit |
| D9222 | Deep sedation/general anesthesia - first 15 minute increment | \$61 | \$136 |
| D9223 | Deep sedation/general anesthesia each subsequent 15 minute increment | \$61 | \$136 |
| D9230 | Inhalation of nitrous oxide/analgesia, anxiolysis, | \$36 | \$41 |
| D9239 | IV moderate conscious sedation/analgesia – first 15 minute increment | \$61 | \$136 |
| D9243 | IV moderate conscious sedation/analgesia – each subsequent 15 minute increment | \$61 | \$136 |
| D9310 | Consultation (diagnostic service by non-treating dentist) | \$59 | \$96 |
| D9439 | Office visit - Not including an FC visit | \$10 | \$10 |
| D9440 | Office Visit - After Regularly Scheduled Hours | \$27 | \$111 |
| D9613 | Infiltration of sustained release therapeutic drug – single or multiple sites | \$190 | \$190 |
| D9910 | Application of desensitizing medicament | \$30 | \$60 |
| D9930 | Treatment of complications post-surgical | \$48 | \$48 |
| D9944 | Occlusal guard – hard appliance, full arch | \$338 | \$519 |
| D9945 | Occlusal guard – soft appliance, full arch | \$338 | \$519 |
| D9946 | Occlusal guard – hard appliance, partial arch | \$338 | \$519 |
| D9950 | Occlusion analysis - mounted case | \$169 | \$169 |
| D9951 | Occlusal adjustment - limited | \$88 | \$115 |
| D9952 | Occlusal adjustment - complete | \$372 | \$597 |
| D9986 | Missed appointment | \$50 | \$50 |
| D9995 | Teledentistry – synchronous; real-time encounter | \$20 | \$20 |
| D9996 | Teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review | \$20 | \$20 |

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.

| ADA CODE | DESCRIPTION OF COSMETIC SERVICES | YOU PAY TO DENTIST | YOU PAY TO SPECIALIST |
|----------|---|---------------------------|---------------------------|
| | <i>Crowns & Bridges ♦</i> | | |
| D2960 ** | Laminate labial veneer | \$533 ⁺ | No Benefit |
| D2961 ** | Lab labial veneer resin | \$960 ⁺ | No Benefit |
| D2962 ** | Lab labial veneer porcelain | \$1318 ⁺ | No Benefit |
| D2970 ** | Temp crown (fractured tooth) | \$188 ⁺ | No Benefit |
| D2980 ** | Crown repair necessitated by restorative material failure | \$138 ⁺ | No Benefit |
| | <i>Bridges & Pontics ♦</i> | | |
| D6721 ** | Crown - resin with predom. base metal | \$656 ⁺ | No Benefit |
| D6722 ** | Crown - resin with noble metal | \$676 ⁺ | No Benefit |
| | <i>Orthodontics- Pre- Authorization Required</i> | | |
| D8080 ** | Invisalign | 15% Discount ⁺ | 15% Discount ⁺ |
| | <i>Adjunctive General Services</i> | | |
| D9972 ** | External bleaching - per arch | \$265 ⁺ | No Benefit |
| D9979 ** | Laser Whitening - per arch | \$200 ⁺ | No Benefit |

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

+ Cost of these services are pre-negotiated discounted rates and payments are not applied toward covered benefits.

** Exclusions and limitations applicable to these procedures can be found in the Adult \$30 Preventive and Cosmetic Dental Plan Appendix.

* An additional cleaning is available for expecting mothers and Diabetics at the copayment listed.

Only current ADA CDT codes are considered valid by Dominion Dental Services, Inc.

Appendix – Adult Dental Benefit

The following dental services are included in the Kaiser Permanente Membership Agreement to which this Adult Dental Benefit is attached.

I. DEFINITIONS

The following terms, when capitalized and used in any part of this Adult Dental Benefit, mean:

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

Covered Preventive Care Dental Services includes, but is not limited to oral evaluation, cleaning and certain diagnostic X-rays.

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

Dental Fee means the discounted fees that a Participating Dental Provider charges you for a Covered Dental Service. Dental Fees are reviewed annually and subject to change upon renewal and only with 60 days advance notice.

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

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

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

II. GENERAL PROVISIONS

- A. Subject to the terms, conditions, limitations, and exclusions specified in the Agreement and this Adult Dental Benefit, you may receive Covered Preventive Care Dental and Covered Dental Services from Participating Dental Providers. In addition, you may receive services from non-participating dental providers for emergencies, urgent care received outside the plan's Service Area, and services obtained pursuant to a referral to a non-participating specialist.
- B. Health Plan has entered into an Agreement with Dental Administrator to provide Covered Preventive Care Dental Services and certain other Covered Dental Services through its Participating Dental Providers.
- C. Attached is a list of Covered Preventive Care Dental Services and other Covered Dental Services and the associated Dental Fees that you will be charged for each Service. You will pay a fixed copayment for each preventive care office visit during which Covered Preventive Care Dental Services are provided. The fixed copayment does not apply to the following preventive services: intraoral complete series of radiographic images (D0210), panoramic radiographic image (D0330), additional cleaning beyond benefit limitation (D1110* - an additional cleaning is available for expecting mothers and Diabetics), preventive resin restoration (D1352) and interim caries arresting medicament application per tooth (D1354). You will pay Dental Fees for certain other Covered Dental Services you receive from Participating Dental Providers. You will pay the applicable Dental Fee directly to the Participating Dental Provider at the time services are rendered. The Participating Dental Provider has agreed to accept that Dental Fee as payment in full of the Member's responsibility for that procedure. Neither Health Plan nor Dental Administrator are responsible for payment of these fees or for any fees incurred as the result of receipt of non-Covered Dental Services or any other non-covered dental service.

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

E. You may obtain a list of Participating Dental Providers, Covered Dental Services and Dental Fees by contacting Dental Administrator or the Health Plan’s Member Services Department at the following telephone numbers:

Toll-Free Number: 855.733.7524
TTY number is: 711

F. Dental Administrator: Health Plan has entered into an agreement with Dominion Dental Services USA, Inc. d/b/a Dominion National (“Dominion National”) to provide Covered Dental Services as described in this Adult Dental Benefit. 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: 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

G. 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 your General Dentist, you require the Services of a specialist, you may be referred to a Dental Specialist who will provide Covered Dental Services to you at the Dental Fee for each procedure rendered.

B. Non-Participating Specialist Referrals

Benefits may be provided for referrals to non-Participating Dental Provider specialists when:

1. You have been diagnosed by your General Dentist with a condition or disease that requires care from a dental specialist; and
2. Health Plan and Dental Administrator do not have a Participating Dental Provider specialist who possesses the professional training and expertise required to treat the condition or disease; or
3. Health Plan and Dental Administrator cannot provide reasonable access to a Dental Specialist with the professional training and expertise to treat the condition or disease without unreasonable delay or travel.

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

C. Standing Referrals to Dental Specialists

1. If you suffer from a life-threatening, degenerative, chronic or disabling disease or condition that requires specialized care, your General Dentist may determine, in consultation with you and the Dental Specialist, that you would be best served through the continued care of a Dental Specialist. In such instances, the General Dentist will issue a standing referral to the Dental Specialist.
2. The standing referral will be made in accordance with a written treatment plan developed by the General Dentist, Dental Specialist, and you. The treatment plan may limit the number of visits to the Dental Specialist or the period of time in which visits to the Dental Specialist are authorized. Health Plan retains the right to require the Dental Specialist to provide the General Dentist with ongoing communication regarding your treatment and dental health status.

IV. EXTENSION OF BENEFITS

A. In those instances when your coverage with Health Plan 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 Agreement and this Adult Dental Benefit 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 and this Adult Dental Benefit 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 Benefit Limitations:

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

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

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 \$50.00 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, VA 22202, ATTN: Accounting Dept. Coverage is provided for emergency dental treatment as may be required to alleviate pain, bleeding, or swelling. You must receive all post-emergency care from your Participating Dental Provider.

VI. EXCLUSIONS AND LIMITATIONS

A. Plan Exclusions

The following services are not covered under this Appendix:

1. Services which are covered under worker's compensation or employer's liability laws.
2. Services which are not necessary for the patient's dental health as determined by the Plan.
3. Cosmetic, elective or aesthetic dentistry except as required due to accidental bodily injury to sound natural teeth as determined by the Plan.
4. Oral surgery requiring the setting of fractures or dislocations except as may be otherwise covered in your medical plan which is described in the Evidence of Coverage.
5. Services with respect to malignancies, cysts or neoplasms, hereditary, congenital, anodontic, mandibular prognathism or development malformations where, in the opinion of the Plan, such services should not be performed in a dental office (except as may be otherwise covered in your medical plan as described in the *Evidence of Coverage*).
6. Dispensing of drugs, except as may be otherwise covered in your medical plan as is described in the Agreement.
7. Hospitalization for any dental procedure.
8. Treatment required for conditions resulting from major disaster, epidemic, war or acts of war, whether declared or undeclared, or while on active duty as a member of the armed forces of any nation.
9. Replacement due to loss or theft of prosthetic appliance.
10. Procedures not listed as a covered benefit under this Plan.
11. Services provided by a non-Participating Dental Provider that was not pre-authorized or otherwise approved by Health Plan, Participating Dental Provider or by the Dental Administrator (with the exception of out-of-area emergency or urgent care, covered dental services and services obtained pursuant to a referral to a non-participating specialist).
12. Services related to the treatment of TMD (Temporomandibular Disorder).
13. Services related to procedures that have such a degree of complexity as not to be performed by a general dentist, unless your participating general dentist refers you to a dental specialist in which case you will only be responsible for payment at the dental fee established by the Plan for each procedure rendered.
14. Elective surgery including, but not limited to, extraction of non-pathologic, asymptomatic impacted teeth as determined by the Plan.
15. The Invisalign system and similar specialized braces are not a covered benefit. Patient copayments will apply to the routine orthodontic appliance portion of services only. Additional costs incurred will become the patient's responsibility.
16. Services which are provided without cost to Member by any federal, state, municipal, county, or other political subdivision (with the exception of Medicaid).
17. Services that cannot be performed because of the general health of the patient.
18. Implantation and related restorative procedures.

19. Procedures relating to the change and maintenance of vertical dimension or major restoration of 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.
20. Lab Fees for excisions and biopsies, except as may be otherwise covered in your medical plan that is described in the Agreement.
21. Treatment of cleft palate, anodontia, malignancies or neoplasms, except as may be otherwise covered in your medical plan as described in Section 3 of the Agreement.
22. Experimental procedures, implantations, or pharmacological regimens which in the opinion of the attending dentist, are not necessary for the patient's dental health.
23. Initial placement or replacement of fixed bridgework solely for the purpose of achieving periodontal stability.
24. Charges for second opinions, unless pre-authorized.
25. Procedures requiring fixed prosthodontic restoration, which are necessary for complete oral rehabilitation or reconstruction.
26. Occlusal guards, except for the purpose of controlling habitual grinding.
27. Dental services for children under age 19.

B. Plan Limitations

Covered Dental Services are subject to the following limitations:

1. Two (2) evaluations are covered per calendar year, per patient, including a maximum of one (1) comprehensive evaluation, which is limited to one per calendar year.
2. One (1) problem focused evaluation is covered per calendar year.
3. Two (2) teeth cleanings are covered per calendar year. One additional cleaning is covered during pregnancy and for diabetic patients.
4. One (1) topical fluoride or fluoride varnish is covered per calendar year.
5. Two (2) sets of bitewing x-rays are covered per calendar year, per patient.
6. One (1) set of full mouth x-rays or panoramic film is covered every three (3) years.
7. One (1) interim caries arresting medicament application per primary tooth is covered per lifetime.
8. Replacement of a filling is covered if it is more than two (2) years from the original date of placement.
9. Replacement of a bridge, crown or denture is covered if it is more than seven (7) years from the date of original placement.
10. Crown and bridge fees apply to treatment involving five (5) or fewer units when presented in a single treatment plan. Additional crown or bridge units, beginning with the sixth unit, are available at the provider's Usual, Customary, and Reasonable (UCR) fee, minus 25%.
11. Relining and rebasing of dentures is limited to once every 24 months.
12. Retreatment of root canal is covered if it is more than two (2) years from the original treatment.
13. Root planing or scaling is covered once every 24 months per quadrant.
14. Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure, once per two years.
15. Full mouth debridement is limited to once per lifetime.
16. Procedure code D4381 is limited to one (1) benefit per tooth for three (3) teeth per quadrant or a total of 12 teeth for all four (4) quadrants per 12 months. Must have pocket depths of five (5) millimeters or greater.

17. Periodontal surgery of any type, including any associated material, is covered once every 36 months per quadrant or surgical site.
18. Periodontal maintenance after active therapy is covered twice per calendar year, within 24 months after definitive periodontal therapy.
19. Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation and in lieu of a covered D1110, limited to once per two years.
20. Coronectomy - intentional partial tooth removal, once per lifetime.
21. Teledentistry, synchronous (D9995) or asynchronous (D9996), limited to two per calendar year (when available).

This Adult Dental Benefit is subject to all the terms and conditions of the Agreement to which this Adult Dental Benefit is attached. This Adult Dental Benefit does not change any of those terms and conditions, unless specifically stated in this Adult Dental Benefit.

ADULT \$30 PREVENTIVE AND COSMETIC DENTAL PLAN

The following dental services are included in the Kaiser Permanente Membership Agreement to which this Adult Dental Benefit is attached.

I. DEFINITIONS

The following terms, when capitalized and used in any part of this Adult Dental Benefit, mean:

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

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

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

Dental Fee: means the discounted fees that a Participating Dental Provider charges you for a Covered Dental Service. Dental Fees are reviewed annually and are subject to change upon renewal and only with 60 days advance notice.

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

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

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

II. GENERAL PROVISIONS

- A.** Subject to the terms, conditions, limitations, and exclusions specified in the Agreement and this Adult Dental Benefit, you may receive Covered Preventive Care Dental and Covered Dental Services from Participating Dental Providers. In addition, you may receive services from non-participating dental providers for emergencies, urgent care received outside the plan's Service Area, and services obtained pursuant to a referral to a non-participating specialist.
- B.** Health Plan has entered into an Agreement with Dental Administrator to provide Covered Preventive Care Dental Services and certain other Covered Dental Services through its Participating Dental Providers.
- C.** Attached is a list of Covered Preventive Care Dental Services and other Covered Dental Services and the associated Dental Fees that you will be charged for each Service. You will pay a fixed copayment for each preventive care office visit during which Covered Preventive Care Dental Services are provided. The fixed copayment does not apply to the following preventive services: intraoral complete series of radiographic images (D0210), panoramic radiographic image (D0330), additional cleaning beyond benefit limitation (D1110*), preventive resin restoration (D1352) and interim caries arresting medicament application per tooth (D1354). You will pay Dental Fees for certain other Covered Dental Services you receive from Participating Dental Providers. You will pay the applicable Dental Fee directly to the Participating Dental Provider at the time services are rendered. The Participating Dental Provider has agreed to accept that Dental Fee as payment

in full of the Member's responsibility for that procedure. Neither Health Plan nor Dental Administrator are responsible for payment of these fees or for any fees incurred as the result of receipt of non-Covered Dental Services or any other non-covered dental service.

- D. You will receive a list of Participating Dental Providers from the Health Plan or from Dental Administrator. You should select a Participating Dental Provider, who is a "General Dentist", from whom you and your covered family members will receive Covered Preventive Care Dental Services and other Covered Dental Services. Specialty care is also available should such care be required, however, you must be referred to a Dental Specialist by your General Dentist. Your Dental Fees are usually higher for care received by a Dental Specialist.
- E. For assistance concerning the dental coverage benefit of your health insurance plan, you may contact the Health Plan's Member Services Department at the following telephone numbers:

Toll-Free Number: 800-777-7902
TTY number is: 711

- F. **Dental Administrator:** Health Plan has entered into an agreement with Dominion Dental Services USA, Inc. d/b/a Dominion National ("Dominion National") to provide Covered Dental Services as described in this Adult and Cosmetic Dental Plan. For assistance concerning dental coverage questions or for help finding a Participating Dental Provider or obtaining a list of Participating Dental Providers, 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 number is: 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

- G. **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 judgement of your General Dentist, you require the Services of a specialist, you may be referred to a Dental Specialist who will provide Covered Dental Services to you at the Dental Fee for each procedure rendered.

B. Non-Participating Specialist Referrals

Benefits may be provided for referrals to non-Participating Dental Provider specialists when:

1. You have been diagnosed by your General Dentist with a condition or disease that requires care from a dental specialist; and

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

The Member's cost share will be calculated as if the provider rendering the Covered Dental Services was a participating Dental provider.

C. Standing Referrals to Dental Specialists

1. If you suffer from a life-threatening, degenerative, chronic or disabling disease or condition that requires specialized care, your General Dentist may determine, in consultation with you and the Dental Specialist that you would be best served through the continued care of a Dental Specialist. In such instances, the General Dentist will issue a standing referral to the Dental Specialist.
2. The standing referral will be made in accordance with a written treatment plan developed by the General Dentist, Dental Specialist, and you. The treatment plan may limit the number of visits to the Dental Specialist or the period of time in which visits to the Dental Specialist are authorized. Health Plan retains the right to require the Dental Specialist to provide the General Dentist with ongoing communication regarding your treatment and dental health status.

IV. EXTENSION OF BENEFITS

A. In those instances when your coverage with Health Plan 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 Agreement and this Adult Dental Benefit 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 and this Adult Dental Benefit 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 when due;
2. Coverage ends as the result of you committing fraud or material misrepresentation;
3. When coverage is provided by a succeeding health plan, and that health plan's coverage:
 - a. Is provided at a cost to you that is less than or equal to the cost to you of the extended benefit available under this Adult Dental Benefit; and
 - b. Will not result in an interruption of the Covered Dental Services you are receiving.

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 \$50.00 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, VA 22202, ATTN: Accounting Dept. Coverage is provided for emergency dental treatment as may be required to alleviate pain, bleeding, or swelling. You must receive all post-emergency care from your Participating Dental Provider.

VI. EXCLUSIONS AND LIMITATIONS

A. Plan Exclusions

The following services are not covered under this Appendix:

1. Services which are covered under worker's compensation or employer's liability laws.
2. Services which are not necessary for the patient's dental health as determined by the Plan.
3. Cosmetic, elective or aesthetic dentistry except as required due to accidental bodily injury to sound natural teeth as determined by the Plan.
4. Oral surgery requiring the setting of fractures or dislocations except as may be otherwise covered in your medical plan which is described in the Evidence of Coverage.
5. Services with respect to malignancies, cysts or neoplasms, hereditary, congenital, anodontic, mandibular prognathism or development malformations where, in the opinion of the Plan, such services should not be performed in a dental office (except as may be otherwise covered in your medical plan as described in the Evidence of Coverage).
6. Dispensing of drugs, except as may be otherwise covered in your medical plan as is described in the Agreement.
7. Hospitalization for any dental procedure.
8. Treatment required for conditions resulting from major disaster, epidemic, war or acts of war, whether declared or undeclared, or while on active duty as a member of the armed forces of any nation.
9. Replacement due to loss or theft of prosthetic appliance.
10. Procedures not listed as a covered benefit under this Plan.
11. Services provided by a non-Participating Dental Provider that was not pre-authorized or otherwise approved by Health Plan, participating Dental Provider or by the Dental Administrator (with the exception of out-of-area emergency or urgent care, covered dental services and services obtained pursuant to a referral to a non-participating specialist).
12. Services related to the treatment of TMD (Temporomandibular Disorder).
13. Services related to procedures that have such a degree of complexity as not to be performed by a general dentist, unless your participating general dentist refers you to a dental specialist in which case you will only be responsible for payment at the dental fee established by the Plan for each procedure rendered.
14. Elective surgery including, but not limited to, extraction of non-pathologic, asymptomatic impacted teeth as determined by the Plan.

15. The Invisalign system and similar specialized braces are not a covered benefit. Patient copayments will apply to the routine orthodontic appliance portion of services only. Additional costs incurred will become the patient's responsibility.
16. Services which are provided without cost to Member by any federal, state, municipal, county, or other political subdivision (with the exception of Medicaid).
17. Services that cannot be performed because of the general health of the patient.
18. Implantation and related restorative procedures.
19. Procedures relating to the change and maintenance of vertical dimension or major restoration of 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.
20. Lab Fees for excisions and biopsies, except as may be otherwise covered in your medical plan that is described in the Agreement.
21. Treatment of cleft palate, anodontia, malignancies or neoplasms, except as may be otherwise covered in your medical plan as described in Section 3 of the Agreement.
22. Experimental procedures, implantations, or pharmacological regimens which in the opinion of the attending dentist, are not necessary for the patient's dental health.
23. Initial placement or replacement of fixed bridgework solely for the purpose of achieving periodontal stability.
24. Charges for second opinions, unless pre-authorized.
25. Procedures requiring fixed prosthodontic restoration, which are necessary for complete oral rehabilitation or reconstruction.
26. Occlusal guards, except for the purpose of controlling habitual grinding.
27. Dental services for children under age 19.

B. Plan Limitations

Covered Dental Services are subject to the following limitations:

1. Two (2) evaluations are covered per calendar year, per patient, including a maximum of one (1) comprehensive evaluation, which is limited to one per calendar year.
2. One (1) problem focused evaluation is covered per calendar year.
3. Two (2) teeth cleanings are covered per calendar year. One additional cleaning is covered during pregnancy and for diabetic patients.
4. One (1) topical fluoride or fluoride varnish is covered per calendar year.
5. Two (2) sets of bitewing x-rays are covered per calendar year, per patient.
6. One (1) set of full mouth x-rays or panoramic film is covered every three (3) years.
7. One (1) interim caries arresting medicament application per primary tooth is covered per lifetime.
8. Replacement of a filling is covered if it is more than two (2) years from the original date of placement.
9. Replacement of a bridge, crown or denture is covered if it is more than seven (7) years from the date of original placement.
10. Crown and bridge fees apply to treatment involving five (5) or fewer units when presented in a single treatment plan. Additional crown or bridge units, beginning with the sixth unit, are available at the provider's Usual, Customary, and Reasonable (UCR) fee, minus 25%.
11. Relining and rebasing of dentures is limited to once every 24 months.
12. Retreatment of root canal is covered if it is more than two (2) years from the original treatment.
13. Root planing or scaling is covered once every 24 months per quadrant.
14. Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure, once per two years.
15. Full mouth debridement is limited to once per lifetime.

16. Procedure code D4381 is limited to one (1) benefit per tooth for three (3) teeth per quadrant or a total of 12 teeth for all four (4) quadrants per 12 months. Must have pocket depths of five (5) millimeters or greater.
17. Periodontal surgery of any type, including any associated material, is covered once every 36 months per quadrant or surgical site.
18. Periodontal maintenance after active therapy is covered twice per calendar year, within 24 months after definitive periodontal therapy.
19. Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation and in lieu of a covered D1110, limited to once per two years.
20. Coronectomy - intentional partial tooth removal, once per lifetime.
21. Teledentistry, synchronous (D9995) or asynchronous (D9996), limited to two per calendar year (when available).

This Adult Dental Benefit is subject to all the terms and conditions of the Agreement to which this Adult Dental Benefit is attached. This Adult Dental Benefit does not change any of those terms and conditions, unless specifically stated in this Adult Dental Benefit.

ADULT \$30 PREVENTIVE AND COSMETIC DENTAL PLAN APPENDIX

I. DEFINITIONS

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

- A. Program** means the Total Cosmetic Dental Services program described in this Appendix.
- B. Program Administrator** is Dominion National, 251 18th Street South, Arlington VA 22202, phone 703-518-5000.
- C. Fee Schedule** amounts mean the amounts a member is responsible for paying directly to Participating Dentists for Cosmetic Dental Services at the time service is rendered as shown in the most current List of Services and Fee Schedule. The List of Services and Fee Schedule may be modified by Health Plan/Program Administrator consistent with terms of the Evidence of Coverage. Neither the Health Plan nor Program Administrator has any responsibility for any payment to a Participating Dentist for the provision of Cosmetic Dental Services or any other services to a Member.
- D. Participating Dentist(s)** means those independent licensed dentists who have contracted with the Program Administrator to provide Cosmetic Dental Services to Members. Participating Dentists are not employees of, nor supervised by, the Health Plan. The list of Participating Dentists is subject to change. The current list of Participating Dentists can be found at Kp.org/totalcosmeticdentalservices or a copy can be obtained from the Program Administrator or Health Plan.
- E. Cosmetic Dental Services** means those services shown on the List of Services and Fee Schedule that are included in the terms of this Program as modified by the list of exclusions and limitations shown below.

II. GENERAL PROVISIONS

Choice of Participating Dentist: You are responsible for arranging appointments for Cosmetic Dental Services directly with the Participating Dentist. You may receive Cosmetic Dental Services from any Participating Dentist. You are responsible for confirming that your dentist of choice is currently a Participating Dentist before you schedule Dental Services with the dentist through this Program.

Missed Appointment Fee: Participating Dentists may charge you an administrative fee if you miss a scheduled dental appointment without giving 24 hours advance notice to the dentist office. The missed appointment fee may vary depending on the Participating Dentist, however in no event shall the missed appointment fee exceed \$50 for a single visit.

Services: Only the Cosmetic Dental Services shown on the most current List of Services and Fee Schedule are offered by this Program. The discounted fixed fees shown on the Fee Schedule apply and cannot be combined with other discounts, programs and/or services. The Cosmetic Dental Services are not covered services and are not intended to duplicate services covered by your health plan coverage. Dental records of Members concerning Cosmetic Dental Services performed hereunder are the property of the Participating Dentist(s).

Payment of Fees: At the time of service, Member must show Health Plan ID Card, Total Cosmetic Dental Services ID Card or some other legal proof of identity. Also at time of service, Member is required to pay the required Service Fee directly to the Participating Dentist. All disputes about payment of such fees are between the Member and the Participating Dentist, and neither Health Plan nor Program Administrator have any responsibility or liability for those fees or payments. The discounted fixed fees listed on the Fee Schedule are guaranteed and the Member will not pay more than the discounted fee listed in the Fee Schedule for a Total Cosmetic Dental Service.

III. EXCLUSIONS AND LIMITATIONS

These Exclusions and Limitations apply solely to the Dental Services described in this Appendix relating to the Cosmetic Dental Program. They do not apply to other terms, including other exclusions and limitations, for benefits described elsewhere in this Evidence of Coverage.

A. Exclusions from Cosmetic Dental Services Program

The following services are not covered under this Appendix:

1. Oral Surgery requiring the setting of fractures or dislocations, except as may be otherwise included in the cosmetic and preventive dental services program fee schedule.
2. Services with respect to malignancies, cysts or neoplasms, hereditary, congenital, anodontic, mandibular prognathism or development malformations.
3. Dispensing of drugs, except as may be otherwise included in the Fee Schedule.
4. Hospitalization for any dental procedure.
5. Replacement due to loss or theft of prosthetic appliance.
6. Services related to procedures that are of such a degree of complexity as to not be normally performed by a participating dental provider, unless referred by your general dentist to a dental specialist who will provide dental services at the dental fee for each procedure rendered.
7. Services which are provided without cost to member by any federal, state, municipal, county, or other political subdivision (with the exception of Medicaid).
8. Services that cannot be performed because of the general health of the patient.
9. Lab fees for excisions and biopsies.
10. Procedures requiring fixed prosthodontic restoration, which are necessary for complete oral rehabilitation or reconstruction.
11. Dental expenses incurred in connection with any dental procedure that was started prior to the effective date. Examples include orthodontic work in progress, teeth prepared for crowns, and root canal therapy in progress.
12. Any bill, or demand for payment, for a dental service that the appropriate regulatory board determines was provided as a result of a prohibited referral. "Prohibited referral" means a referral prohibited by Section 1-302 of the Maryland Health Occupations Article.
13. Non-medically necessary orthodontia and Phase I Treatment for Medically Necessary orthodontia are not covered benefits under this policy. The provider agreements create no liability for payment by the Plan, and payments by the member for these services do not contribute to the Out-of-Pocket Maximum. The Invisalign system and similar specialized braces are not a covered benefit.

IV. NO REPRESENTATION OR WARRANTY; DISCLAIMER OF LIABILITY

Member acknowledges that Services are provided by Participating Dentists and arranged by the Program Administrator and that no Services are provided hereunder by Health Plan. HEALTH PLAN MAKES REPRESENTATIONS OR WARRANTIES, AND ACCEPTS NO LEGAL LIABILITY OR RESPONSIBILITY, FOR THE SERVICES MEMBER ELECTS TO RECEIVE FROM PARTICIPATING DENTISTS. IN NO EVENT WILL HEALTH PLAN BE LIABLE FOR ANY LOSS OR DAMAGE RESULTING FROM MEMBER'S RECEIPT OF SERVICES FROM PARTICIPATING DENTISTS.

V. COMPLAINTS

Complaints about services or quality of services or Payment of Fees should be brought to the attention of the Participating Dentist. If the issue is not resolved to the Member's satisfaction, Member may call the Program Administrator at the number shown below or send the complaint in writing to the Program Administrator AT:

Manager of Complaints and Appeals
Dominion National
251 18th Street South
Suite 900
Arlington, VA 22202
1-888-271-7310

If complaints are not resolved with the Program Administrator send the complaint in writing to:

Manager of Complaints
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
2101 East Jefferson Street,
Rockville, MD 20852